

Patient Management Task Force
A Ten-Point Plan for the Future
July 2001

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The Ten-Point Plan

- 1 Establish three emergency services clusters and coordinating hospitals
- 2 Create effective alternatives to emergency care
- 3 Improve elective surgery patient flow
- 4 Expand ambulatory care
- 5 Extend use of care pathways and new models of care
- 6 Focus on care for older Victorians
- 7 Improve relationships with residential care, community and home-based services
- 8 Foster collaboration and leadership
- 9 Introduce new incentives and focus on performance
- 10 Develop metropolitan wide hospital plans

Introduction

THE CURRENT SITUATION

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 couple of 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. Victoria is not alone in facing these kinds of problems. Hospital systems in other States and overseas are experiencing similar pressures.

While there are many theories about why these problems are occurring, there is substantial agreement on what the problems are and on a range of solutions.

THE TASK FORCE

The Patient Management Task Force was established in November 2000 to identify specific areas for improvement in hospital patient management processes and to advise on the system drivers that will encourage best practice in patient management.

Chaired by Dr Michael Walsh, the chief executive of Bayside Health, the seven Task Force members engaged with hospital management, clinicians and a wide range of stakeholders to understand the problems confronting people working in the field.

The Task Force was set up to:

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

THE FINDINGS

Seven months down the track, the Task Force has identified a clear need for greater collaboration and improved coordination in the way hospitals treat their patients. Hospitals need to overcome unnecessary variability in service delivery. The Task Force has identified a number of strategies to

tackle the issues that are summarised in this Ten-Point Plan and set out in more detail in the Task Force's issues papers.

Innovation and adoption of new ways of streamlining patient care are integral to ensure the success of the health system in the future. Hospital staff need to look beyond their own institutions, to other health services, to other States and overseas to tap into practical solutions to many of the common problems. The Task Force has identified several examples of innovation—from within Victoria and from elsewhere—which are ready to be embraced more widely across the field.

The Task Force believes that open and transparent performance monitoring should be fostered as should inter-hospital benchmarking and incentives for change. Coordinated, metropolitan-wide planning is needed to ensure a balance between overall system-wide performance and individual hospital functioning.

The fundamental strength of any health system is the people who work in it. The Task Force believes involvement and engagement from those in a position to make a difference is essential. Senior clinicians and executive leaders are the key drivers of change. For example, there must be greater reliance on senior clinicians to set and monitor standards of clinical practice. Through greater cooperation at this level, the system can respond more rapidly to changes in clinical practice and advances in technology.

But a sense of collaboration will not flourish without practical support. The Department of Human Services has a crucial role to play in bringing the Task Force initiatives to reality. The Department must work with hospital management, clinicians and consumers to encourage links in services, improve funding models and foster better communication. It must take up these recommendations if systemic change is to occur. Therefore, the Task Force envisages that its directions will be incorporated in the Department's annual business plan and progress recorded in its annual report.

The changes suggested do not rely on a huge injection of funds. Many of the initiatives have already been implemented in some metropolitan health services and can be taken up more widely. Others are more complex and will require significant effort and energy, as well as collaboration.

The recommendations are practical and achievable. They will help to deliver affordable and effective health care through a well-integrated system. Of course, nothing stays the same for long and the Task Force expects that the health system will continue to adapt as technology offers new care alternatives and the needs of the community change.

THE TASK FORCE'S 10 POINT PLAN

The ten-point plan is drawn from a much wider set of recommendations contained in the Task Force's issues papers. It draws together the principal areas for action and identifies the major initiatives that are likely to have the greatest impact.

The Task Force believes that there is a need for a new model of collaboration in which the Department, health service managers, clinicians and consumers/community have a shared responsibility to work together towards better patient management. The metropolitan chief executives group and the metropolitan board chairs have indicated a willingness to take on more responsibility and they should play their part with the Department in fostering the implementation of this plan.

