Australian College of Nursing

Value-based health care through nursing leadership (abridged)

A WHITE PAPER BY ACN 2022

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EXECUTIVE SUMMARY

This White Paper outlines how the Commonwealth, state, and territory governments can enable nursing services to address issues that impact access, equity, and the financial sustainability of Australia's health and aged care systems.

The Australian College of Nursing (ACN) recommends complementing traditional health funding models with new outcome-based funding models and other variants, including access to Medicare Benefits Schedule (MBS) items for nurses.

Health is one of the largest and fastest-growing fiscal pressures facing the Australian government. An ageing population, the development of new and often more expensive technologies, and the growing public expectation of a better health system will require further public investment in health.[1]

Getting the most value from our health resources requires health and economic reform that puts patient outcomes at the centre of an effective and efficient universal health care system. This paper highlights the benefits of value-based health care (VBHC), what it means for patients, how it is categorically reliant on nurses and team-based care models, and how the adoption of innovative nurse-led models of care has the potential to positively impact all Australians and ensure the sustainability of Australia's health and aged care systems into the future. **Recognising and utilising the value of nursing services is paramount to achieving VBHC in Australia.**

New funding approaches are being implemented effectively in European countries and the United States and are now being trialled in various settings across Australia. This paper includes several case studies demonstrating the success of such approaches here and abroad.

ACN argues there is a need to shift the whole system towards models that target core issues in our health and aged care settings. ACN strongly believes the **right incentives** need to be in place to provide the **right care** at the **right time** for the **right price**, in the right place by the **right provider** (adapted from the Australian Commission on Safety and Quality in Health Care (ACSQHC) definition for patient quality and safety).[2]

RECOMMENDATIONS

ACN calls for fundamental reform of Australia's health and aged care systems to ensure all Australians can access high-quality health care. This paper argues that a value-based health care (VBHC) approach should guide the development of a comprehensive reform agenda and recommends a key role for nursing in this process.

To achieve this, ACN recommends the following actions:

Principles to guide reform

- The principles developed by the Productivity Commission[3] should be used to guide a reform process in Australia. These principles could form the starting point for developing a VBHC plan in Australia.

Building an evidence base

- The Australian Government and other relevant bodies should work with the ACN and other nursing leaders to accurately document all current VBHC nurse-led initiatives underway, capturing program designs, evaluation results, and lessons learnt. Collation and diffusion of this information will form a substantial evidence base for further VBHC reform.
- The Australian Government should undertake a complete feasibility study into the broader application of VBHC, including consultation with nurses, identification of appropriate outcome measures, a complete cost/benefit analysis of potential gains and identification of organisational and governance barriers.
- The Australian Government should fund research that provides transparent and clear evidence on the long-term impact of nursing interventions and the contribution of other health professional groups within a VBHC service delivery model.
- The Australian Government, in conjunction with the states and territories, should fund the development of a national minimum dataset for nursing to facilitate measurement of improvements in patient care or patient outcomes to benefit health services at the local, state, and national levels, thus translating into improved patient care and enhanced outcomes for patients. This should be based on the preliminary list of minimum dataset data elements developed by ACN.

Funding reform

This evidence can be used to incorporate a VBHC approach into current funding mechanisms at the federal level, including:

- The Commonwealth, states, and territories, via the National Federation Reform Council, should adopt patient-centric concepts and outcome measures into the National Partnership Agreement.
- The Australian Government and the Independent Hospital Pricing Authority should work with the Australian College of Nursing and other key bodies to actively trial the adoption of VBHC into aspects of the hospital, aged care, community, and primary health care funding.
- Amend relevant legislation, including the National Health Act 1953 to enable Registered Nurses access to Medicare Provider numbers and subsequent access to Medicare item numbers for patients of Registered Nurses.

INTRODUCTION

Australia has a world-class health system that offers a high standard of nursing, medical, and allied health services.

