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THE LEGISLATIVE ASSEMBLY FOR

THE AUSTRALIAN CAPITAL TERRITORY

MINISTERIAL STATEMENT
SELECT COMMITTEE ON ESTIMATES REPORT RECOMMENDATION 92: PROGRESS REPORT ON A PATIENT NAVIGATION SERVICE

Presented by
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Madam Speaker, thank you for the opportunity to provide the Assembly with a progress report on a Patient Navigation Service in line with Recommendation 92 of the Report of the Select Committee on Estimates 2019-20.

Members may recall that the Government Response to Recommendation 92 of the Report of the Select Committee agreed that the ACT Health Directorate will continue to explore options for a patient navigation service.

In 2017, the ACT Government commissioned the Health Care Consumers' Association (HCCA) to develop a model of patient care navigation in the ACT. I would like to take the opportunity to thank the HCCA for the final report completed in September 2018: *A model of patient care navigation in the ACT for people with chronic and complex conditions*. While the report is already publicly available on the HCCA website, I also table the Report for the record.

The objective of the Report's proposed model is to address and remove barriers preventing a smooth transition between hospitals and the community for people with chronic and complex conditions.

The Report describes barriers to patient care navigation, and outlines key principles, criteria for a successful service, and intended outcomes.

The Report's findings are informed by examples of care coordination in hospital and the community, two patient care navigation case studies, and interviews with health professionals and consumers. It also provides background on patient care navigation, and recommendations for governance, IT and workforce requirements to implement a successful model. These examples will be useful as the ACT Health Directorate completes further policy work in this space.

In researching patient navigators, the HCCA reviewed two services operating in other jurisdictions – the Queensland Nurse Navigator Service and the Western Healthlinks Service operated by Silver Chain Group in Victoria.

The Queensland model is led by senior nurses and has an open referral system. The service provides end-to-end care with key aspects including advanced hospital discharge, nurse navigator led outpatient clinics and co-ordinating patient and caregiver care. Navigators are based in hospitals and community health centres.

By way of comparison, the Victorian Western Healthlinks Service is primarily operated out of a central office by Health Navigators, who are registered nurses or allied health professionals. Patients are identified through an emergency department algorithm that targets high users and frequent inpatient admissions. Navigators are accredited through the Flinders University Program of Chronic Conditions Management.

The model proposed by the HCCA is based on the lessons learnt from the two case studies, including the staff profile and referral systems. The Report's analysis of the two services also noted the critical importance of IT systems to enable e-referrals and sharing of patient information. Anecdotal evidence in the report suggested that both services were well received by patients.

The Report indicates that a successful patient navigation service should provide a single point of contact for individuals, where they can receive assistance to navigate across health settings and take a coordinated care approach.

This approach aligns with ACT Health's commitment to providing patient-centred care, which emphasises a commitment that every person with a chronic condition receives the right care, in the right place, at the right time with the right team. A patient navigator service will support this commitment and improve the management of chronic conditions.

Madam Speaker, the Report also identifies examples of care coordination being delivered across the ACT, including clinical care coordinators, the Geriatric Rapid Acute Care Evaluation (GRACE) Program and the Chronic Care Program (CCP).

The CCP was highlighted as providing excellent coordination services.
This program provides care coordination through a clinical care coordinator.
A comprehensive patient-centred assessment is performed. Goal setting interventions are then developed with the patient and the health professionals involved in care.

The aim of CCP is to assist in maintaining a coordinated approach to managing the patient's condition. CCP assists the client to remain well in the community, navigate and engage with our health system and prevent unnecessary hospital presentations and admissions. The Report notes that CCP is the closest we have to a patient navigation service at present in the ACT.

A successful navigation service should support a person to self-manage their conditions as much as possible. In doing so, navigation services improve patient outcomes and the overall quality of health care delivery.

The Report suggests that a more coordinated approach to patient care in the ACT, including better data systems, and better discharge practices, could improve the patient experience for those with complex or chronic conditions and reduce the incidence of avoidable hospital admissions.

Madam speaker, the Report identifies the flow of information as critical to enabling effective patient navigation services. The Report noted that the Canberra Health System had over 200 IT systems that capture and store patient information, leading to fragmentation and frustrating coordination of care.

As members may recall, in May of this year the ACT Government released the ACT Digital Health Strategy 2019-2029. The Government is investing $106 million in capital over the next eight years to support the Digital Health Record, which is a key activity to support the achievement of the Strategy.

The Strategy sets out the Government's vision for enabling and delivering person-centred care through digital innovation. A core component of the Strategy is progressing clinical information integration, ensuring information can be shared across systems and is accessible to healthcare providers.

Key to realising this vision will be the delivery of the Digital Health Record. The Digital Health Record is a comprehensive record of interactions between a person and publicly funded health services in the ACT. It will be centred around the person, rather than focused on clinical speciality or treatment location.

Additionally, a patient's health care team will be able to more readily access information, improving care and reducing errors. It will enable them to better focus on the person requiring care, rather than spending time searching for key health information.

Finally, the Report highlights the importance of addressing the social needs of the patient, including lifestyle factors or social issues that are either contributing or protective factors to a patient's condition. For example, financial security, transport to and from appointments, and health literacy. Importantly, lay-person navigation programs have proven particularly successful in improving access to health services for vulnerable populations, such as lower-socioeconomic groups and culturally and linguistically diverse communities.

Other issues, such as the mapping of privacy implications and consent arrangements to allow data sharing across health services, still need to be considered in the development of a patient navigation service.

Madam Speaker, I acknowledge that patient navigation services should be implemented more broadly, and we can apply these learnings to other areas of the health system.

Providing a holistic and supportive health navigation service for the broader ACT community is a long-term objective. As part of that objective, the ACT Government has committed an additional $500,000 over three years to the Health Care Consumers' Association to develop clear information to help patients better understand the health system.

We know that actively engaging individuals in their own treatment enables them to take control of the management of their health and improve their quality of life. Coordination of different health care providers, settings and across different sectors, as well as active engagement, has significant potential to lead to better health outcomes.

Further work is required to develop a detailed model of patient care navigation for the ACT. The Health Directorate is exploring options to implement a model for a patient navigation service that would include, but may not be limited to, chronic conditions.

Madam Speaker, the Government acknowledges the importance of having patient navigation services available to all members of the community as part of providing person-centred care.

The Government is constantly working to improve the coordination of care across the health service. The information reported by the HCCA enables us to reflect on areas of success, identify areas for improvement and commence further policy work to support the development of patient navigation services and support the Government's commitment to delivering exemplary person-centred care across the ACT health system.

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