Access to Care in Hospital

1. Establish three emergency services clusters and coordinating hospitals
2. Create effective alternatives to emergency care
3. Improve elective surgery patient flow
4. Expand ambulatory care
5. Extend use of care pathways and new models of care

Access to Care Before and After Hospital

6. Focus on care for older Victorians
7. Improve relationships with residential care, community and home-based services

Incentives and Strategies to Bring About Change

8. Foster collaboration and leadership
9. Introduce new incentives and focus on performance
10. Develop metropolitan wide hospital plans

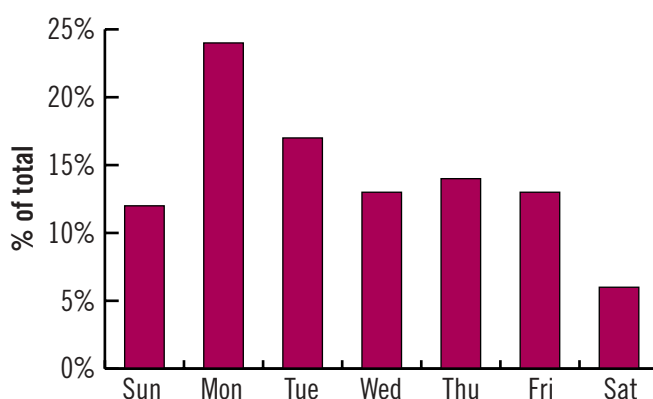
1 Establish three emergency services clusters and coordinating hospitals

Ambulance bypass policies and procedures vary widely between hospitals and there is little collaborative effort across health services to prevent bypass or to manage it when it does occur. A coordinated approach is required.

THE CURRENT SITUATION

- The Victorian public hospital system, like many hospital systems around the world, is facing increasing pressure to meet demand for acute inpatient care.
- An increasing number of patients await elective surgery, wait in emergency departments and there has been a substantial increase in ambulance bypass.
- Ambulance bypasses of Melbourne's major hospitals have increased from 27 per month a year ago to an average of 325 a month.
- Emergency departments are seeing more patients. There has been a 22.6 per cent increase over four years in the number of people being admitted from the emergency department in Melbourne's major metropolitan hospitals.
- The acute sector is working at close to capacity with most hospitals operating at 90 per cent or above. This results in regular bed management pressures.

Figure 1: Percentage of Ambulance Bypass by Day of the Week, 1999–2000



Source: Hospital Access Program

THE WAY FORWARD

Ambulance bypass policies and procedures vary widely between hospitals. The Task Force believes a coordinated approach is now required.

- Metropolitan health services must establish systems to avoid bypass and to deal with it when it is happening. Collaboration and cooperation amongst hospitals is essential.
- The Department should set up a working group of health service managements, emergency clinicians and the Metropolitan Ambulance Service (MAS) to develop guidelines for hospitals on ambulance bypass policy and procedures. Hospitals will then draft their own internal policies for managing bypass.

There is room for a major shift in the way hospitals communicate during peak periods and bypass. Innovation is the key.

- The Task Force proposes the development of emergency service ‘clusters’. Based on bypass information, the Task Force believes the clusters could be:
 - Southern, Bayside and Peninsula,
 - Melbourne, St Vincent’s and Western,
 - Austin and Repatriation Medical Centre, Eastern and Northern.

Clusters will improve coordination, review and monitoring. The Task Force expects that the networks would coordinate the emergency services of local hospitals and the MAS.

- Hospitals should adapt the clusters to meet local needs. At least one hospital in each network should always accept ambulance emergencies. Hospitals should be required to monitor and maintain data on frequency, duration and reasons for bypass.

References

Task Force Paper 2—Meeting Demand for Emergency Services: Better Management of Emergency Patients, Recommendations 1–5.