However, like other developed countries, Australia's health system is under pressure and will need to change to meet our community's health care needs. This pressure is due to a range of inter-related factors, which include:

- the ageing of our population;
- increased rates of chronic disease, requiring complex and coordinated care over time and across sectors;
- new developments in treatments and technologies, which increase health care costs;
- workforce shortages in many areas;
- inequitable access to care for some sectors of the population;
- an inadequate focus on prevention, leading to a high rate of preventable diseases and hospital admissions;
- poor performance of some health and social care systems sectors, including mental health and aged care.

The current structure and funding mechanisms of our health and aged care systems were developed a generation ago when the health care needs of our population were very different from those of today.

Reform of these systems is required if our health system adapts to meet our current and emerging needs and continues to provide world-class care to all Australians. It is clear from experience that incremental and piecemeal changes will not ensure the sustainability of our current system.[4]

This White Paper proposes that a VBHC approach should be taken to developing a reform agenda for Australia's health system and highlights the central role of nursing in this process.

The paper was developed by the Value-Based Health Care (VBHC) Working Group, comprising Australian nurses with expert knowledge in health care delivery models. ACN established the VBHC Working Group in 2019 to review international and national literature around the defining principles of VBHC, the implementation of VBHC with measurable outcomes across a range of health care settings, departments and disciplines, and the centrality of nursing to VBHC's authentic and effective functioning.

The paper identifies the critical components of VBHC relevant to the health care needs of Australians. It proposes some specific recommendations for how this approach could reform the funding and delivery of health care to achieve a more equitable, efficient, and effective health system for our future.

CURRENT FUNDING MODELS

Australia's complicated mix of public, private, and not-for-profit funding means there is no simple approach to introducing a VBHC approach across our health system. Funding for health care comes from Commonwealth, state, and territory governments and non-government organisations, private health insurers, and individuals. A VBHC approach has implications for all these funding sources.

Some of the central funding models used in the Australian health system and their limitations are outlined below.

AUSTRALIAN FUNDING MODELS IN THE HEALTH SECTOR INCLUDE:

Activity-based funding (ABF) is the model of funding for public hospitals by the Commonwealth through state and territory governments. The fundamental concern with ABF within an integrated care framework is that its incentives only relate to hospital care. ABF does not encourage prevention and limits the coordination of patient care across care settings inside and outside hospitals.[5]

Fee-for-service funding is the dominant health care funding model for primary care in Australia through the Medicare Benefits Schedule (MBS).[6] As nurses do not have provider numbers, MBS item numbers are not accessible to nurses in general practice, other than a limited number of items for nurse practitioners. The fee-for-service funding model is easy to manage and administer within a system that incentivises accessibility (by incentivising volume of care). However, it does not reward successful efforts to prevent chronic conditions or stop people from entering the hospital system.[7] It has been suggested that fee-for-service funding contributes to the fragmentation of care[8] between health professionals and service providers.

Block funding is a periodic global lump sum payment independent of the number of patients treated. It is implemented through grants provided by the Commonwealth to the states and territories to fund specific services or activities such as small rural hospitals, teaching, training and research, non-admitted mental health, and other public health activities. The 2020 Workforce Incentive Payment (WIP) is a form of block funding described by Services Australia as payment that "provides incentives to general practices which employ nurses".[9] However, the WIP does not cover the total cost of employing eligible health professionals and needs to be offset by combining specific service items, such as MBS items paid to GPs for nursing interventions.

FUNDING MODELS ACT AS A BARRIER TO COORDINATED CARE

Australia's fragmented funding and governance systems, and over-reliance on ABF and fee-for-service funding, discourage service provision that would provide the best outcomes for expenditure. By driving a supply-centric healthcare system, current funding models and budget silos encourage activity but create barriers to the delivery of team-based healthcare that ensures patient-centred continuity of care.

