

*SERVING THE NEEDS OF THE PATIENT:
BETTER PATIENT MANAGEMENT IN
MELBOURNE'S PUBLIC HOSPITALS*

Paper No 1 of the Patient Management Taskforce



**Serving the Needs of the Patient:
Better Patient Management in
Melbourne's Public Hospitals**
Overview Paper: Introduction and Key Themes

February 2001

Acknowledgments

Published by Patient Management Taskforce
Victorian Government Department of Human Services Melbourne Victoria

February 2001

Also available at www.dhs.vic.gov.au/ahs/patman

© Copyright State of Victoria 2001

(0451200)

Foreword

Victoria's public hospitals have gradually become clogged over the past two years. Emergency departments are stretched and stressed, surgeons cannot find hospital spaces for their elective patients, and ambulances are taking more emergency calls but sometimes cannot deliver their patients to the nearest hospital. Those who have been around for a while say that this happens to our hospitals every few years, that it seems to be a cyclical problem, and that we will 'battle through'. Others say that something fundamental must change or the system will collapse. However, Victoria is not alone in facing these kinds of problems. Hospital systems in other States, and overseas, are experiencing similar pressures.

Everyone has an opinion on why this is happening. Some say Victorians are using public hospitals more, as a result of changes in general practice and nursing home care. Others say Victorians are getting older and sicker. Many claim that we are simply feeling the effects of the funding austerity of the 1990s, which has led to staff shortages and bed shortages. Perhaps the way in which we use our hospitals is outdated, or we do not adopt new technology quickly enough, or our hospitals are too parochial to cooperate with each other and with community-based health services. Some hospitals do not hear about, or maybe simply ignore, ideas that work well to improve patient care in other hospitals. Maybe it is all an inevitable consequence of the cumbersome division of health care responsibilities between Commonwealth and State governments, frequently lamented by policy analysts but dogged in its persistence.

There may be many theories about why problems are arising, but there is relative agreement on what the problems are. And the good news is the abundance of innovative activity 'at the coalface' to try to overcome the problems. This activity can form the basis for system-wide initiatives to help relieve the current blockages. However, today's problems cannot be solved by a simple fine-tuning of what hospitals do. Contributing at least as much to these problems are much deeper social and political issues about how our health system is structured and how it operates, and about what we expect of it and what we are prepared to pay to achieve what we want. Such issues cannot be fixed by hospitals alone.

The Patient Management Task Force is undertaking a review of what hospitals and health services are doing to maintain and improve their ability to service the needs of their patients. The task force aims to identify which ideas work in terms of improving services to patients, so these ideas can be widely adopted across Victoria's public hospitals. We also intend to identify opportunities for broader change, in the hope that they will be taken up by the appropriate authorities.

A handwritten signature in black ink, appearing to read 'Michael Walsh', with a long horizontal line extending from the end of the signature.

Dr Michael Walsh
Chair

Contents

Introduction	7
Patient Management	7
Related Work	7
The Patient Management Task Force	9
Membership	9
Terms of Reference	9
Work Plan	9
The Current Situation	11
Population Changes	11
Access to Emergency Services	12
In-hospital Phase	14
Elective Surgery Waiting Lists	15
Discharge and Post-discharge Phase	16
Preliminary Observations	17
Critical Factors Affecting Performance	17
– Patient Admission/Pre-admission Phase	18
– In-hospital Phase	19
– Use of Alternatives to Inpatient Care	19
– Discharge and Post-discharge Phase	20
Incentives and Other System-wide Enabling and Inhibiting Factors	20
Ethically and Socially Responsible Decision Making about Treatment	21
Action Papers	22
Appendix 1: List of Organisations Consulted	23

Introduction

Pressures on access to the public hospital sector have significantly increased in the past two years. These pressures have been strongest in Melbourne’s metropolitan health services, but the phenomenon is common to the advanced health systems throughout Australia and overseas.

Meeting these challenges may eventually require a combination of more available beds, more nurses and other health professionals, and more discharge options, including aged residential care beds. New disease and chronic illness management practices may prevent some admissions. But, action on these solutions can only have an impact in the longer term. Basic issues of patient management practice need to be addressed urgently if Melbourne’s hospitals are to respond to legitimate community and government expectations. This is already happening, but there is considerable variability across the sector. We must do better with what we have now.

Patient Management

Process management is likely to yield some immediate gains. Victoria’s public hospitals are responding to the new demand pressures by reviewing and reorganising their patient management processes, but this response is occurring to a varying extent and with varying degrees of success across hospitals.

There is also a need for a closer focus on how improved performance in specific settings can be encouraged. The Department of Human Services has indicators of access to emergency, elective surgery and critical care, and it is developing indicators of the effectiveness of discharge planning. However, routine monitoring of indicators of good in-hospital patient management practice is lacking and there is scant focus on patient management in specific medical specialties.

The Patient Management Task Force has been set up to identify specific areas for improvement in in-hospital patient management processes and to advise on the system drivers that will bring about the adoption of best practice in patient management. An objective of the task force is to engage actively with hospital management and clinicians in dealing with problems of access to emergency services and elective surgery — both at the individual health service level and in professional forums. The task force is also seeking to obtain views from a wide range of stakeholder groups on effective solutions.

Related Work

The Department of Human Services is undertaking work in related areas and the output of these studies will be available to the task force. These projects include:

- A study of the aged care/acute care interface — a project that aims to increase bed availability in the aged residential care sector, investigate and improve assessment and referral processes, and inform negotiations with the Commonwealth Government about the supply and distribution of residential care beds.