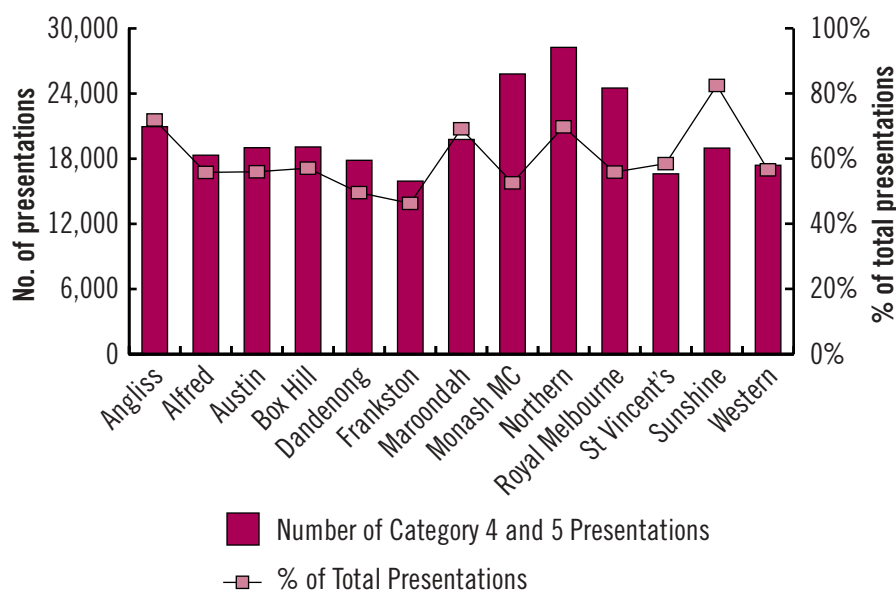
2 Create effective alternatives to emergency care

A number of people who present at emergency departments do so because of access barriers to more appropriate and convenient services, or a lack of knowledge of alternative sources.

THE CURRENT SITUATION

- Demand for lower level hospital emergency services reflect problems with access to GPs and also community and consumer expectations of the hospital service.
- Some 73 per cent of hospital attendances at emergency departments do not arrive by ambulance.
- Many of these are less acute, triage four and five patients
- Many triage category four and five patients' care could have been provided by a GP or other community-based service
- The use of hospital in the home (HITH) and post acute care (PAC) services to prevent avoidable emergency admissions is under-utilised.

Figure 2: Number of Triage Category 4 and 5 Presentations 1999–2000 and Percentage of Total Presentations



Source: Victorian Emergency Minimum Dataset

THE WAY FORWARD

Substitution and diversionary strategies can help to clear hospital emergency departments.

- All metropolitan health services should increase the use of HITH and PAC services as an alternative to inpatient admission. This will increase care options available to emergency patients.

Rapid access to specialist expertise and faster response times for diagnostics will improve the turnaround time within the emergency department.

- The Department and the hospitals should formulate an indicator of total turnaround time in the emergency department. This will ensure the smooth flow of patients through the emergency department and enhanced approaches to managing emergency care. Those patients not requiring an emergency admission will be discharged appropriately.

Hospitals should aim to treat no more than 50 per cent of total presentations from triage categories four and five.

- The Department should provide a quarterly comparative report to hospitals on the trends in presentations of these two groups.
- The Department should support the proposal for a Metropolitan Ambulance Service triage pilot project that will better identify less urgent cases over the phone.

Improved links with GPs and community-based services has the potential to divert patients who do not require emergency department resources to a more appropriate setting.

- Metropolitan health services should build links with GPs to develop their role in discharge planning from the emergency department.

References

Task Force Paper 2—Meeting Demand for Emergency Services: Better Management of Emergency Patients, Recommendations 9–18.

Task Force Paper 5—Improving Hospital Care for Older Victorians, Recommendations 3–9, 15.

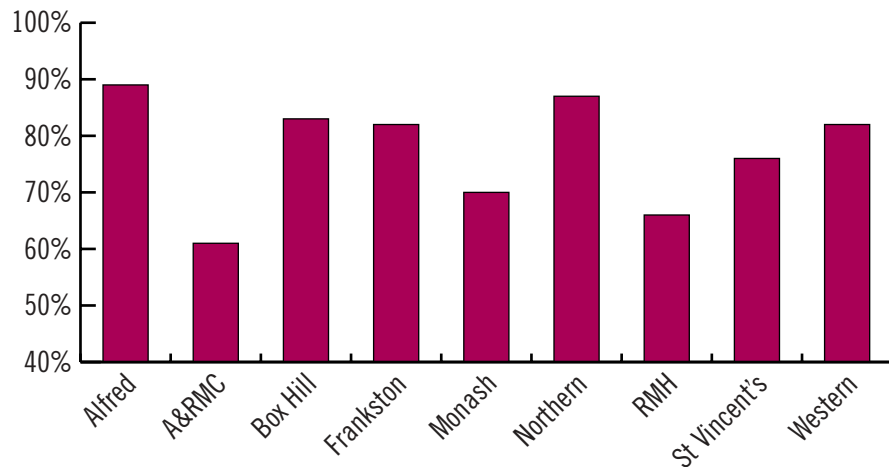
3 Improve elective surgery patient flow

The issue for hospitals is not whether to establish day-of-surgery and pre-admission programs, but to ensure that they are well implemented and functioning effectively.

