Queensland
Clinical Senate

Clinician leadership. Consumer collaboration. Better care.

Maximising Benefits of Care

1-2 August 2019 - Meeting Report

Queensland Government

Maximising Benefits of Care, Meeting Report

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Chairs' report

Not one of us comes to work with the intent of hurting our patients. But despite our best intentions, we know that we are often providing care that is of little or no benefit and can even harm our patients. Low benefit care consumes patient and staff time, costs money and reduces our capacity to deliver high benefit care.

In a health system that is under pressure from an ageing population and chronic disease, a growing population and decreasing workforce, we must find ways to ensure we are providing the right care, to the right patient at the right time.

Reducing low benefit care not only means we are providing better care to our patients, but it also ensures a more efficient and sustainable health system. If we want to reshape the care that we provide to our patients and ensure that the next generation has access to the same quality care that we expect, it's critical that we take action now. The health system is already in crisis.

As clinicians, it is our responsibility to lead this change and this is why the Queensland Clinical Senate, in partnership with the Statewide Clinical Networks brought together more than 170 of the state's most senior clinicians to determine what the priorities for change should be.

A number of priorities were identified and recommendations made (see next page) as to how this work can be progressed. We ask clinicians across the state to actively champion this work and look for opportunities to reduce low benefit care in your everyday practice. We must lead by example and question our drivers for doing a test or procedure - 'it's always been done this way' is not acceptable. In doing so, we will be educating the next generation of doctors and health professionals about low benefit care and the importance of thinking about the consequences of the decisions we make.

And we must empower consumers and their healthcare providers to discuss what care is needed, and identify which interventions are helpful and which are not. The B.R.A.N (Benefits, Risks, Alternatives, what if we do Nothing?) framework can help guide these conversations and make it easier to proceed (or not) when the choice is right. Consumers have a vital role to play in this space and we sincerely thank those consumers who gave up their time to be part of this conversation.

While this is a complex space, both because of the reasons behind it and the challenge of how we are going to improve it, Queensland clinicians are in a unique position. We can start by asking patients *what matters to them*, rather than *what is the matter with them.* And we should bring B.R.A.N into every consultation—just because we can do a test or treatment doesn't mean we should. With the help of managers who can ensure meaningful data is available, clinicians will know how they compare with peers in what they do and the outcomes – clinical, consumer-reported and value.

We have been entrusted by Queensland Health to identify where change can be made and to drive that change. Let's not waste this opportunity to be the leaders in this space and reduce care that is not helping, even harming, those who trust us to provide the best possible care and outcomes.

Dr Alex Markwell
Chair
Queensland Clinical Senate

Prof Liz Kenny AO
Chair
Queensland Clinical Networks Executive

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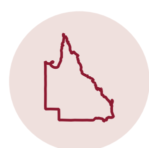
August 2019

Recommendations

The Queensland Clinical Senate believes there is an individual and collective responsibility of all those in the health system, including consumers, to identify and reduce any care provided to patients that is of low benefit. At its August 2019 meeting the Senate identified the following key recommendations:



1. Statewide Priorities

While there are many procedures and interventions that may provide little or no benefit to patients, attendees at the August 2019 Senate meeting identified the following as key priorities for Queensland Health in collaboration with consumers to collectively pursue:

a. Improving the **quality use of medicines** to optimize care in
frail and older patients

b. Improving end of **life planning** and care in end-stage disease

c. 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

» Use of evidence-based approaches such as public statements of intent to **demonstrate an organisational commitment** to interventions which reduce low benefit care, including promotion of the Choosing Wisely “5 Questions” approach (refer to Appendix 3 for more detail), and

– 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 impact of any interventions for reducing low benefit care.

2. Improve data quality

Improve data quality across the following aspects to ensure meaningful information is provided to clinicians:

a. Collection

b. Analysis

c. Interpretation

d. Availability.

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3. Become a Choosing Wisely hospital and health service

Encourage healthcare organisations across Queensland to become **Choosing Wisely Australia** '*Champion Health Services*' or familiarise themselves with the relevant tools

a. http://www.choosingwisely.org.au/members/champion-health-services

b. Link with existing Queensland Health Choosing Wisely Australia Champion organisations:

1. Gold Coast Hospital and Health Service
2. Mackay Hospital and Health Service
3. Metro South Hospital and Health Service
4. Royal Brisbane and Women's Hospital
5. Sunshine Coast Hospital and Health Service
6. Wide Bay Hospital and Health Service.

4. Establish, support and promote clinical and consumer champions

Establish, support and promote **clinical and consumer champions** to lead and assist in the reduction of low benefit care locally.

5. Endorse and empower health consumers

Endorse and **empower health consumers**, and health consumer groups (such as Hospital and Health Service Consumer Advisory Groups) to help drive the reduction of low benefit care.

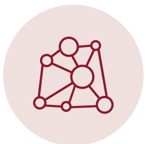
6. Grow local knowledge and expertise about change management

Grow local knowledge and expertise about **change management** with regard to adopting innovation and efficiency by identifying:

a. existing expertise in Queensland Health

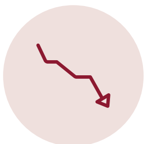
b. characteristics for successful sustained change

c. methods for widespread adoption of change



7. Strengthen connections

Strengthen connections with **primary care services** around referrals into the acute system and **reducing preventable hospital presentations and admissions**.



8. Reduce instances of low benefit care

Encourage or **incentivise facilities/hospital departments** to identify and reduce instances of low benefit care by ensuring any savings realised through the reduction of low benefit care is reinvested in high benefit care.

For more information please see the Maximising benefits of care report

Introduction

Despite wanting to do our best for our patients, we still provide care that is of low benefit to patients. It is a poor use of patient's time and energy, bringing little or no benefit, and even causing harm. It distracts our teams, reduces our capacity to provide high benefit care and is costly.

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.

The Senate meeting

The Queensland Clinical Senate, in partnership with the Statewide Clinical Networks, brought together more than 170 clinicians, consumers and health executives from across the state to showcase low benefit care programs (see appendix one) and select treatments and procedures identified as low benefit that could become the priorities for change in Queensland. See appendix two for the methodology used to identify the priorities. The Senate has had two previous meetings about this topic – high value innovative models of care and unexplained variation.