- An investigation of substitution and diversionary services — an investigation of the use of such services and care planning and coordination to prevent presentations at emergency departments and admissions to acute beds from emergency departments.
- A study of the sub-acute care/acute care interface — work that will investigate the management of older people in acute and sub-acute care, and recommend strategies to ensure the best use of acute and sub-acute resources in managing demand.
- The Designing Care Program offers 30 health and ambulance services an opportunity to involve clinicians and managers in redesigning patient management processes across the health system. To date, the common patient management processes emerging from the project submissions are the process of care for elderly and general medical patients from emergency departments to sub acute, the process of care for elective patients from pre-admission to discharge and patient safety processes. Health services working on similiar projects can collaborate to share experiences and insights.
- Other projects — for example, a clinical prioritisation project to develop a better system to prioritise key groups of elective surgery patients; a medical inpatient study; a study of the use of short stay units; and the introduction of a computer-based waiting list optimisation system.

The Patient Management Task Force

Membership

- Dr Michael Walsh (Chair) — Chief Executive, Bayside Health
- Dr Jim Breheny (Deputy Chair) — Chair, Austin and Repatriation Medical Centre Board
- Professor Gordon Clunie — Chair, Ministerial Advisory Emergency and Critical Care Committee
- Ms Ella Lowe — Executive Director Operations, Peninsula Health
- Mr Robert Burnham — General Manager, Northern Hospital
- Dr Heather Buchan — Assistant Director, Quality and Care Continuity Branch, Acute Health Division, Department of Human Services
- Mr Geoff Lavender — Project Director, Patient Management, Acute Health Division, Department of Human Services¹

Terms of Reference

1. To identify essential organisational and patient management practices that should be in place in all hospitals.
2. To determine the extent to which these practices are occurring in metropolitan health services, identify specific areas where improvements should occur and advise on how these improvements could be quickly achieved.
3. To determine key indicators of good patient management practice and the benchmarks that should be achieved by health services.
4. To advise on incentives and other strategies that could be used to encourage health services to achieve benchmarks.
5. To communicate and engage with representative bodies of health professionals, practitioners, managers and other stakeholders in identifying and implementing good patient management practices.

Work Plan

Established in November 2000, the task force will complete its work by 31 March 2001. The project has a principal focus on the 12 major metropolitan hospitals.² The task force is carrying out its work in three stages. The first stage, information gathering, is now largely complete. The task force (or secretariat) has met with 29 professional and peak bodies (Appendix 1) and conducted site visits to each of the metropolitan health services and three major regional hospitals. Metropolitan health services have provided statistical data, information about their bed/patient management practices, and relevant internal key performance indicators. The task force has also commissioned reviews of international literature to inform its work and is obtaining data analyses to provide comparative information about hospital and system performance. The two literature reviews are available on the Task Force web site at www.dhs.vic.gov.au/ahs/patman.

The second stage involves producing papers on 'action areas' for consideration and comment by the field. The task force will invite written responses (by submission or email at patient.management@dhs.vic.gov.au).

The final stage will be the preparation of a short final paper incorporating (a) a summary of the principal themes of the task force's work, (b) key areas for action and (c) any changes to the views of the task force as a result of the consultations.

¹The Department of Human Services project team comprises Robynne Cooke (on secondment from the Austin and Repatriation Medical Centre), Nick Legge (Aged, Community and Mental Health Division), Peter Lewis (Acute Health Division), Amos Yee (Acute Health Division) and Julie La Gamba (Executive Assistant).

²The Alfred Hospital (Bayside Health); Austin and Repatriation Medical Centre; Box Hill, Maroondah and Angliss Hospitals (Eastern Health); Frankston Hospital (Peninsula Health); Monash Medical Centre (Clayton and Moorabbin) and Dandenong Hospital (Southern Health); Northern Hospital (Northern Health); Royal Melbourne Hospital (Melbourne Health); St. Vincent's Hospital; Western Hospital (Footscray and Sunshine) (Western Health)

The Current Situation

Factors that have been proposed as contributing to the access problems in Melbourne's public hospitals include:

- Advances in technology that allow more treatments to be provided to older and sicker people than have ever been possible in the past.
- Increasingly sophisticated consumer and provider expectations in relation to treatment availability and its application.
- Increased emergency department attendances for complex psychiatric and alcohol and drug-related conditions.
- A reduction in the availability of general practitioners for home visits and out-of-hours care.
- A proportional reduction in the number of aged residential care places available to meet demand and/or a poor geographic distribution of these places.
- A growing tendency for nursing homes to transfer unwell residents to hospital emergency departments rather than make use of alternatives to hospitalisation.
- The potential for over-treatment of this nursing home group as a result of limited information about patients' previous medical history and prognosis.
- Societal changes that have effectively reduced the capacity of the informal carer network in the community.
- Inadequate recognition of the importance of sub-acute care and rehabilitation alongside the continuum of acute care.
- The structure and educational background of the health workforce, which may not have kept pace with changing care options.
- Inefficient in-hospital patient management processes that lead to patients unnecessarily occupying hospital beds when (at least) equally effective alternatives may be available.

It is difficult to collect evidence (especially quantitative data) to test such assertions, no matter how plausible they may appear. The recent Senate Community Affairs References Committee inquiry into public hospital funding concluded that:

"If the Committee was to select a single thread that links all aspects of this inquiry, lack of data would be an obvious choice. It is quite staggering just how little is known about many important aspects of the operation of public hospitals." (*Healing Our Hospitals*, December 2000, p xii)