For instance, patients at high risk of heart disease would benefit from education and ongoing management in the primary health care (PHC) setting. This education and support should commence in the acute care setting following diagnosis with constant revision and management of their treatment plan in the PHC setting. Several evidence-based non-pharmacological strategies improve outcomes for patients with heart failure, including multidisciplinary disease management, nurse-led medication titration and exercise training.[10] This requires continuity of care across the health care settings between acute and PHC providers.

The fee-for-service funding model is also a significant barrier to increasing the provision of services by nurses, particularly in general practice.[11]

Within the PHC setting, practice nurses provide health assessment, triage and referral, management, self-management support and education, health promotion, and health system coordination of care.[12] Nurses working to their full scope of practice as part of an interdisciplinary team can enable more integrated, efficient, and accessible healthcare.[13]

Nurses undertaking these activities improve patient outcomes, enhance productivity, and provide better value for money for health services.[14] A national survey of practice nurses[15] found that 39% of respondents reported not using their knowledge and skills to their full extent. Nurses said they were being held back by general practitioners and practice managers who would not approve requests to undertake more complex activities. These practices create inefficiencies in the PHC setting, limiting nurses' autonomy, and restricting them from working to their full scope of practice. Ultimately, this impacts the care provided to people in our communities and their ability to enjoy the highest attainable standard of health.

To achieve the full potential of PHC, we need to recognise the increasing roles of all health professionals in providing care as part of an interdisciplinary team-based approach that is safe, equitable, accessible, cost-effective and meets patients' needs.

Within Australia, access to appropriate ongoing community-based healthcare is limited, with access to outpatients or ambulatory care services such as nurse-led cardiac clinics, obesity clinics, hospital-in-the-home, and other nurse-led mobile services restricted through the requirement for GP or medical specialist referral. Many rural and remote communities are dependent on nurse-led services, and in these communities, nurses are often the sole resident health practitioner available to a community.[16]

Existing funding models and outdated attitudes limit access to community and primary health care services and the provision of genuine team-based care approaches that meet the care needs of individual patients.

ACN suggests that a VBHC approach could reform Australia's funding system to address the above issues and support nurses in the community setting to work at their full scope of practice.

PROPOSED FUNDING MODEL

Value-based health care

"There is a need to create better structures and new incentives that promote efficient prevention and management of chronic illness throughout the health system."[17]

ACN argues for models of care that provide the **right incentives** and the **right care** at the right time for the **right price**, in the **right place** by the **right provider**.[18] This requires whole system reform and a central role for nursing in addressing issues of access, equity and ensuring the financial sustainability of Australia's health care system.

VBHC can be defined as *"the health outcomes that matter to patients relative to the resources or costs required".*[19] It is a framework that focuses on what patients value in terms of their health and allocates resources according to the health outcomes provided by the system.[20]

VBHC can also be understood as a simple equation:

The set of outcomes that matter for the condition
divided by the total costs of delivering these outcomes over the entire care cycle.[21]

Initially devised by Harvard economist Michael Porter, VBHC is increasingly being adopted by countries worldwide to improve standards of care while also ensuring the sustainability of their health systems.

VBHC is a broad concept that can differ in its application depending on the setting and context. However, there are fundamental differences between a VBHC approach and traditional funding models on this value equation's outcome and cost sides.

Traditionally, outcome measures have focused on health care provider behaviour and overall patient success. Measures for VBHC are different in that outcomes are:

- measured by the patient's condition(s), not by specialty and intervention;
- multi-dimensional in that they focus on what matters to the patient and not just the health care provider;
- inclusive of patient-reported outcomes; and
- focused on the entire cycle of care.[22]

The premise of VBHC also promotes cost efficiency in delivering outcomes across the entire cycle of care. It presents a 'whole-of-system' paradigm that incentivises all practitioners within the system to deliver the results that matter to patients in the most efficient manner.