Speakers and panellists

Meeting facilitator: Prof Louise Cullen, Eminent Staff Specialist, Emergency & Trauma Centre, Royal Brisbane and Women's Hospital

Dr Stuart Bade, Chief of Surgery, Queensland Children's Hospital

Dr Deborah Cole, Chief Executive, Dental Health Services Victoria

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

Mr Shaun Drummond, Chief Executive, Metro South Hospital and Health Service

Dr Erin Evans, Chair, Health Consumers Queensland

Dr David Farlow, Executive Director Research/Innovation Mackay Hospital and Health Service

Ms Melissa Fox, Chief Executive Officer, Health Consumers Queensland

Prof Paul Glasziou, Director, Institute of Evidence-based HealthCare, Bond University

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

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

Prof Liz Kenny AO, Chair, Queensland Clinical Networks Executive

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

Dr Robyn Lindner, Client Relations Manager, NPS MedicineWise
Ms Alisha Lucas, Director Health Information Services, Royal Brisbane and Women’s Hospital
Dr Lawrence Malisano, Co-Clinical Lead, Getting it right first time
Dr Catherine McDougall, Co-Clinical Lead, Getting It Right First Time
Prof Keith McNeil, Assistant Deputy Director-General and Chief Clinical Information Officer, Clinical Excellence Queensland
Dr Kowsi Murugappan, Breast and Endocrine Surgeon, Royal Brisbane and Women’s Hospital
Mr Gary Power, Health Consumer Representative
Prof Ian Scott, Chair, Statewide General Medicine Clinical Network
Dr Dale Steinhardt, Data analyst, Statistical Analysis and Linkage team
Ms Jessica Toleman, Acting Executive Director Women’s and Newborn Services Royal Brisbane and Women’s Hospital
Dr Kerstin Wyssusek, Director, Department of Anaesthetics and Perioperative Medicine, Royal Brisbane and Women’s Hospital

Key messages

- In 2017, the Organisation for Economic Co-operation and Development (OECD) flagged that as much as 30 per cent of our healthcare is wasteful or could be classified as low value.
- There is an opportunity to modify 20-40 per cent of our current practice to ensure we are giving the right care to our patients.
- Low benefit care can be divided into over-diagnosis and overtreatment. Over-diagnosis is diagnosing something that never would have disturbed a person in their lifetime. For example, 40 per cent of all prostate cancers that are now detected would never have presented in the patient's lifetime. Overtreatment is the provision of unhelpful and unnecessary treatment for the correct diagnosis. For example, knee arthroscopy as a therapeutic intervention for osteoarthritis.
- We need to increase awareness among consumers about overtreatment and over-diagnosis and that this can potentially do more harm than no treatment and no diagnosis.
- Medical training programs need to instil a value-based cost-conscious ethic. The United States, and to a lesser extent the United Kingdom, are doing this now and the benefits are beginning to show.
- Despite the evidence, we are not achieving the required quantum of cultural change. Change takes time – up to 17 years to get traction.
- The evidence suggests that top-down approaches don't work in this space – it is critical that clinicians, clinical networks and senior leaders take the lead. Engagement of clinicians and consumers statewide and locally is essential.
- Working with consumers to co-design change is vital – consumers must be involved from the beginning.
- There are varying levels of change and progress across the State's Hospital and Health Services.
- Statewide Clinical Networks are progressing a number of programs to reduce low benefit care in Queensland, including renal artery angioplasty for hypertension and the use of endoscopy in dyspepsia.
- Barriers to change: activity-based funding, patient expectation, time needed to make change, issues and challenges of measuring clinical activity, minimal access to systems required to measure benefit or harm, external factors influencing decisions, emerging and new technology.
- Embed the reduction of low value care into the way we do things.
- Data are essential in helping to choose priorities and evaluate whether the changes are making a positive difference.
- The imperative is now – change must start, even if it is small incremental changes in the beginning. If we don't begin to own this change and drive this change, we will have an unsustainable health care system.

Prof Louise Cullen, Meeting Facilitator and Eminent Staff Specialist, Emergency and Trauma Centre, RBWH
'This has got to be a movement, a cultural change and a different way that we do business. We have to start, and we have to start now. I am genuinely concerned that if we don't begin to own this problem now, our grandchildren won't get the same quality care that we get now.'
19/09/2019

Dr Robyn Lindner, NPS MedicineWise
'When health professionals know they are undertaking a treatment, test or procedure that isn't in the best interests of patients, there are varied and complex drivers behind that, from systems-based issues, a patient is demanding the treatment, or perceived inappropriate referrals.'

Dr Paul Glasziou, Institute of Evidence-Based Healthcare, Bond University
'Over-diagnosis is occurring across the board in virtually every area of medicine.'

Dr Lawrence Malisano, Co-Clinical Lead, Getting it Right First Time
'If clinicians don't lead this there will be an external party that will, and while I am nervous about what that will do for clinicians, I am terrified about what that will do for patients.'

Prof Ian Scott, Chair, Statewide General Medicine Clinical Network

'We have reached a pendulum where we are just not getting the quantum of benefit at a population level that we did 30-40 years ago and that's our problem – it's us, the clinicians and users of technology. The responsibility lies primarily with clinicians, in partnership with consumers.'

Ms Melissa Fox, Chief Executive, Health Consumers Queensland
'It's not just about consumers being involved in their own care but also about consumers being involved in conversations like these at the Senate – being involved in identifying the problems with clinicians and coming up with solutions.'

Ms Jane Hancock, Chief Executive, Central West Hospital and Health Service
'If we don't address this, the health and wellbeing of the workforce and the ability to attract staff will become increasingly problematic.'

Prof Liz Kenny AO, Chair, Queensland Clinical Networks Executive
'This is a unique opportunity for the clinicians of Queensland. Really the only way the Department (of Health) can manage demand is simply to stop paying for things, and so we either just let that happen, or we as clinicians in partnership with consumers take the reins. There is a big responsibility on our shoulders.'