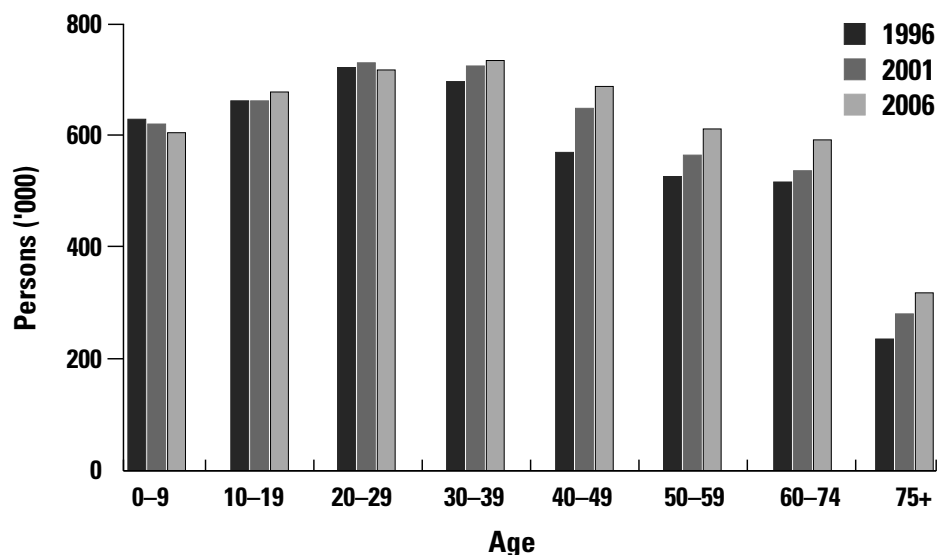
Data that are available to shed light on the current situation include the following areas.

Population Changes

Population growth and ageing trends are well known (Figure 1). The population aged 55 years and over, which uses around 60 per cent of all public hospital patient days, is projected to grow by around 15 per cent over the next five years. Based on current clinical practices and utilisation rates, this equates to around 400 beds for multi-day admissions, plus the capacity for a further 140 000 same-day admissions.

A growing proportion of this ageing population is living alone — a trend that is associated with both a rise in morbidity (for example, an increase in falls) and an increased need for post-hospital care. The resulting demand for health care, despite debate about how it will be affected by other factors (such as private hospital use, morbidity trends and technological advances), clearly puts pressure on health services to deliver care in new and innovative ways.

Figure 1: Victoria's Population, 1996–2006



(Source: Department of Infrastructure)

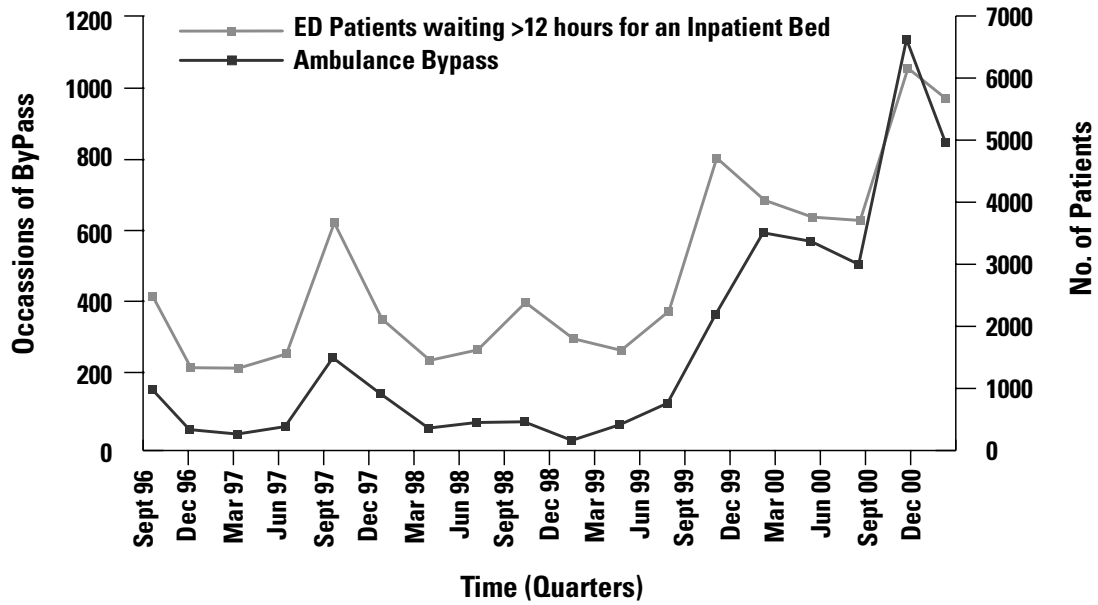
Access to Emergency Services

Since 1995-96, when the emergency services enhancement scheme was introduced, emergency department presentations at Melbourne's major hospitals have been growing at an average of 1.7 per cent a year. However, emergency admissions are growing by 6 to 7 per cent a year, placing pressure on bed capacity and elective surgery. This is occurring in the context of a number of key changes in recent years:

- Bed occupancy rates have risen to very high levels in many metropolitan hospitals, and while this can be a measure of system efficiency, it also diminishes the system's capacity to cater for peaks in emergency demand.
- The proportion of presentations that lead to admission as an inpatient has risen from 33% to 39% in 1999-00.
- Emergency cases transported by ambulance, which contribute a large share of emergency department caseload, have been growing at an average of 7% per annum.
- Patients presenting are older with complex and multiple problems and this generally means that managing them appropriately takes longer.

Ambulance bypass and 12-hour admission blocks have been on an upward trend since the winter months of 1999 (Figure 2).