The health outcomes that matter to patients are multidimensional, including factors much broader than traditional clinical indicators. The resources or costs required must reflect the actual costs of the care provided to a patient over a complete cycle of care, recognising that a patient's entire course of care requires an interdisciplinary team-based approach over time. The value-based approach to health care enables a patient-centric way of designing and managing health systems.[23]

VBHC is not to be viewed in the context of a hospital, care location, specialty, or intervention. Instead, value is created at the individual level of the patient, precisely their conditions, over the entire cycle of care across the health sector.[24]

There is a range of benefits of a VBHC approach for health care, including:

- an alignment of incentives to improve patient outcomes while decreasing the long-term costs of care;
- a focus on systems-wide efficiency, which reduces perverse incentives for cost-shifting between sectors;
- a flexible approach that can be tailored and adopted in many different areas of the health system;
- a focus on achieving outcomes across different domains, including health, wellbeing, fiscal and economic.

This requires an approach to health services planning and delivery that involves the following key steps:

1. Systematically agreeing on and measuring outcomes that matter to patients and the costs required to deliver those outcomes over a complete cycle of care.
2. Tracking those outcomes and costs for defined populations on an ongoing basis.
3. Developing customised interventions to improve value for each population.[25]

VALUE-BASED HEALTHCARE IN AUSTRALIA

VBHC is gaining increasing attention with various initiatives based on this concept underway or established in Australia. An assessment of the enabling environment in Australia,[26] combined with the principles to guide the broader adoption of VBHC, form a valuable set of tools for policymakers.

VBHC has been supported by several key health experts and stakeholder groups, including the Australian Healthcare and Hospitals Association,[27] the Australian Medicare Association[28] and local health districts.[29]

At the state level, there has been an uptake in New South Wales, Western Australia, and Victoria with successful initiatives in areas including cancer, diabetes, renal, musculoskeletal, cancer, respiratory disease, and dental care.[30] These have demonstrated promising results, such as significant increases in preventive interventions and clinicians working to the top of their scope of practice, reduced low-value care and improved patient appointment attendance.[31]

The Commonwealth has been slower to adopt a VBHC for national health programs. However, the Productivity Commission has recognised both the health and economic outcomes of reforms that place the patient at the centre of the health system.[32]

MEASURING VALUE

VBHC requires a paradigm shift from a supply-driven model to a more patient-centred care system. This relies on agreed methodologies for measuring the costs, outcomes, and value of health programs and services.

A VBHC approach to measuring value differs from a traditional approach by considering broader and longer-term impacts of health interventions. In a public health system like Australia's, value is also defined individually and socially.

Measuring costs

The main difference between a VBHC and a traditional approach to measuring costs is that a VBHC approach takes a more comprehensive perspective and is not confined to measuring resources and costs of single episodes of care. This can include assessing costs across multiple services and sectors and taking a longitudinal view of a person's care over time to determine the outcomes and expenses incurred.

Measuring outcomes

A traditional approach to measuring outcomes involves a narrow focus on the clinical measures of single treatment episodes. In contrast, a VBHC system incorporates outcomes that reflect patients' experiences and priorities, often defined through developing Patient Reported Outcome Measures (PROMS) and patient-reported experience measures (PREMs).

PROMs and PREMs are structured to include patients' values and perspectives in measurements of healthcare value. They enable patients to report on issues that matter to them, such as quality of life, daily functioning, symptoms, and other aspects of health and well-being.

Measuring value

In Australia's health system, both individuals and the public bear costs through the funding governments provide for public hospitals and health services, Medicare, the Pharmaceutical Benefits Scheme, and other government-supported health resources. The broader community also bears the cost of ill health and disability through forgone productivity and social participation. Therefore, the concept of value must be considered both in terms of personal value and public (or societal) value.

Australia's universal health system also includes a commitment to equity, which should be incorporated into measuring value at the population level.

THE ROLE OF NURSING IN VBHC

The value of nursing is instrumental in delivering gains under a VBHC care model.

Nursing is integral to efforts to introduce a VBHC funding model in Australia. Nurses should play a leadership role in developing and implementing reforms to improve the Australian health system's equity, efficiency, and sustainability.