Meeting facilitator Prof Louise Cullen with Queensland Senate Chair, Dr Alex Markwell.

Dr Robyn Lindner, NPS MedicineWise, Prof Ian Scott, Statewide General Medicine Clinical Network with Dr Lawrence Malisano, Getting it Right First Time.

The consumer voice is vital to all of our discussions. Thank you Health Consumers Queensland.

More than 170 clinicians, consumers and health service executives attended the Senate meeting.

Dr David Rimmer and Anthony West from Central West Hospital and Health Service.

Queensland Clinical Networks Executive Chair Prof Liz Kenny AO with Queensland Clinical Senate Chair Dr Alex Markwell.

Next steps

The recommendations contained in this report will be presented to the Department of Health for endorsement. The Senate will then partner with relevant organisational units to progress endorsed recommendations.

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.

The Senate will explore opportunities for follow-up meeting/s on this topic.

Special thanks to

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

Director-General, Queensland Health, Mr Michael Walsh

Deputy Director-General, Clinical Excellence Queensland, Dr John Wakefield

Clinical Excellence Queensland

Songwoman Maroochy

Organising committee

Dr Alex Markwell, Chair, Queensland Clinical Senate

Dr Erin Evans, Chair, Health Consumers Queensland

Prof Louise Cullen, Eminent Staff Specialist, Emergency and Trauma Centre, Royal Brisbane and Women's Hospital

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 AO, Chair, Queensland Clinical Networks Executive

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

Ms Champs 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

Appendices

Appendix 1 - Low Benefit Care program showcase

Name	Description	Contact
Getting it Right First Time (GIRFT)	A clinician-led program that uses data to decrease unwarranted variation to improve care and reduce costs and unnecessary procedures.	Clinical Leads Dr Catherine McDougall and Dr Lawrence Malisano
Promoting Value-based Care in Emergency Departments (PROV-ED)	The PROV-ED Project supports widespread implementation of established clinical redesign initiatives to improve value-based care of patients presenting to emergency departments across Queensland Health.	Prof Louise Cullen, Eminent Staff Specialist, Emergency and Trauma Centre, RBWH
HealthPathways	HealthPathways is a web-based portal with evidence-based information on the assessment and management of common clinical conditions including referral guidance. The pathways are written by general practitioners with support from local GPs, hospital-based specialists and other subject matter experts.	Dr Carl de Wet, GP/GPLO Gold Coast Hospital and Health Service Dr Jon Harper, Sunshine Coast Primary Health Network
National Surgical Quality Improvement Program (NSQIP)	NSQIP is a risk-adjusted data-driven program that looks at outcomes after surgical procedures, enabling clinicians to identify quality improvement projects, patient care and outcomes and healthcare costs. Currently being piloted in Queensland at Queensland Children's Hospital, Logan and Redcliffe hospitals.	Dr Brian McGowan, Director of Surgery, Logan Hospital
RBWH Choosing Wisely – Local anaesthetics project	An education program that empowered scrub nurses to offer surgical staff more cost-effective options for incisional local anaesthetic infiltration.	Dr Kerstin Wyssusek, Director, Department of Anaesthetics and Perioperative Medicine, Metro North Hospital and Health Service.

Appendix 2 - Methodology

To prioritise areas of change for Queensland, meeting delegates and their organisations participated as follows:

1. Prior to the Senate meeting, Hospital and Health Services (HHS), Statewide Clinical Networks (SCNs) and other member organisations were provided with lists of low benefit care procedures and interventions [Choosing Wisely (194 items) and the 27 items identified by Prof Adam Elshaug et al in Low-value care in Australia public hospitals: prevalence and trends over time]. They were asked to identify key low benefit care priorities relevant to the healthcare they deliver, that could be considered for potential reduction as well as any additional priorities to consider. These responses were then shortlisted for further consideration at the Senate meeting.
2. During the table work sessions at the Senate meeting, participants (grouped geographically or by clusters of SCNs, etc.), identified 3 priorities for the state and 2 priorities for their local area/organisation.
3. Participants then explored issues around the measurement of these priority areas and identified the components of a Queensland Health implementation plan using the Choosing Wisely Toolkit as a template.
4. Finally, attendees identified clinical and system leaders/champions to drive action forward.

Appendix 3 – Public statement of intent / compact

Empowering and educating consumers and clinicians can be more effective if organisations make a public statement of intent (compact), whereby, next to, or with, the Choosing Wisely Australia 5 questions (see below), there is a message that proclaims that particular organisation as one that:

1. avoids low benefit care,
2. wants to actively engage consumers in every clinical interaction in ensuring all care is of high value, and
3. has already undertaken, or is currently undertaking, with summarised examples, several low benefit care interventions.

Randomised control trials have shown that such publicly displayed compacts for specific interventions (such as not giving antibiotics for viral infections) actually reduce low benefit care.

The Choosing Wisely Australia 5 questions to ask your doctor or healthcare provider before you get any test, treatment or procedure:

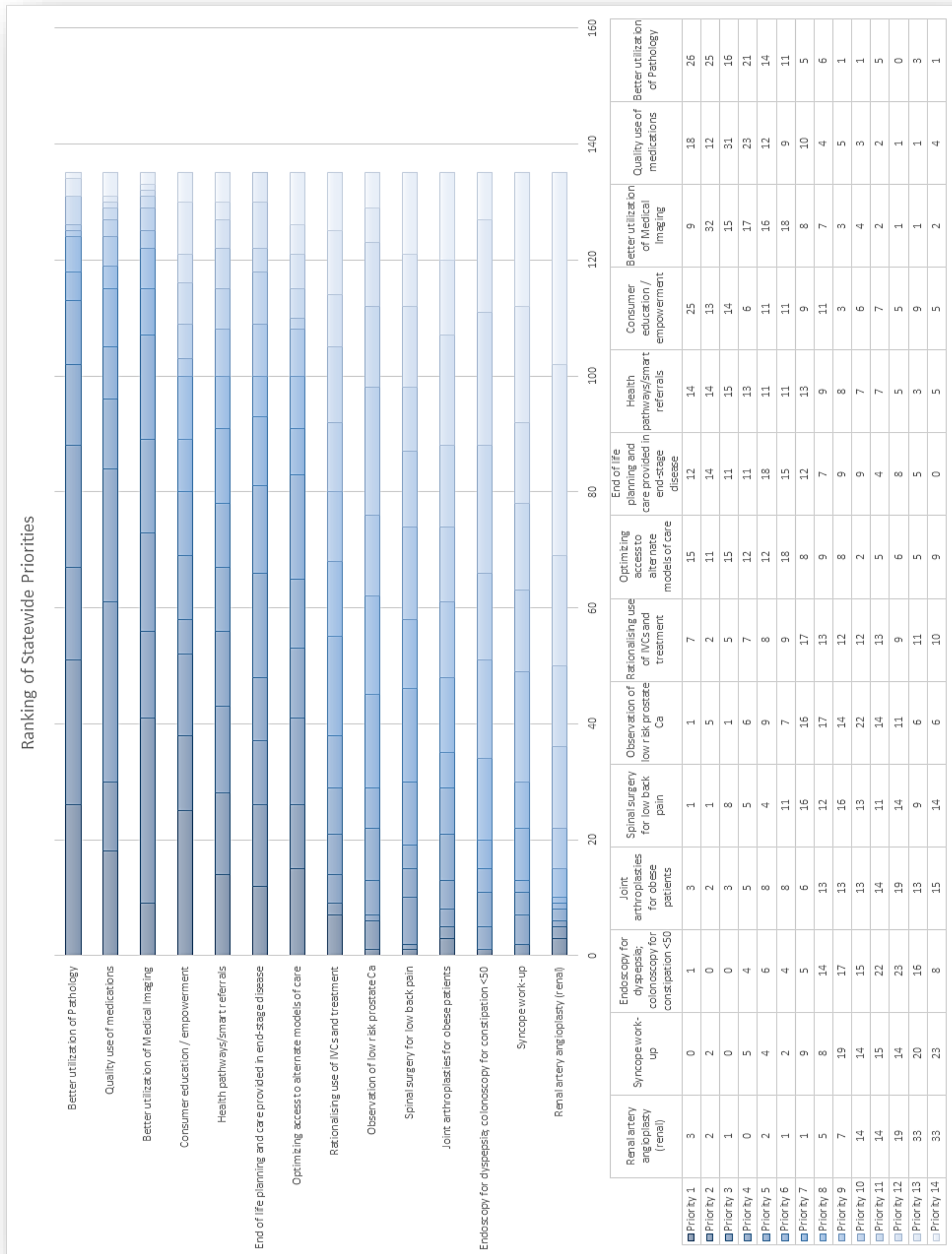
1. Do I really need this test, treatment or procedure?
2. What are the risks?
3. Are there simpler, safer options?
4. What happens if I don't do anything?
5. What are the costs?

Appendix 4 – Improving care at the end of life in Queensland

The Statewide strategy for end-of-life care 2015 is intended to integrate care at the end of life as a core element of health services in Queensland. Visit the website to find out more: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/end-of-life/strategy

Appendix 5 - Summary of table work

Approximately 170 attendees participated in the workshop and feedback sessions, using a live digital polling solution. Attendees responded to queries relating to the prioritisation of high value care (Figures 1-5), as well as three open ended questions relating to the measurement, implementation and accountability for high value care activities (tables 1-3).



	Renal artery angioplasty (renal)	Syncope work-up	Endoscopy for dyspepsia; colonoscopy for constipation <50	Joint arthroplasties for obese patients	Spinal surgery for low back pain	Observation of low risk prostate Ca	Rationalising use of IVCs and treatment	Optimizing access to alternate models of care	End of life planning and care provided in end-stage disease	Health pathways/smart referrals	Consumer education / empowerment	Better utilization of Medical Imaging	Quality use of medications	Better utilization of Pathology
Priority 1	3	0	1	3	1	1	7	15	12	14	25	9	18	26
Priority 2	2	2	0	2	1	5	2	11	14	14	13	32	12	25
Priority 3	1	0	0	3	8	1	5	15	11	15	14	15	31	16
Priority 4	0	5	4	5	5	6	7	12	11	13	6	17	23	21
Priority 5	2	4	6	8	4	9	8	12	18	11	11	16	12	14
Priority 6	1	2	4	8	11	7	9	18	15	11	11	18	9	11
Priority 7	1	9	5	6	16	16	17	8	12	13	9	8	10	5
Priority 8	5	8	14	13	12	17	13	9	7	9	11	7	4	6
Priority 9	7	19	17	13	16	14	12	8	9	8	3	3	5	1
Priority 10	14	14	15	13	13	22	12	2	9	7	6	4	3	1
Priority 11	14	15	22	14	11	14	13	5	4	7	7	2	2	5
Priority 12	19	14	23	19	14	11	9	6	8	5	5	1	1	0
Priority 13	33	20	16	13	9	6	11	5	5	3	9	1	1	3
Priority 14	33	23	8	15	14	6	10	9	0	5	5	2	4	1