THE CURRENT SITUATION

- Waiting lists for elective surgery in Melbourne's hospitals have continued to increase since June 1998.
- The average waiting time for category one (urgent) patients is between five and 15 days—well within clinically recommended limits.
- Category two (semi-urgent) patients have been facing increased waiting times since July 1999, as have those with category three (non-urgent) conditions.

Figure 3: Day of Surgery Admissions for the Six Months July–December 2000



Source: Data provided by hospitals

THE WAY FORWARD

Day of surgery admission is a key element in accessing elective surgery. Day of surgery admission (DOSA) rates are increasing but vary between hospitals for a variety of reasons.

- Hospitals should aim to admit patients only on the day of their surgery.

The Task Force has found no evidence that admitting people on the day of surgery delays discharge or increases morbidity or mortality. Best practice DOSA rates are achieved when hospitals collaborate with clinicians and with each other. Reliable reporting and accountability are crucial.

- The Department should adopt a DOSA rate as a key performance indicator and should also publish a specialty-by-specialty report on DOSA rates.
- CEOs will need to liaise with clinicians to ensure DOSA rates are met.
- Health service boards must include DOSA rates as a key performance indicator in the performance plans of CEOs.

Pre-admission planning is a vital building block in improving DOSA rates. More patients will be able to arrive on the day of the surgery if they have already been assessed for their readiness for surgery and their levels of risk.

- Hospitals should establish pre-admission clinics to meet agreed DOSA targets for all areas of surgery.

References

Task Force Paper 4—Improving the Management of Multi-Day Admissions: Better Utilisation of Hospital Beds, Recommendations 1–5.

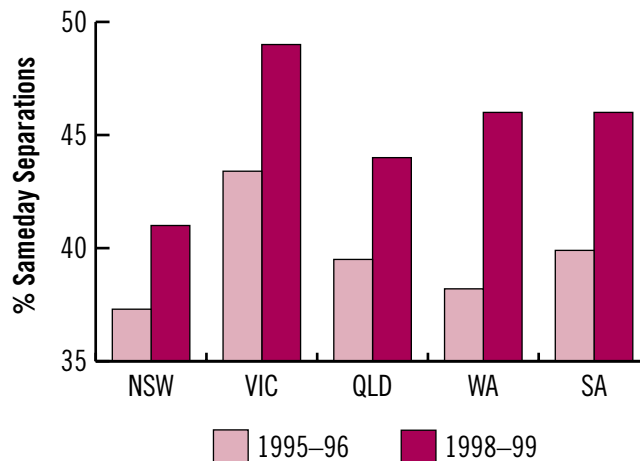
4 Expand ambulatory care

The question is no longer ‘Which procedures can be performed on a same day basis?’ It must be ‘What is the justification for not performing this procedure on a same day basis?’

THE CURRENT SITUATION

- Same day hospital treatment is widespread in Victoria (49 per cent of acute separations with renal dialysis making up 28 per cent). There is potential to shift from multi day to same day care, reducing the demand for hospital beds.
- Hospitals need to boost same day care to treat more patients.
- The number of patients treated on a same day basis varies widely across the metropolitan health system.

Figure 4: Sameday Separations in Five State Public Hospital Systems, 1995–96 to 1998–99



Source: AIHW Australian Hospital Statistics 1998–99 and 1995–96

THE WAY FORWARD

Increases in same day care in Melbourne’s metropolitan health services will free-up in-patient beds.