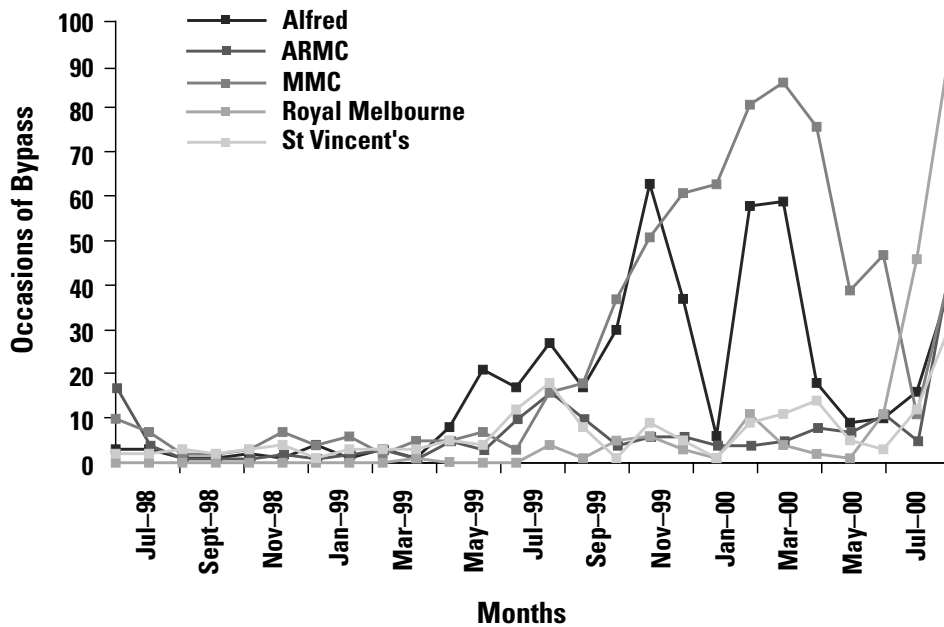
Figure 2: Ambulance Bypass and Emergency Department Patients Waiting 12 or More Hours for Inpatient Bed, Victorian Hospital Access Program Hospitals, by Quarter, 1996–2000



(Sources: Metropolitan Ambulance Service’s Ambulance Bypass Reports and Victorian Emergency Minimum Dataset Reports)

Performance has also been variable across the sector over time (Figure 3).

Figure 3: Ambulance Bypass, Selected Victorian Hospital Access Program Hospitals, by Month, 1998–2000

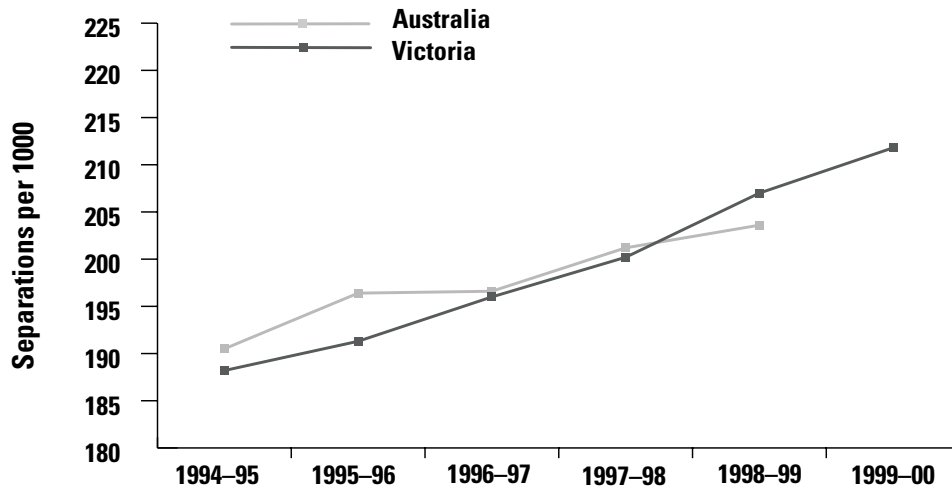


(Source: Metropolitan Ambulance Service’s Ambulance Bypass Reports)

In-hospital Phase

Victorians are using public hospitals more. On a per capita basis, Victorian public hospital separations have increased at an average of 2.4 per cent per annum over the past five years in line with the national average (Figure 4).

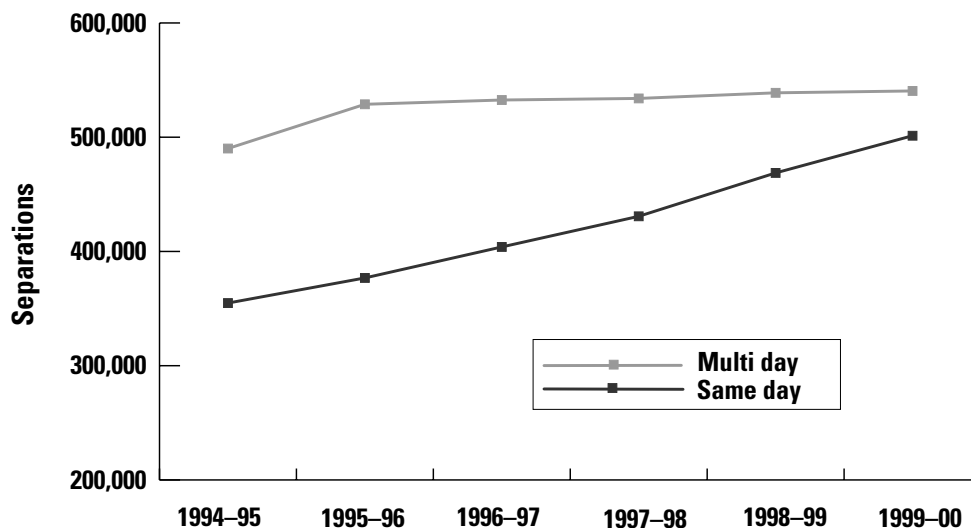
Figure 4: Separations per 1000 Population, 1994–95 to 1999–2000



(Source: Victorian Admitted Episodes Dataset and Australian Institute of Health and Welfare)

This was largely driven by a substantial growth in same-day separations — up from 354 829 in 1994–95 to 510 290 in 1999–2000 (Figure 5). This growth is in line with national and international trends, and has been facilitated primarily by technological and clinical advances.

Figure 5: Separations in Victorian Public Hospitals, 1994–95 to 1999–2000



(Source: Victorian Admitted Episodes Dataset)

Average length of stay has fallen sharply, mainly driven by the increase in same-day separations. The overall average length of stay declined over the period 1994–95 to 1999–2000 from 4.2 days to 3.8 days — a reduction of around 10 per cent.