Figure 1

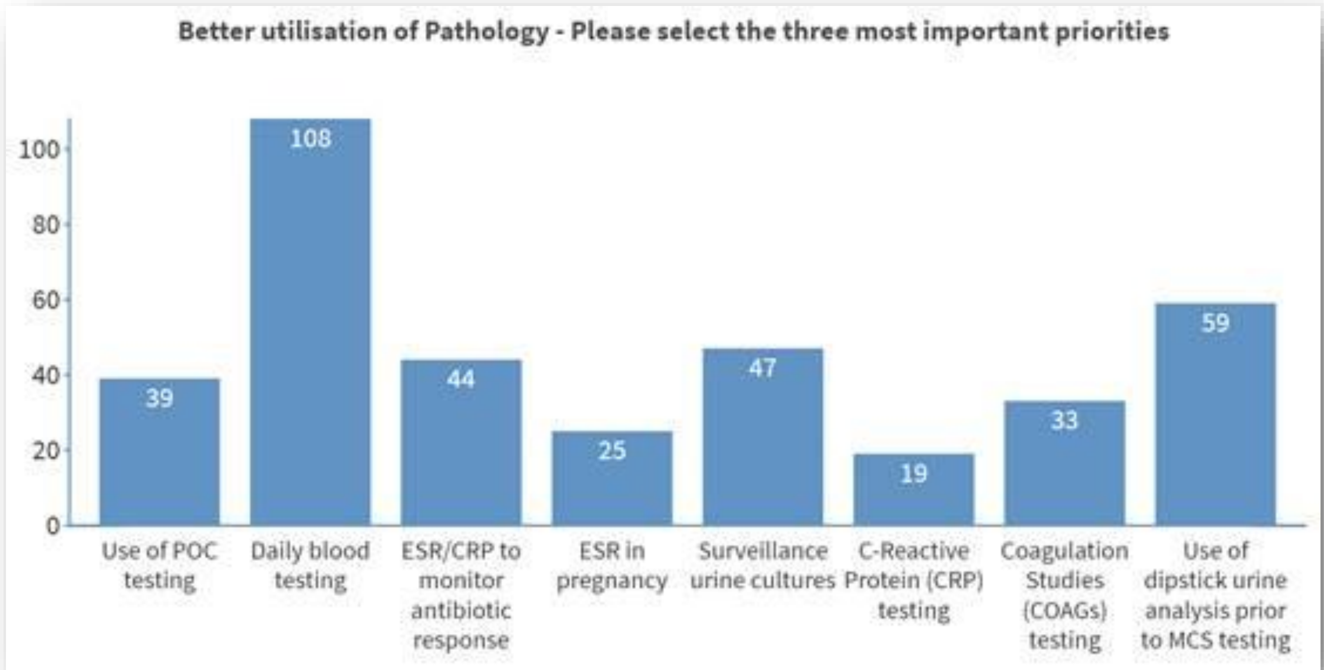


Figure 2

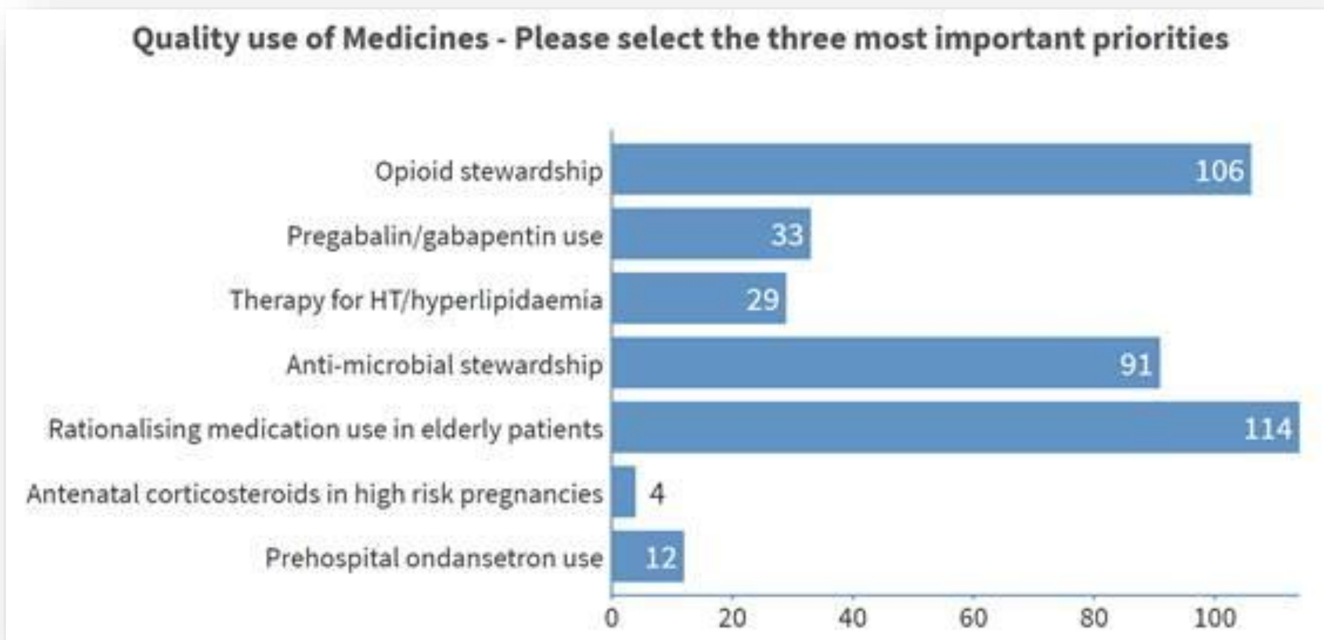


Figure 3

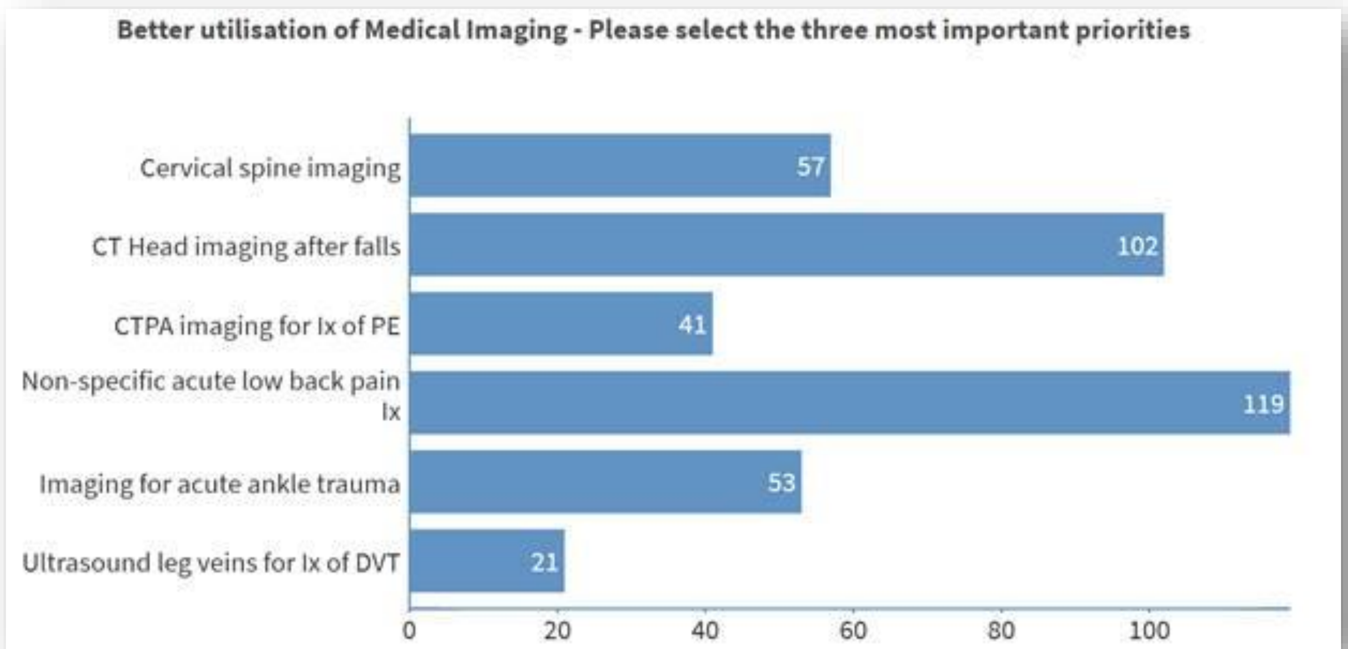
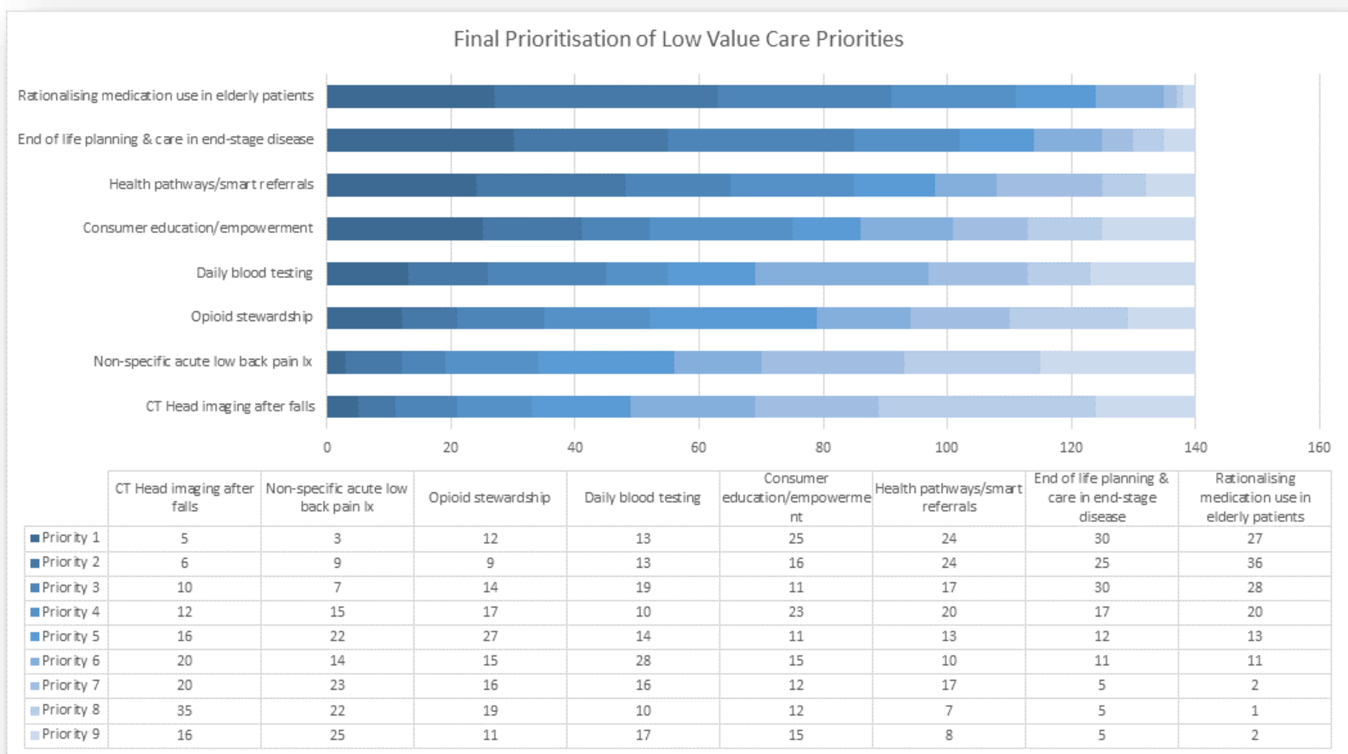


Figure 4



	CT Head imaging after falls	Non-specific acute low back pain Ix	Opioid stewardship	Daily blood testing	Consumer education/empowerment	Health pathways/smart referrals	End of life planning & care in end-stage disease	Rationalising medication use in elderly patients
Priority 1	5	3	12	13	25	24	30	27
Priority 2	6	9	9	13	16	24	25	36
Priority 3	10	7	14	19	11	17	30	28
Priority 4	12	15	17	10	23	20	17	20
Priority 5	16	22	27	14	11	13	12	13
Priority 6	20	14	15	28	15	10	11	11
Priority 7	20	23	16	16	12	17	5	2
Priority 8	35	22	19	10	12	7	5	1
Priority 9	16	25	11	17	15	8	5	2

Figure 5

Table 1: Priorities Recommended for progression (*n.b. these submissions were made by the members of the organisations / groups present on the day and may not reflect official policy*)