- The Department should work with metropolitan health services towards specific targets for a basket of individual procedures (both medical and surgical) suitable for same day care. The suggested procedures and targets are:
 - Tonsillectomy or adenoidectomy, 90 per cent
 - Vein ligation and stripping, 90 per cent
 - Abdominal, umbilical and other hernia procedures age >0, 90 per cent
 - Inguinal and femoral hernia procedures age >0, 90 per cent
 - Local excision and removal of internal fixation device excl. hip, 90 per cent
 - Other wrist and hand procedures, 90 per cent
 - Cholecystectomy w/o closed CDE w/o catastrophic or severe CC, 80 per cent

- Chest pain, 60 per cent
- Otitis media and URI w/o CC, 60 per cent

Re-engineering internal procedures in hospitals will enable benchmark same day care targets to be achieved.

- CEOs need to collaborate with clinicians to redesign their patient management practices.
- CEOs also need to analyse work practices, skill mix, information technology and equipment to ensure they are in place for same day care.

Observing national and international trends will help drive the shift from multi to same day care.

- The Task Force believes collaboration among leading clinicians, metropolitan health services and the Department will be a vital step in the sharing of ideas.

References

Task Force Paper 3—Better Access for Patients: Extending Ambulatory Care and Same Day Services for Medical and Surgical Patients, Recommendations 1, 2, 5, 6, 8, 10.

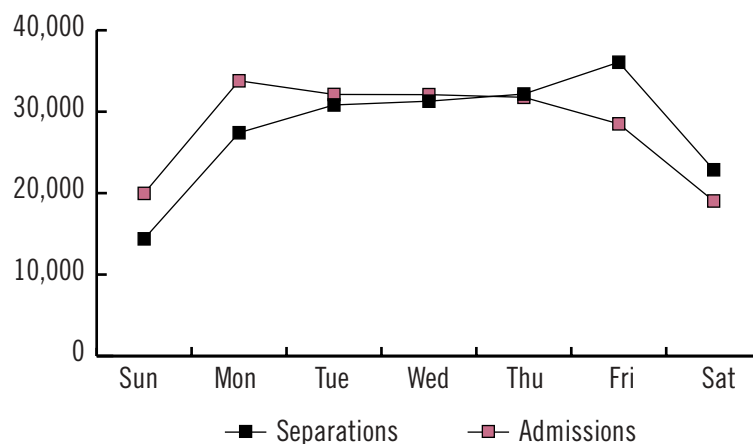
5 Extend use of care pathways and new models of care

Better access to treatment and care can be achieved by improved utilisation of hospital beds, rather than increased numbers of beds.

THE CURRENT SITUATION

- There is not enough collaboration among Melbourne’s health services, preventing the sharing of innovative ideas and practices that improve acute hospital capacity.
- Some entrenched routines prevent efficient operation. Hospitals do not operate on a seven days a week, 24 hours a day, 365 days of the year cycle.
- Hospitals are still admitting some patients who could be treated on the same day, rather than overnight.
- Patients sometimes face delays or are subjected to a duplication of services due to a lack of structured, standardised clinical planning.

Figure 12: WIES Funded Admissions and Discharges by Day of the Week YTD Dec 2000—12 Major Metropolitan Hospitals plus Moorabbin and Sunshine



Source: Victorian Admitted Episodes Dataset

THE WAY FORWARD

The Task Force has found many strategies already in use in metropolitan health services to help improve capacity, to create new clinical structures and to process patients more efficiently. They must be taken up more widely. The key initiatives are covered in more detail in the Task Force papers, but a brief synopsis of some of the major points is provided here.

Accurate medical assessment and evaluation of a patient in the emergency department is crucial to avoiding unnecessary admissions.

- The Task Force believes fast track strategies are the way to go. Metropolitan health services should identify fast-track strategies (such as short stay and observation units) and promptly adopt systems that meet local needs. Patients can then be directed quickly from emergency departments to appropriate levels of care.

- Hospitals should also introduce or expand medical assessment and planning units, where appropriate, which focus on longer-term assessment and care planning for medical patients.

Clinical pathways will allow the care of high volume conditions to be standardised.

- Hospitals should introduce clinical pathways to avoid duplication or delay in the provision of care and to help coordinate roles of different clinicians when treating patients.
- Clinical pathways are particularly useful when caring for frail aged patients. They improve patient outcomes, allow shorter lengths of stay, increase patient satisfaction and permit timely transfer to sub-acute settings.

Better integration of residential care, GPs and community-based services with hospitals enhances efficiency and improves care.