As a consequence of increasing hospital inpatient use and tight fiscal constraints, occupancy rates have risen. High occupancy means hospitals are very efficient, but they are less able to cope with the increasing number of admissions and seasonal fluctuations because there are insufficient ‘flexible’ beds in the system.

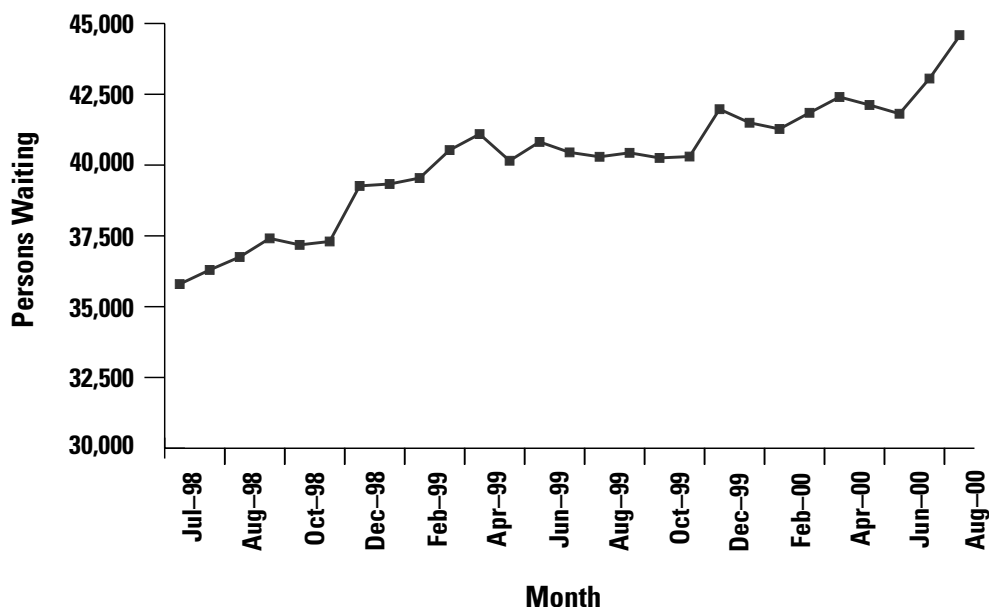
For many years, throughput in the State’s public hospitals has accommodated seasonal variations. Typically, emergency demand peaks in winter (partly a result of the prevalence of influenza and other infections) and is at its minimum during summer (when a significant proportion of the workforce takes holidays). Elective admissions can be adjusted to deal with prolonged high demand but such adjustments were relatively minor until 1999 and 2000. Higher average bed occupancy means that peaks in emergency demand must be accommodated by longer stays in the emergency department (and consequent higher bypass and 12-hour stay rates) or the cancellation of elective surgery, or even both.

Some metropolitan hospitals, particularly those with an inner city catchment and a Statewide role, are finding that high levels of emergency demand are no longer just a winter phenomenon.

Elective Surgery Waiting Lists

Elective surgery waiting lists steadily increased over the past two years (Figure 6).

Figure 6: Total Patients Waiting for Elective Surgery in Victorian Public Hospitals, 31 July 1998 to 30 September 2000



*Footnote Sept 00 Quarter figures are provisional

(Source: Elective Surgery Information System)

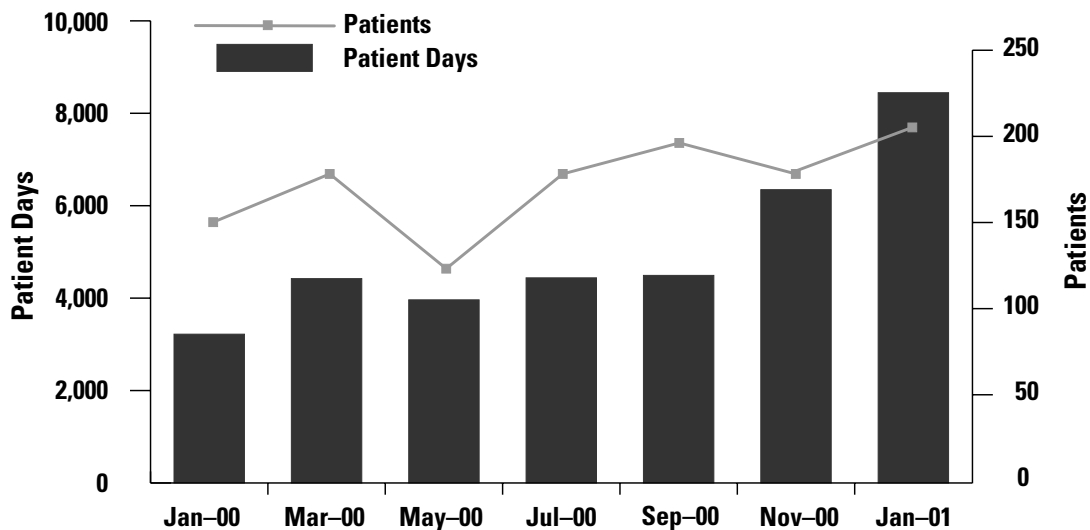
Waiting lists vary across the Metropolitan Health Services both in size and in the trends they reveal. The task force will explore issues of best practice in waiting list management by health services.

Discharge and Post-discharge Phase

The decreasing average length of stay, driven by a shift to same-day activity, has allowed existing hospital beds to become more productive. However, this is now sensitive to a hospital's ability to discharge patients, which in turn is related to the availability of community-based services and post-acute institutional services.

Patients assessed as requiring aged residential care are becoming increasingly difficult to place. Over the past year the number of bed days associated with patients in acute beds who are simply waiting to be placed in a nursing home or hostel has more than doubled. (Figure 7).