Type of Agency	Agency	Action
Department of Health		DH improved communication across the health continuum through health pathways.
		Development of health pathways and real time data reporting
Clinical Networks		End of life care. Agreement that many consumers are treated without being fully informed of palliation options, and many clinicians are not empowered to offer palliation as a treatment option
		Networks continue to work together
		Each network identify a medication outcome for elderly
Consumers		Community and clinical health education and communication
QAS		Inappropriate PIVC insertion, Quality use of Medicine (specifically ondansetron).
PHN		End of life care GP
		Primary care health pathways
Hospital and Health Service	*CHHHS*	Care co-ordination across hospital and community sectors
		Using technology to drive optimal pathways
		Deprescribing in conjunction with GPs
		Post-discharge medication review by pharmacists
		Rationalisation of medications in the elderly
		Opioid stewardship
	CQHHS	Low risk day surgery in specialist outpatient wards
		Medication in the elderly
		Care coordination
	CHQ	Consumer education empowerment
		Alternative models/ Alternate Pathways
		Consumer education/ empowerment
		Pathology; quality use medicines
	CWHHS	Strengthen primary care especially quality use medicines
		Health pathways / smart referrals
	DDHHS	Health pathways and obesity joint replacement
	GCHHS	Health pathways
		Palliative care medicines review
		End of life/palliative care/ deprescribing in elderly
	MNHHS	Use and market standardised 5 choosing wisely questions across bulk QH saturation marketing, HHS and PHN/community /GP setting
		Consumer engagement and education - either BRAN or " 5 question "
		Pathology utilisation
		Patient education in shared decision-making.
		Roll out a patient empowerment & education campaign across metro north - including primary, secondary & tertiary care.
	MSHHS	Health pathways for elderly in care and at home
		End of Life care planning in collaboration with Brisbane South PHN, incorporating indigenous community through established networks
		Improve Advanced Health Care Planning across the District as there is huge variability
	NWHHS	Choosing Wisely
	SCHHS	Advanced care planning - work with PHN & consumers to improve early planning to avoid complexities that occur when no plan is in place, particularly with the elderly population.

		Focus on improving integration of advanced health directives and EoL planning across health sectors- primary care and hospitals and RACFs
		End of life planning across health sectors (GP, primary health and HHS) with consumer and carer engagement and shared decision making
	SWHHS	Strengthen primary care especially quality use medicines
		Health pathways / smart referrals
	TCHHS	Clinical consumer pathway. Health Literary
	THHS	Outpatients overhaul to maximise Telehealth utilisation between clinic, patient and their GP
		Clinical consumer pathway. Health Literary
		Sign up to Choosing Wisely
		Choosing wisely champions
		Outpatient integrating with GP priorities
	WBHHS	Push for more telehealth - needs to ensure that providers are available Region Sunshine Coast wide bay
		Rationalising medication use in older patients
	WMHHS	Health pathways
Clinical Network	*DHIN (Digital)*	Consumer education empowerment
		Rationalising medication use in the elderly
		Opioid Stewardship
	SAC (Surgical)	1) end of life decision making 2) Health care pathways
	SCCN (Cardiac)	Don't commence therapy for hypertension or hyperlipidaemia without first assessing the absolute risk of a cardiovascular event.
		Don't screen asymptomatic low risk patients (<10% absolute 5-year CV risk) using EST, CACS or carotid ultrasound.
	SCCCN (Cancer)	Development of health pathways and real time data reporting Cancer Stream
		Consumer literacy and incorporating goals of care for end of life and palliative care instead of constant intervention.
	SDCN (Diabetes)	Better utilisation of pathology
		SDCN have identified rationalising medication use in the elderly as a top priority and have already begun a working group on this. The second priority identified was for not delaying end of life planning discussions and enhancing early and timely discussions regarding Advance Health Directives, Statement of Choices, Enduring Powers of Attorney and Advanced Resuscitation Plans.
	SGMCN (Gen Med)	CTPA use
		Syncope work-up
		Rationalising use of medications in elderly patients
		End of life care planning
	SMNCN (Maternity and Neonatal)	Educate and improve health literacy to improve autonomous and better-informed decision making
		Education for community/Patients so decision making is easier and more autonomous for women/families/patients who are better informed as they make choices. Maternity and Neonatal Clinical Network
	SOPHN (Older Persons)	CT brain for falls
		1. Investigation and treatment of asymptomatic bacteriuria. 2. Quality use of medications (especially use of potentially inappropriate medications in elderly patients)
		Management of asymptomatic bacteriuria
	SPPMCN (Persistent Pain)	Research and Education in pain management including opioid stewardship

	SRCN (Renal)	Consumer empowerment, rationalizing medication use in elderly
		Not treating patients with asymptomatic bacteriuria/ not doing MCS in asymptomatic elderly people
	STCN (Trauma)	Early expert clinical advice and increased use of end of life care strategies
Tables	*Table 7*	phone a friend for expert clinical advice - Futile end of life care and Medication rationalisation for elderly
	Table 8	Consumer education/ empowerment
	Table 9	Essential to marry with PHN around choosing wisely recommendations for cardiac cancer and respiratory.
		Don't image low back pain
Unidentified authors		Duplicating investigations
		The conversation with both consumers and clinicians has to be about achieving better outcomes, not reducing activities.
		Culturally appropriate engagement, user friendly language, utilise ALO where necessary to support the consumer
		Expand and invest in improving health literacy and access to information to assist with empowered decision
		Critical requirement to network choosing wisely priorities between clinical networks HHSs and PHNs to enable choosing wisely topics
		Embedding pathways and coordinating between the GP, tertiary and the consumer to understand the pathway. Ensure consumers can respond and speak about their needs and wishes
		Optimising opioid prescribing
		Stop X-ray on admissions automatically. Many times repeats when transfers are made.
		Expand health pathways
		Rational use of medication in the elderly
		Consider use of a structured approach to change to focus effort for increased probability of success
		Adopting ideas from the trade displays
		End of life care. Agreement that many consumers are treated without being fully informed of palliation options, and many clinicians are not empowered to offer palliation as a treatment option
		Health pathways and smart referrals
		Outpatient strategy to engage GPs and patient via telehealth
		Choosing wisely
		Expert clinical advice
		Consider what low value healthcare considered by consumers to be important be delivered by non-clinicians e.g. Pharmacists etc.
		Better scaling and reporting of implementation of agreed recommendations beyond major public centres
		Early senior clinician decision making in elderly/end-of-life care
		Observe men with low risk prostate cancer.
		Expanding and enhancing the First Nations Workforce to expand care closer to home by a culturally competent known care provider
		Oral beta agonists for asthma
		Work with networks to inform a rural and remote perspective
		Systemic - alternative pathways, better models of care
		Combination steroid/long acting beta agonists for mild asthma
		HHS health pathways. Obesity joint replacement