- Hospitals need to ensure services—like home and community care—are available for elderly patients on discharge.
- They also need to build relationships with primary care providers to ensure patient discharge notes and ongoing patient health information is available to all carers.

A review of weekend and weekday admission and discharge practices reduces regular overcrowding.

- Hospitals should move as quickly as possible to a continuous 24-7-365 cycle. Changes in work practices within each hospital are required to increase weekend discharges and reduce Monday congestion.

References

Task Force Paper 2—Meeting Demand for Emergency Services: Better Management of Emergency Patients, Recommendations 6–8.

Task Force Paper 4—Improving Management of Multi-day Admissions: Better Utilisation of Hospital Beds, Recommendations 15, 16.

Task Force Paper 5—Improving Health Care for Older People, Recommendation 1.

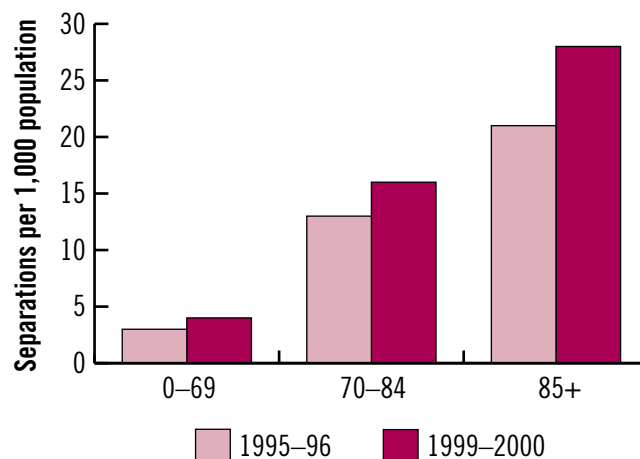
6 Focus on care for older Victorians

Concentration of effort and resources on the needs of older patients will improve patient satisfaction, efficiency and outcomes.

THE CURRENT SITUATION

- Older people (aged 70+) comprise nine per cent of Victoria's population, but last year accounted for 24 per cent of Victorian public hospital separations and 40 per cent of patient days.
- Looking at growth in hospital use, on a per capita basis, the greatest rise in the past four years has been medical separations for older people (excluding renal dialysis).
- Medical separations for patients over 85 have increased by 34 per cent over the past five years.

Figure 3: Emergency Medical Separations Per 1,000 Population, 12 Major Hospitals



Source: Victorian Admitted Episodes Database (VAED) and Department of Infrastructure

THE WAY FORWARD

Programs and initiatives targeting the care of older patients have the potential to deliver gains to the health system as a whole.

Changes to pre-admission practices can avoid unnecessary admissions to acute wards.

- Metropolitan health services should develop and implement strategies expanding the role of general geriatric outpatient and assessment services, adoption of rapid response short stay units, and clinical pathways transfer to sub-acute settings.

Hospitals can improve care for older patients by appointing geriatricians, senior nurses skilled in aged care and other experienced clinicians.

- Hospitals should structure more access to geriatric expertise in medical wards and emergency departments.

Post acute care (PAC) programs deliver a positive alternative to inpatient care, but until recently, PAC funds have not been provided for home-based convalescent care for sub-acute patients.

- Metropolitan health services must ensure that PAC services are made available to sub-acute patients.

Funding arrangements must provide incentives to reduce excessively long stays in sub-acute care, and to encourage direct admission (where appropriate) to sub-acute facilities.

- The Department needs to examine and improve the sub-acute per diem price structure during 2001–2002.
- The Department, in consultation with health providers, should implement a formal designation process for geriatric evaluation and management, and interim (non-acute) care.

Sensitive and proper management of patients at the end of life is an important feature of hospitals' and health care professionals' objective of providing the right care at the right place at the right time.

- The Department of Human Services should ask an appropriate body, such as the Health Services Commissioner, to hold a workshop involving hospital clinicians, ethicists, general practitioners, the public advocate, representatives of residential aged providers, palliative care specialists and consumers to consider ways of improving awareness and use of the *Medical Treatment Act 1988*.
- The Department of Human Services should work with metropolitan health services to establish a collaborative forum on end of life care, with the aim of identifying and consistently implementing best practice.