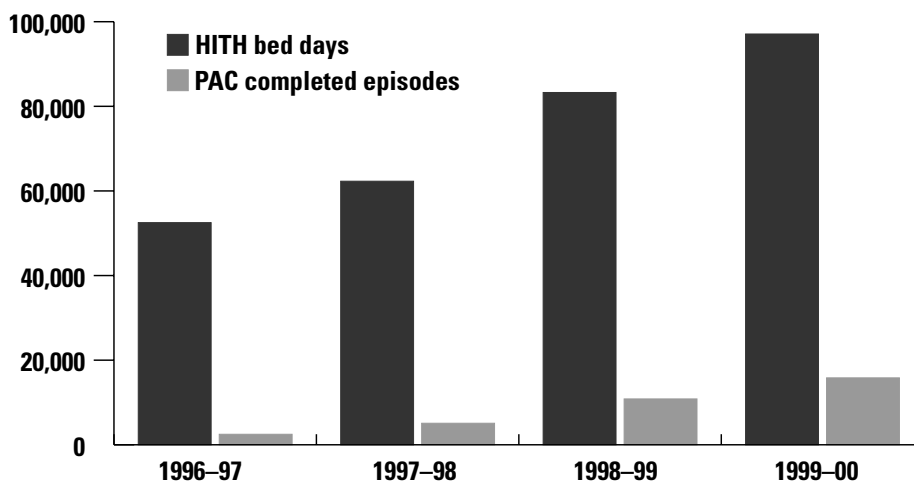
Figure 7: Patient Days in Victorian Public Hospital Acute Beds Occupied by Patients Awaiting Placement in Residential Care



(Source: Department of Human Services Bed Surveys)

Growth in hospital-in-the-home and post-acute care services has been substantial. Hospital-in-the-home bed days increased from 52 511 in 1996–97 to 97 097 in 1999–2000, while post-acute care completed episodes increased from 2486 to 15 819 in the same period (Figure 8).

Figure 8: Growth in the Hospital-in-the-Home Program and Post-acute Care Program in Victorian Public Hospitals, 1996–97 to 1999–2000



(Sources: Hospital-in-the-home — Victorian Admitted Episodes Dataset; post-acute care—Post-acute Care Program Care Manager)

Preliminary Observations

The system is clearly under considerable pressure. This is not unique to Victoria. Similar stresses are being experienced in other States and other countries. However, there are innovative responses to this pressure in Victorian hospitals. Some innovation will always be specific to local circumstance, but it is clear that patient management practices vary among hospitals and that best practice is not uniform. A culture of sharing information, experience and learning is not widespread, so there is a significant opportunity to improve patient management through more cooperation and dissemination of knowledge and expertise.

Useful comparable information on patient management practices and key aspects of clinical care is scarce. Some health services have made more effort to gather and use this information than others have. Far greater effort is invested in gathering and using financial information than in using information that relates to the care that people receive from the acute health sector. The lack of such important data on hospital performance makes it extremely difficult to monitor or compare basic patient management processes. Reliable information on the degree of variation is unavailable in many areas. There is also a lack of uniform standards in the measurement of performance, which places doubts on the comparability of the data that can be obtained.

Appropriate care of the frail elderly is a particular issue, because aged residential care and community services are lacking. One of the most consistent and dominant themes of the task force's consultations has been the declining access to aged residential care and the importance of Commonwealth action on this issue. The task force has noted the difficulties experienced by hospital staff in accessing adequate and appropriate community-based and home-based services, especially at weekends.

Changes in the private health system are having an impact on the public sector. The public sector is steadily becoming the only source of care for patients with complex and longer stay medical conditions. The Senate Committee inquiry into public hospital funding found:

“... no evidence that there is a direct link between the level of coverage of private health insurance and demand for public hospital services and that as the level of coverage increases, so the demand for public hospital services will fall.” (*Healing Our Hospitals*, December 2000, p xii)

Critical Factors Affecting Performance

The task force is examining patient management practices within the three basic phases of hospital care: pre-admission, in-hospital and discharge/post-discharge. It has already identified a number of practices that contribute to effective and sustained improvements in in-hospital patient management.

Patient Admission/Pre-admission Phase

Emergency Department Presentations

- *Bypass processes and decision making.* Decision-making criteria and processes about ambulance bypass appear to vary across hospitals. There are few effective early warning systems to give nearby hospitals the time to gear up in case of 'flow-on' emergency presentations. Informal arrangements to provide early warnings to ambulance services do not appear to have been effective in avoiding unnecessary ambulance arrivals at the emergency departments.
- *Short-stay units.* Short-stay units have been established in or near emergency departments in some hospitals. Typically, these are either an observation unit (such as for chest pain) or a rapid and concentrated packaging of care (often using intensive social work or allied health resources) to enable a rapid discharge (within 12 hours, for example). The second category (variously named as the Rapid Assessment and Management Unit, Emergency Management Unit, etc.) offers the hospital an opportunity to streamline its patient care process. Hospitals that do not have such units should consider establishing them or be able to demonstrate that they achieve equivalent results by changing local work practices.
- *Access to specialist geriatric, psychiatric and alcohol and drug services in the emergency department.* The characteristics of people presenting at emergency departments are changing. Increasing numbers of older people with complex needs, people with psychiatric disorders, and drug users require special expertise. Emergency departments should have rapid and seamless access to such specialist capability, but hospitals vary in the extent to which such services are available. All Metropolitan Health Services are funded to provide an immediate and direct mental health response to major emergency departments on a 24 hour basis, with a particular focus on people at risk of suicide, although not all of them have an on-site mental health presence.
- *Opportunities for the prevention of emergency department presentations.* Some Metropolitan Health Services have made arrangements with general practitioner groups to set up general practice clinics near the hospital emergency department. This enables category 4 and 5 patients to have the option of faster and more appropriate care in a general practice setting. In view of the task force's extensive anecdotal evidence that declining out-of-hours general practitioner services are contributing to increased emergency department presentations, there is a clear opportunity for hospitals to adopt a more vigorous and organised approach to developing joint arrangements with general practitioners.