Nursing is vital to any broad health system reform as it is the largest single health profession in Australia with the highest match to population across the country. Nurses are most likely to be the first health professionals seen by people in rural, remote, and very remote communities both for specialist and primary care needs.

Nursing is also crucial as it is unequivocally linked to improving the health and wellbeing of our communities through professional and social impacts. The public has regarded nursing as the 'most trusted profession' for many years, making its contribution unique due to its scale and the range of roles that nurses have in our communities. Nurses are a part of their local communities, sharing common cultures, strengths, and vulnerabilities. They possess the ability to shape and provide effective interventions to meet the needs of patients, families, and communities.[34]

Nurses also have the potential to develop and deliver innovative models of funding that can address Australia's current health system challenges within a VBHC framework.

Nurses are accountable and responsible for their practice, with legislation and regulation guiding the scope of that practice. Registered nurses (RNs) are regulated healthcare professionals who provide holistic patient-centred care in collaboration with other health professionals and individuals requiring care. Nursing's regulatory body is the Nursing and Midwifery Board of Australia, whose role is to protect the public. RNs do not require supervision by other health professionals. Furthermore, it is neither appropriate nor valid for nurses to provide care "for and on behalf of" any other healthcare professional.

The nursing model of practice has a unique care profile, as nursing is both a service and an intervention.[35] A distinguishing characteristic of the nursing model is nurses' relationship with individuals and communities. This puts nurses in an ideal position to take a leadership role in a VBHC approach to developing and implementing new funding and service delivery models.

ACN has consistently highlighted the potential of advanced practice nurses and the role of nurses in chronic disease prevention and management, particularly in rural and remote areas. In providing palliative care, nurse-led models of care demonstrate improved symptom outcomes, psychological wellbeing, end of life care planning, and care coordination.[36]

Australia's extensive, cost-effective, and highly skilled nursing workforce is ideally placed to be better utilised. Indeed, there are numerous examples where existing nurse-led initiatives (Appendix 1) demonstrate how nursing services provide real value to the most at-risk cohorts. Unfortunately, these services are limited and are not currently accessible to most Australians.

The nurse-led initiatives in Appendix 1 are examples of how nurses provide outcomes that matter to people impacted by older age or chronic disease or those at higher risk of poor health because of their location, background, or income level.

These initiatives are critical in that they:

- demonstrate success in terms of both patient outcomes and experiences and cost savings;
- provide the foundations for an evidence base and library of best practice to inform future program design, delivery, and evaluation;
- demonstrate the wide applicability of VBHC initiatives, encompassing a broad spectrum of patient needs that have been met in a coordinated and integrated manner by different parts of the current system;
- engage clinicians and administrators in innovative programs which begin with the patient and break down traditional institutional, bureaucratic, and funding barriers. The experience of these individuals, and the lessons learnt through these programs, are valuable when considering more extensive institutional and systematic reform.

Overall, nurse-led initiatives demonstrate the potential of nursing to improve access to care, quality of care and health outcomes equivalent or superior when compared to medical-led care.[37] This reflects the findings of other studies which demonstrate the benefits of nurse-led models/ interventions for patients, services, and health systems in caring for people with life-limiting conditions.[38]

Nursing is also central to developing PREMs and PROMs to measure health care outcomes from a VBHC perspective. PROMs demonstrate the significant interprofessional value of nursing services in enhancing patient outcomes and experiences. This is because the experience of patients who receive acute healthcare is, in many instances, heavily weighted towards nursing care.

The nursing practice model has long been patient-centred and based on collaborative and respectful partnerships. It is a “core business” for nurses to consider the care and health-related services, and the needs (physical, preventive, therapeutic, economic, emotional, and spiritual), wants, and expectations of the person, their family and significant others.