Reference

Task Force Paper 5—Improving Hospital Care for Older Victorians, Recommendations 1, 2, 12–14.

Task Force Paper 7—The Right Health Care: Balancing Clinical Science and Decision Making with Individual Wishes, Recommendations 1, 2, 4.

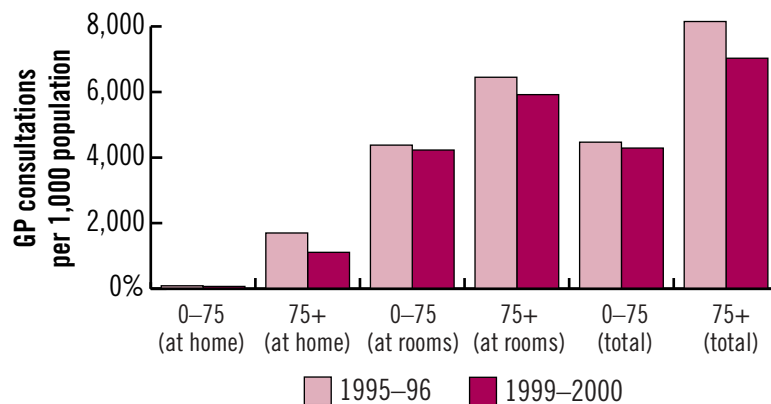
7 Improve relationships with residential care, community and home-based services

Better integration of residential care, GPs and community based services with hospital services will enhance efficiency and improve care.

THE CURRENT SITUATION

- According to 1996 Census figures, when local areas in Australia are ranked according to the number of older persons as a proportion of their total population, eight of the top 12 areas are in Melbourne.
- When local areas in Australia are ranked according to the number of older lone person households, six out of the top eight are in Melbourne.
- In the future, an increasing proportion of older people will be living alone, leading to increased needs for hospitalisation and post-hospital care.
- Social circumstances, cognitive functioning and nursing needs, not age, are the main factors in long hospital stays (greater than 13 days).
- The number of GP consultations to people under 75 has declined by 4 per cent, but number for people over 75 has declined by 14 per cent. These trends may be related to the rise in emergency hospital admissions by people in this age group.

Figure 4: Non Institutional GP Attendances, Victoria



Source: Australian Institute of Health and Welfare (AIHW)

THE WAY FORWARD

Strong liaison and support between hospitals and residential care units results in fewer transfers of residents to hospital emergency departments, and greater willingness by providers to accept high needs patients.

- Metropolitan health services should work with local general practices and residential aged care services to allow GPs and residential aged care nurses a greater role in managing a number of simpler health conditions arising in residents.

When supported by hospitals, GPs can provide short-term intervention that reduces the number of older people presenting to the emergency department.

- Hospitals should extend their care co-ordination services to accepting GP referrals.

There has been a steep increase in emergency medical separations for older people. This trend is likely to continue.

- The Department should initiate a study to identify the factors as to why older people are using emergency departments more.

Reference

Task Force Paper 5—Improving Hospital Care for Older Victorians,
Recommendations 3–6, 9.

8 Foster collaboration and leadership

A culture of collaboration among the metropolitan health services (and with community-based health services) is essential so that hospitals can learn from each other and so that ideas that work well to improve patient care in some hospitals are communicated and taken up more widely.

THE CURRENT SITUATION

- In the 1990s, a competitive policy environment discouraged collaboration between organisations.
- Today, government policy developments encourage a more partnership-oriented approach.
- To achieve a health service that gives the best ‘value for money’, it must work as an integrated system, not as a collection of vaguely related, autonomous providers.
- Victoria’s health services have been slow to adopt new information technologies that could significantly enhance service delivery and improve performance.

THE WAY FORWARD

For change to occur, there must be strong leadership and collaboration.

Inter-hospital collaboration allows health services to examine and share ideas, practices and performance.

- Together, metropolitan health services and the Department should establish collaborative projects to implement changes proposed by this Task Force.
- To achieve best practice in patient management, a culture of collaboration should be encouraged by clinicians, CEOs and hospital boards. The chief executives’ group and the Department should examine ways to resource and promote further partnerships across metropolitan health services.

The active involvement of clinicians is critical to achieving best possible clinical practice and improvements to patient care management. Clinicians must take a leadership role in implementing these changes.