Elective Admissions

- *Day-of-surgery admissions (DOSAs).* Such admissions are well established as an area of essential patient management practice. Evidence from a number of metropolitan hospitals suggests that DOSA rates vary widely across and within hospitals. One issue identified as affecting the ability of organisations to increase DOSA rates is medical staff acceptance of this practice. Figures provided to the Task Force for the year to date 2000–01 vary from 61 per cent to 87 per cent.
- *Pre-admission procedures and tools, patient education and risk assessment.* Pre-admission procedures to support the day-of-surgery and admission process have been identified as critical. Appropriate pre-admission procedures should lead to fewer cancellations for elective surgery, and appropriate risk assessment prior to admission is vital in mapping the care plan and discharge plan. The use of appropriate risk assessment tools in the emergency department has also been identified as a useful mechanism for care planning.

In-hospital Phase

- *Theatre use, including emergency theatre use, after-hours use, spatial issues, peri-operative facilities, interview rooms, etc.* Theatre use and the ways in which the efficiency of operating room services are measured vary across the sector. Further, the management of emergency theatres and the availability of access to these emergency theatres 'in hours' affect the performance of hospitals. Physical operating room capability and the availability of appropriate peri-operative areas also affect operating room efficiency.
- *The use of clinical pathways for selected patients/procedures.* Clinical pathways are one way of improving patient management across the system. Pathways are used in varying degrees across hospitals and across the system as a whole. There appears to be limited sharing of pathways among hospitals, so there are opportunities for determining where the use of pathways provides most value and for sharing knowledge and experience across organisations.
- *Timely in-hospital access to specialists and diagnostic testing.* Systems are not universally geared to cope with changed patterns of hospital use. Given current pressures on the hospital system, it is inappropriate for patients to be waiting for prolonged periods of time in hospital for diagnostic tests or specialist opinion or review.
- *Dedicated elective surgery facilities and campuses, and quarantined beds.* The task force is concerned that emergency department pressures may be distorting clinical priorities in such a way that category 2 elective surgery patients on the waiting list may be in greater clinical need than some medical patients who receive a bed. Several Metropolitan Health Services have a capacity to employ one campus as a dedicated elective surgery facility. Others have considered quarantining beds for elective surgery. The task force has not yet formed a definitive view, but it does expect that (a) hospital policies and practice explicitly provide for the allocation of beds on the basis of clinical need, and (b) that at a local level there are systems for reviewing the comparative needs of patients receiving care and those waiting for care. Some hospitals have been able to allocate beds to take account of seasonal differences. A more rapid and flexible response to seasonal and other variations should be part of a hospital's essential patient management practice. Many hospitals could make more effective use of their knowledge of patterns of emergency admission to assess the likely demands on their resources, and to improve the planning of the number and types of elective admission they can accept.

Use of Alternatives to Inpatient Care

- *Hospital in the home.* There is variation in the use of hospital-in-the-home with four of the twelve major hospitals providing 55 per cent of hospital-in-the-home separations in 1999-2000. Clinical specialisation may account for some of this variation, but there appear to be substantial opportunities for more extensive use of the program. A person's home may be a nursing home. The program's guidelines allow for 'hospital in the nursing home', but there is relatively little evidence of Melbourne's public hospitals providing this form of care.
- *Same-day medical and surgical treatment, and ambulatory care facilities.* Ambulatory care facilities can be used in the treatment of both surgical and medical patients. They are different from hospital-in-the-home services in that patients receive day care services on site. Already, a significant (although widely varying) proportion of elective surgery is carried out on a same-day basis. However, the task force believes there is considerable room to increase substantially the rate of same-day procedures in Victorian hospitals. There is also potential to explore and develop this concept in the care of medical patients to free overnight beds.

Discharge and Post-discharge Phase

- *Access to aged residential care and sub-acute/interim care, and nursing home liaison.* Speedy access to aged residential care and also to the sub-acute sector in the form of rehabilitation beds, respite beds and interim care beds is crucial in the ability of organisations to respond to and manage emergency and elective demand. Actively engaging nursing homes and developing links between the sectors through assertive social work and allied health practice has led to the improved capacity of some hospitals to place patients assessed as requiring nursing home care, but the extent of this practice varies across the system. Process redesign (including measuring and reducing the steps involved in patient placement from assessment to discharge) is an area for further development in some hospitals, as is the establishment of routine monitoring of the time taken to place patients in appropriate forms of care.
- *Post-discharge follow-up and access to in-home supports.* Many hospitals have taken steps to improve their discharge planning processes to tackle external causes of delay — for example, by notifying local community services more promptly of a patient’s need for assessment, which may help the services initiate patient assessment and ongoing care services earlier. The post-acute care program was identified as having made a significant contribution to improved patient flows. The task force is aware of patient difficulties in accessing district nursing services (with delays of up to three weeks in some health services) and lengthy waiting lists for other home based services in some areas. The task force recognises that addressing these issues also requires action on the part of the Commonwealth and local governments. However, more extensive use of post-acute care services, along with their application in the sub-acute sector, could help address the current stresses on community services.
- *Discharge planning, transit lounges, etc.* The Department of Human Services recently published *Performance Indicators for Effective Discharge* (November 2000), which covers this area in detail. There is scope for more hospitals to follow the lead set by others, by planning patient discharge earlier (before or at the time of the patient’s admission) and by regularly examining the internal causes of delayed discharges and working to resolve the obstacles identified. Hospitals can further develop the role of the discharge coordinators to address any internal causes of delayed discharge and to secure the maximum degree of cooperation among health and community providers in meeting the needs of discharged patients. Many hospitals provide suitably situated and staffed discharge lounges for patients ready to leave hospital, to enable the patients to vacate beds promptly and to admit new patients. They may also provide alternative services (such as home support) to allow patients to return home promptly, as well as step-down care beds for use when the provision of services from other care providers is delayed and occupation of an acute ward bed is no longer appropriate.