TOWARDS VALUE-BASED HEALTH FUNDING

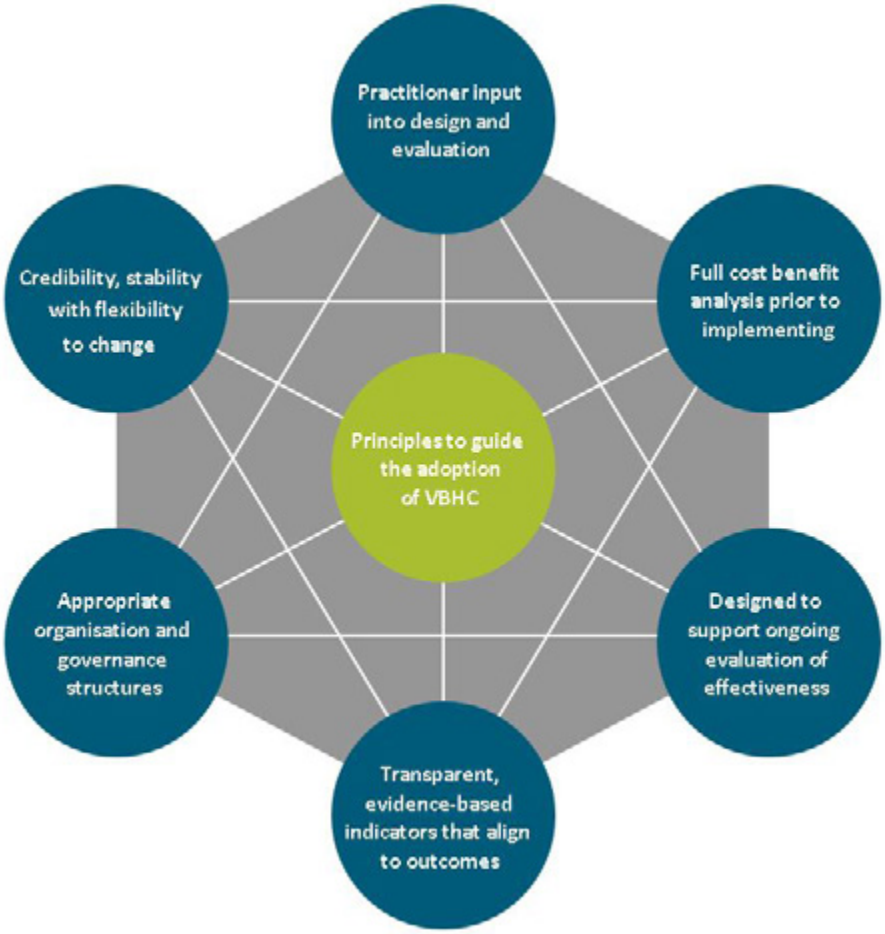
ACN believes that a VBHC approach provides the best possible framework for reforming the Australian health system to ensure it can meet our future health care needs. However, we appreciate that such a significant reform carries some risks and supports a considered and collaborative approach to developing a reform plan involving health care funders, providers, and consumers.

Some key steps in this process are outlined below.

PRINCIPLES TO GUIDE REFORM

The Productivity Commission[39] outlines a set of principles for health care payment models to guide a reform process in Australia. These principles could form the starting point for developing a VBHC plan in Australia.

Figure 1 - Principles to guide the adoption of VBHC



Sourced and adapted from principles outlined in the Productivity Commission Report (2015)

These principles could be used to build on the success of trials and programs already in place in states and territories (Appendix 1).