- Together the Department and health services should establish a clinical leadership program to support clinicians, promote leadership and disseminate data and ideas.
- A Council of Clinical Leadership should be established to advise on the development and implementation of the leadership program. It could be established by the Minister or be developed ‘from the ground up’ through collaboration between the presidents of clinical professional bodies—including medical, nursing and allied health representation.

New information and communications technologies are providing speedy, effective tools for disseminating relevant health care statistics and comparative data to hospital management and clinicians to help improve performance and reduce unnecessary variability. They are also major drivers of improved patient management practice.

- The Department should publish basic hospital-specific performance data and regular comparative analyses on a designated web site.
- Metropolitan health services should strengthen the use of IT initiatives and strategies in order to utilise the latest research and current information to improve patient care processes, and to inform patients and the general community about care options and approaches.
- The Department should accelerate the introduction of health information strategies including clinical information systems, an electronic health record and unique patient identifier to support better clinical decision-making and encourage better service integration across sectors.

The system needs to reward and acknowledge innovation in patient management practice.

- The Department should establish annual industry awards for individuals and organisations that have achieved excellence in health care.

Reference

Task Force Paper 7—Improving the System: Capacity and Capability Building, Recommendations 1–6, 17, 19, 22, 26.

9 Introduce new incentives and focus on performance

Stronger links are needed between policy objectives, performance measurement and accountability arrangements

THE CURRENT SITUATION

- Process and quality improvement funding has become overly complex with too many small funding pools and reporting requirements.
- Some incentive schemes directed at some patient access targets, like emergency services, have reached the end of their 'product lifecycle'.

THE WAY FORWARD

Key priorities in the health system must be identified and tied to adequate funding arrangements.

- The Department should establish a new consolidated funding program that is tied to metropolitan health services' performance in meeting agreed targets.

To adequately assess performance, hospitals need to know how they compare with other metropolitan health services. A 'balanced scorecard' set of consolidated indicators is a tool which health care organisations can use to measure their performance and achieve industry benchmark targets.

- In collaboration with the industry, the Department should develop a set of performance indicators on output, resource use, quality and safety, access and patient care improvement.

Boards and CEOs are accountable for their hospitals meeting statewide policy objectives.

- Hospital boards must develop a strategic plan that sets out how the organisations will attain benchmark performance in patient management practice.
- CEO performance plans must reflect these targets and the progress towards implementing these changes should be included in annual CEO performance appraisals.

References

Task Force Paper 7—Improving the System: Capacity and Capability Building, Recommendations 6, 7, 9, 11, 14.

10 Develop metropolitan wide hospital plans

Co-ordinated metropolitan-wide planning is needed to ensure a balance between system-wide performance and individual health service performance

- It is not cost effective for hospitals to offer all health services.
- Patients want proximity to hospitals for treatments that require frequent attendance, but they do not mind travelling greater distances for treatments that are needed only once or twice in a lifetime.
- New technologies are providing new care and management opportunities. They are currently not well coordinated across the metropolitan health services.

THE CURRENT SITUATION

Development of a best practice health service requires hospitals to become specialist zones where services (such as ophthalmology and paediatrics) are clustered across geographical areas.

THE WAY FORWARD

- The Department and metropolitan health services should develop a strategic plan that rezones hospitals into a co-ordinated system of specialist services so that:
 1. each hospital performs complementary roles;
 2. treatments that patients use regularly (like dialysis) are evenly distributed across the city;
 3. greater inter-hospital networking is encouraged; and
 4. outer metropolitan hospitals continue to provide a range of basic services, but develop links with inner city hospitals that provide specialist services.
- The metropolitan health services plan should cover service planning across hospitals, individual hospital planning (particularly role delineation) and information technology planning.

Hospitals must take collective and individual responsibility for implementing practice and process change, especially with regard to collaborative arrangements, greater use of performance indicators and patient management practice changes.

- Metropolitan health services should establish a coordinating group to guide the implementation of strategies that will foster best practice in patient management. The CEOs group has already begun to take on this role.

References

Task Force Paper 7—Improving the System: Capacity and Capability Building, Recommendations 23, 27.

Appendix 1: Patient Management Task Force

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.

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

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