Incentives and Other System-wide Enabling and Inhibiting Factors

The task force has been asked to advise on incentives and other strategies that could be used to encourage health services to achieve benchmark performance in patient management. A range of ‘levers’ can be used to influence performance at the individual hospital level and across the metropolitan system. The task force will issue a paper on these system-level issues, with specific proposals in areas such as the following.

- *Benchmarking and inter-hospital information exchange.* The ability of organisations to share information and cooperate on patient management practices and issues occurs to varying degrees across the system. There appears to be more interState and overseas cooperation through such organisations as the Health Round Table, although the Breakthrough series is

one recent successful local development. Some clinician groups have highlighted opportunities for improved use of comparative clinical performance data to inform and improve practice. There is an opportunity for metropolitan health services and the Department of Human Services to facilitate the sharing of information and best practice through cooperative structures.

- *Incentives and disincentives in current funding systems.* Stakeholders have widely divergent opinions about the value and effectiveness of current bonus/incentive schemes, particularly those associated with the delivery of emergency services. Some argue that the schemes have brought about a higher level of senior management and clinician attention to emergency performance. Others suggest that they have ceased to be effective because the bonuses are too small relative to the overall level of funding, or the targets are simply unachievable in the current environment, or the bonuses are not paid back to the areas of the hospital that have actually delivered the outcome, or a combination of all three reasons. The task force will be reporting on this issue in a future paper. Views about key performance indicators and targets vary too. There is a tension between the 'equal targets for all' (for example, five occasions of ambulance bypass a month) concept (favoured by some on the grounds of transparency and objectivity) and hospital-specific targets (approved by others on the grounds of flexibility and local relevance). The task force will consider a range of options in this area, including improvement targets.
- *Clinician leadership and focus.* A common theme in many of the presentations to the task force has been the importance of clinician engagement and leadership in achieving process and cultural change. The National Health Service clinical governance initiative in the United Kingdom has been established to strengthen the involvement of clinicians in a range of improved performance management arrangements. New South Wales recently established a Health Council to fulfil a similar function.
- *Hospital role delineation.* The task force will raise the issue of metropolitan hospital role delineation. To what extent is it possible or desirable for the Statewide specialist teaching hospital to continue to combine its role as a suburban hospital serving a large local community? What is the impact of dedicated elective surgery hospitals on service delivery to patients? Should hospital emergency departments be clustered across a geographic area so they operate under common policies and procedures with uniform decision-making criteria and with a lead or 'reserve' emergency department that is always available as back-up to the others?
- *Managing community expectations of the emergency department.* While the proportion of emergency department presentations in triage categories 4 and 5 has decreased over recent years, there is still a substantial volume of such presentations. This may reflect problems of access to general practitioner services, especially out of hours, but is also heavily influenced by community and consumer expectations of the hospital emergency service. New South Wales has run mass media-based education campaigns to inform the community about the services available from emergency departments and alternative care providers. The task force will examine the effectiveness of this and similar initiatives elsewhere.

Ethically and Socially Responsible Decision Making about Treatment

In their discussions with the task force, a number of key professional bodies identified the need to engage in professional and public debate on the issues related to responsible decision making about patient management and the importance of patients' individual choices about the care that they receive. The task force believes that this is an important theme for the professions and consumer representative groups (rather than governments or departments) to take up, and one for which they need to develop appropriate guidelines and procedures. It will provide a more detailed discussion of these issues in a future paper.

Action Papers

The task force has identified areas for more detailed examination and for the development of recommendations for change. Papers will be released covering the following themes:

- Opportunities for, and the implications of, increasing the proportion of same-day elective surgery procedures and developing ambulatory complex medical care services.
- The better (faster) management of multi-day medical and surgical cases (having regard for the potential for increases in unplanned re-admissions).
- Patient management practices in the hospital emergency department.
- The improved management of frail aged and chronically ill patients, including the acute/sub-acute interface and the more streamlined placement of patients into nursing homes.
- Ways of making the most of community and home-based alternatives to inpatient care, such as hospital in the home, outreach services to nursing homes and ambulatory care centres.
- Ethically and socially responsible decision making about treatment.
- System drivers for capacity and capability building (including key performance indicators and reporting; structured inter-hospital benchmarking and information sharing; modifications to funding arrangements and incentives; and medium-term initiatives covering the better use of information technology, clinician leadership and developmental programs).

These papers will provide information on how widespread good practices are, identify areas for improvement and propose specific indicators and benchmarks. They will outline proposed recommendations — for hospitals and for the Department of Human Services, and provide opportunity for comment from the field.

Appendix 1: List of Organisations Consulted

Advisory Committee on Access to Elective Surgery
Australasian College for Emergency Medicine
Australian and New Zealand College of Anaesthetists
Australian and New Zealand Intensive Care Society
Australian Association of Gerontology
Australian College of Health Service Executives
Australian Medical Association
Australian Nursing Federation
Carers Association
Chronic Illness Alliance
College of Pathologists
Committee of Chairmen of Senior Medical Staff of Major Hospitals
Council of Directors of Nursing of Nursing Homes
Discharge Planners Group
General Practice Divisions Victoria
Health Issues Centre
Melbourne Medical Locum Services
Metropolitan Ambulance Services
Office of the Coordinator of Emergency and Critical Care
Office of the Health Services Commissioner
Royal Australasian College of Surgeons
Royal Australian and New Zealand College of Radiologists
Royal Australian College of General Practitioners
Royal Australian College of Medical Administrators
Royal Australian College of Physicians
Royal College of Nursing, Australia
Royal District Nursing Service
Victorian Centre for Ambulatory Care Innovation
Victorian Healthcare Association