BUILDING AN EVIDENCE BASE

Further investigating and consolidating the evidence base for a VBHC reform agenda should include the following steps:

- The Australian Government and other relevant bodies should work with the Australian College of Nursing and other nursing leaders to accurately document all current VBHC nurse-led initiatives underway, capturing program designs, evaluation results, and lessons learnt. The collation and diffusion of this information will form a substantial evidence base for further VBHC reform.
- The Australian Government should undertake a complete feasibility study into the broader application of VBHC, including consultation with nurses, identification of appropriate outcome measures, a complete cost/benefit analysis of potential gains, and identification of organisational and governance barriers.
- The Australian Government should fund research that provides transparent and clear evidence on the long-term impact of nursing interventions and the contribution of other health professional groups within a VBHC service delivery model.
- The Australian Government, in conjunction with the states and territories, should fund the development of a national minimum dataset for nursing to facilitate measurement of improvements in patient care or patient outcomes to benefit health services at the local, state, and national levels; and translate into improved patient care and enhanced outcomes for patients. This should be based on the preliminary list of minimum dataset data elements developed by ACN.[40]

FUNDING REFORM

This evidence can be used to incorporate a VBHC approach into current funding mechanisms at the federal level, including:

- The Commonwealth, states, and territories, via the National Federation Reform Council, should adopt patient-centric concepts and outcome measures into the National Partnership Agreement.
- The Australian Government and the Independent Hospital Pricing Authority should work with the Australian College of Nursing and other key bodies to actively trial the adoption of VBHC into aspects of the hospital, community, and primary healthcare funding.
- Amend relevant legislation, including the National Health Act 1953 to enable Registered Nurses access to Medicare Provider numbers and subsequent access to Medicare item numbers for patients of Registered Nurses.

CONCLUSION

The Australian health system needs fundamental reform to meet our future population's health needs and continue to provide all Australians with access to high-quality healthcare. This paper argues that a VBHC approach should guide the development of a comprehensive reform agenda and that nurses should take a leading role in developing and implementing these reforms.

Nurses are central and well-positioned to undertake a leadership and advocacy role in health care system reforms. The existing funding models and regulations in Australia are limiting the role of nurses in providing outcomes that matter to patients. This is in a context where equity and access to care are limited for some patient cohorts, and health care costs are increasing.

The very nature of the nursing practice model places the patient at the centre of their care, enabling and supporting them to remain in their communities, manage self-care requirements, and be experts in their health. A VBHC approach allows nursing services to work as equal partners in a collaborative team across multiple settings and complex structures in the health and aged care systems.

This paper provides an overview of the potential role of nursing in leading a collaborative approach to health systems reform from a VBHC perspective. ACN urges all Australian governments to adopt the recommendations in this paper and work together with nursing leaders and other health stakeholders to ensure our health system can provide sustainable, patient-centred, high-value care.

APPENDIX 1 Nurse-led value-based health care initiatives in Australia

QUEENSLAND HEALTH LBC PRIORITIES

Overview

The Government Election Commitment created 400 nurse navigator positions in hospitals and health services across Queensland (QLD) to work beyond the traditional silos of care and engage with health care providers to address the holistic requirements of patients with complex health care needs.

Value delivered

Six months post-implementation, results demonstrated a reduction in emergency department (ED) visits, decreased day representations to ED within 28 days, reduced readmissions within 28 days, reduced day readmissions, decreased unplanned admissions via ED, reduced bed days, and a significant cost benefit is saving to the health care system.[41] During the first 12 months following this new nurse-led model of care, QLD Health demonstrated an estimated cost saving to the system of $876M whilst achieving outcomes that mattered to patients.[42]

INTEGRATED CARE MODEL AT SYDNEY CHILDREN'S HOSPITALS NETWORK (SCHN)

Overview

This model is part of an initiative encouraging care coordination for children with chronic conditions. It was designed for children with medical complexity and benefited the SCHN, health providers and families.

Value delivered

The benefits include reduced hospital encounters, a 40% reduction in ED visits, a 42% reduction in day admissions, 370 school absences prevented and 50,000km saved in family travel. It is estimated that these findings amount to roughly $5M in cost savings over a 2-year period.[43]

THE QUALITY IN ACUTE STROKE CARE (QASC) IMPLEMENTATION PROJECT

Overview

A collaboration between St Vincent's Health Australia Sydney and the Australian Catholic University on the landmark NHMRC-funded QASC cluster trial demonstrated decreased death and dependency following nurse-initiated, multidisciplinary protocols to manage fever, hyperglycaemia, and swallowing post-stroke. An NSW Health collaboration, Leading Better Value Care[44], led the successful translation of these protocols into all 36 NSW stroke services.