Table 2: Measuring what matters

Thematically Collated Table Responses
1. *Appropriateness of measurement* a. Understanding and being smarter with what we are already measuring b. Clearly and carefully defining the problem to be addressed through data c. Developing ways to audit appropriateness as well as outcomes 2. *Consumer engagement* a. There is a one question PREM that has been shown to give the best results. It is "would you recommend this service to your family & friends?" b. Continuing to ask whether the data is important and relevant to the consumer 3. *Daily Blood Tests:* a. Development of machine learning for daily blood tests *4. Data Improvement: Accuracy* a. Data quality can be improved b. Data once would be great c. Databases are not risk stratified and not measuring metrics post-acute care *d.* Lack of trust in data reliability pushes people to do it themselves *5. Data improvement: Collection* a. Operating records should have an accompanying electronic database embedded that the surgeon enters, that would include relevant elements b. Mandate collection of ‘indication’ and ‘diagnosis’ for operation/procedure notes c. We need a way to automate clinical data into structured data (e.g. 50 pack per year smoking history -> nicotine addiction) d. Patient recorded outcome measures must be collected to improve health pathways and smart referrals e. ieMR and MAR should be used productively to gather clinically relevant data f. Data must be demonstrated to be valuable to all stakeholders in order to improve quality of collection – ‘what’s in it for me’ *6. Data improvement: Linkages* a. Data-sets about the same patient must be linked to clinical and patient reported outcomes to allow for analysis of appropriateness of care b. Consumer relevant data should be linked to remuneration – pay for what consumers value c. Close the loop between nursing home, ED, GP, family d. Standalone databases must be minimised as they prevent benchmarking 7. *Data Transparency/Access* a. To improve data input quality, data output must be available b. Clinical access to data must be improved; maximised c. ieMR should be accessible to rural and remote HHSs without cost to allow patient centred data sharing 8. *Medication Management* a. Patient reported outcomes are needed with regards to medication management 9. *PROMS/PREMS* a. Better processes are needed to operationalise and embed PROMS and PREMS into routine clinical practice at the point of care delivery b. PROMS and PREMS must be measured at the most appropriate time points 10. *Staff capability and availability* a. Support and resources are needed to support, entry and evaluation of data to improve standardisation and quality of care b. Skills of front-line staff should be improved so they can interrogate data c. The most junior and least experienced people in the team are often responsible for data 11. Training a. Need to ensure that junior doctors are confident to make decisions to reduce pathology and medical imaging b. Consider the tension between the need for training in surgical specialties, and low value procedures

Table 3: Implementation Strategies

Thematically Collated Table Responses
1. *Build Case for Change/Change management methodologies* a. An education campaign to engage community more broadly which would support HHSs, clinicians and partners b. Organisations don't change unless the people in the organisation change. A change community of practice in pathology using the ProSci methodology can allow for efforts to be focussed on the areas which will bring the most benefit c. Winning the hearts and minds is key d. Senior clinicians need to believe and model the behaviour that questions does this benefit the patient e. Clearly define the "why", not just cost, efficiency 2. *Use Clinical Champions* a. Always have a consumer and a clinical champion - Our value lies in clinician and consumer buy-in, at a care level, not financially b. Recognise the importance of people who don't have formal leadership roles but who are key leaders and influencers c. Champions, sensitive and comprehensive disclosure of expected benefits and dis-benefits d. Cognitive champion network and clinical pharmacists 3. *Structure/Governance* a. Governance structure is something we already have and need to leverage. Critical is about delivering better care. The financial discussion is secondary b. Changes need to be hardwired in - engineered in. We can't rely on a few champions and initial excitement. That's why we continuously struggle with this. c. Align the whole organisation around quality outcomes for patients. Create transparent cross- functional governance structures with clear channels of communication across the organisation. d. Methodology /framework that promotes integration of initiative(s) to business as usual /sustainable beyond life of the 'project' e. Governance needs to be different to usual approach. Include consumers and set this as close to the consumer as possible - use a collaborative design methodology f. Governance structures to include gatekeeper champions who appeal to the wide range of stakeholders. Must include consumers and a culture of community co-design 4. *Consumer leadership* a. Narrative must be patient focussed not cost saving b. Define LBC from consumers perspective c. Consumer driven, need to be part of the planning process d. Greater engagement with parents of our consumers to better understand what is important / valuable / a priority for them. e. More patient stories like prostate Pete across the whole gamut of choosing wisely 5. *Culture/Alignment* a. Executive, clinical leaders and coal face must all be aligned b. Change culture to ‘It's everyone's role to come to work to do their job and improve their job’ c. Aligning with people’s values 6. *Education* a. Educate training doctors in value-based care

7. *Clinical Support*
    a. The fear of litigation and complaints is in the forefront of many clinicians' minds. Choosing wisely needs to back up clinicians for following its recommendations and the ombudsman, coroner and health boards need to be part of this discussion
8. *Evidence base for activity*
    a. Provide clear evidence based clinical guidelines so clinicians are obliged to do the right thing and not do expensive unnecessary care
    b. Weaving evidence-based guidelines into decision support systems
    c. Prioritise projects with a large evidence base behind them as to their low benefit
    d. Benchmarking of surgeons through medical and consumer feedback.
    e. Should start with smaller well-defined projects not large Ill-defined ones
9. *Clinical Network Leadership*
    a. Develop the structure in place to see this through. Networks to identify the one question they will see through. Identify network champions across one or some HHSs. Identify senate HHS champions to match. Identify consumers to match. Identify background support required.
10. *Use of existing knowledge, experience and models*
    a. Not reinventing the wheel e.g. gen med PAH has a "cease protocol" to combat polypharmacy
    b. We have an existing care at the end of life programme addressing end of life care
    c. Use Kotter's leading change model.
    d. Think about issues of Immunity to Change (non-rational reasons that change doesn't happen)
11. *JUST DO IT!*
    a. Pick one and move - just get started