Value delivered

An independent economic evaluation demonstrated that if only 65% of eligible Australians received care in line with these protocols over 12 months, there would be a saving of $281M to the health care system. This work now informs care recommendations in the Australian Clinical Guidelines for Stroke Management. These protocols have been translated into 12 languages and implemented in 300 hospitals in 14 European countries.[45] [46] [47]

SIR CHARLES GAIRDNER HOSPITAL PATIENT BLOOD MANAGEMENT PROGRAM

Overview

Sir Charles Gairdner Hospital (SCGH) in Western Australia (WA) led the Patient Blood Management (PBM) program, which aimed to decrease the risk of blood transfusion by optimising haemoglobin (Hb) and iron stores before elective surgery involving significant blood loss. Preoperative optimisation facilitates the post-op recovery of Hb and can change transfusion practice. This intervention has significantly reduced transfusion rates in elective joint replacement patients. The model has been replicated at a secondary site and is now rolled out to other surgical specialties at SCGH.

Value delivered

Over 1000 patients across Western Australia have been referred to SCGH annually, and auditing has shown that 99% of joint replacement patients receive PBM review and care. Educating clinical staff about the impact of blood transfusion and PBM has led to GP clinical pathways and education of health professionals. Since PBM was introduced, the overall transfusion rate has fallen by 30% at SCGH. This has significant cost benefits saving over $1.2M annually in WA and contributing to patient safety and reducing demand on blood supply, ensuring that donor blood is available for trauma or transfusion-dependent patients.[48]

INSPIRED AT CALVARY HEALTH CARE, CANBERRA

Overview

Calvary Health Care, Canberra, established the INSPIRED trial, which integrates specialist palliative care nurses into residential aged care through Palliative Care Needs Rounds. The trial found that regular rounds identified residents most at risk of dying without an adequate plan in place.

Results

The INSPIRED trial included 1700 residents in 12 Residential Aged Care Facilities (RACF), significantly reducing annual costs to the system by $1.759M, reducing hospitals admissions by 67%, reducing the length of hospital stay and a 10% reduction in hospital deaths with enhanced consumer satisfaction with more support for residents to die in their preferred place.[49 50 51 52] Importantly, participants were more likely to experience better quality death with better symptom control, advance planning, closeness with relatives and spiritual care.

RACF staff have reported they are more confident in discussing death and dying with families and planning for symptoms and goals of care at the end of life. This initiative supports palliative care in RACFs and normalises death and dying while providing essential anticipatory prescribing and better decision-making leading to planned care for residents.[53 54 55 56]

NURSE ENDOSCOPY – LOGAN HOSPITAL

Overview

Logan Hospital (QLD) developed the Nurse Practitioner (NP) endoscopy model of care to address the growing demand for endoscopy services. The NP endoscopist has reduced the endoscopy waiting list. The trial found that nurse endoscopy is safe and comparable to medical endoscopy in performance quality and clinical management and is proven cost-effective.[57]

Value delivered

NP endoscopists performed approximately 4,000 procedures demonstrating a reduction in costs and increased throughput, with NPs providing 37% of the backfill when gastroenterologists were absent compared to 18.1% backfill by gastroenterologists.[58]

Clinical results for patients have demonstrated both the caecal intubation rate and the adenoma detection rate are higher for NP endoscopists when compared to gastroenterologists.[59] Patients seen by NP endoscopists reported higher satisfaction levels, felt their privacy and dignity were preserved and were satisfied with the information provided.[60] Overall, NP endoscopists are more cost-efficient, detect 30% more cancer-causing adenomas, and have higher patient satisfaction.[61]

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