

National Partnership  
Agreement 2009  
Taking Pressure off  
Public Hospitals  
Implementation Plan  
Tasmania 2009-  
2013

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## Introduction

The National Partnership Agreements (NP) on Hospital and Health Workforce Reform provides \$16.636 million to Tasmania over 4 years to help in taking the pressure off emergency departments in public hospitals. This injection of funding will relieve some of the pressure on public hospitals, while initiatives to improve the efficiency of public hospitals and the primary care reforms of the Commonwealth are implemented.

This NP recognises that emergency departments are currently treating an increased number of patients, including some who could otherwise be treated in a primary care setting. This is resulting in added pressure on emergency departments, with longer waits for patients and avoidable costs to the public hospital system.

The role of the states and territories under this NP is to relieve the pressure on emergency departments thereby improving access for patients and increasing the quality and safety of care. Specifically, this will result in increased numbers of patients being treated within a clinically appropriate period of time and decrease the number of patients experiencing access block with the associated long waits in the emergency department. Timely, quality data will be provided to the Commonwealth for the reporting of emergency department performance.

## The Tasmanian Context

Tasmania has long been grappling with escalating demand across its public hospital emergency departments (EDs). This has been due to the changing demographic profile with an ageing population, poor socio-economic profiles in some areas limiting access to primary care and a high proportion of rural patients. These factors, especially when combined, tend to lead to increased morbidity from chronic disease and accidents, all of which present at the ED requiring care.

### Tasmania's Ageing Population

Over the last decade, Tasmania's population has experienced both growth and decline. Current predictions suggest that the size of the population will increase slightly over the next 20 years, but the composition will change as the age of the average Tasmanian increases.

This is due, in part, to the conventional causes of population ageing experienced across Australia (i.e. low birth rates and increased life expectancy), but is exaggerated by large numbers of older migrants entering the state, coupled with many younger people moving interstate or overseas.<sup>i</sup>

The growth in Tasmania's ageing population suggests that Tasmania will find it increasingly difficult to provide adequate medical care to its population.

**Table 1: Tasmania population growth 2007 to 2018**

State population	Population by region			
	Tasmania	South	North	North West
<b>2007</b>	493 371	243 820	139 466	110 085
<b>2018 projected</b>	528 556	264 122	149 509	114 925

**Table 2: Tasmanian population, by region, aged 70 years and over and 80 years and over**

Population	Pop 70-100 by region			Pop 80-100 by region		
	South	North	North West	South	North	North West
2007	24 624	14 781	11 941	9 649	5 627	4 517
2018 projected	32 724	20 244	16 651	11 616	7 200	5 972

## Emergency Department Performance

Emergency departments around Australia have experienced strong growth in presentations in recent years. New South Wales recently commissioned a major study (Booz, Allen, Hamilton Report, December 2007) into the reasons for ED demand growth. This report considered data from public hospitals in Queensland, Victoria, South Australia and Western Australia, as well as from New South Wales. The Report concluded that multiple factors are responsible for demand growth. These factors included demographic factors with older patients having increasing use of EDs with increased chronic illness amongst older patients a major factor in demand increase. These patients generally required genuine emergency treatment.

There was also a significant growth in the number of younger patients attending EDs for primary care treatment rather than emergency treatment. This represented a substitution for general practice services where patients could not access these services due to either non-availability of services or the cost of accessing general practice services. Declining private hospital emergency services and the decreasing availability of GP out-of-hours services were also relevant factors.

The percentage of patients seen within the recommended timeframe by triage category is also an important indicator of ED performance. The Australasian College of Emergency Medicine (ACEM) provides performance indicator thresholds by triage category as follows:

**Table 3: Australian College of Emergency Medicine (ACEM) Benchmark**

<b>Australasian Triage Scale category</b>	<b>Recommended time to treatment (minutes)</b>	<b>Benchmark percentage of patients to be treated within recommended time (%)</b>
<b>ATS 1</b>	Immediate	100
<b>ATS 2</b>	10	80
<b>ATS 3</b>	30	75
<b>ATS 4</b>	60	70
<b>ATS 5</b>	120	70

## Emergency Department Performance in Tasmania

Tasmania has experienced the same general trends as identified in the Booz, Allen, Hamilton Report. There has been demand growth at Tasmanian EDs and growth has been strongest where substitute services are more limited in availability.

The Mersey Community Hospital data has been excluded from these figures, as comparative data is unavailable due to the hospital being Australian Government managed for part of the period.

## Tasmania's Performance and the National Healthcare Agreement

The new the National Healthcare Agreement has defined benchmark targets for ED performance. These have been agreed to by the Council of Australian Governments and were developed by the Australian Institute for Health and Welfare. These benchmarks are:

1. By 2012-13, 80% of ED presentations are seen within clinically recommended triage times as recommended by the Australasian College of Emergency Medicine; and
2. By 2013-14, 95% of Hospitals with an ED report to the non-admitted emergency department care national minimum data set collection.

As at the December quarter 2008-09, around 60% of Tasmanian ED presentations were seen within clinically recommended triage times as recommended by the Australasian College of Emergency Medicine.

Currently, 100% of Tasmanian public hospitals with an ED report to the non-admitted emergency department care national minimum data set collection. This includes the Royal Hobart (RHH), Launceston General (LGH), North West Regional (NWRH) and the Mersey Hospitals. Other useful access indicators of ED performance include: the number and percentage of patients seen within the recommended time for each triage category (Table 4); waiting times for service at the median and 90th percentile by triage category (Table 4); and the percentage of patients who are admitted whose total time in the ED is less than eight hours (Table 5).

**Table 4: Tasmanian ED performance by triage category**

Triage Category	Presentations Total	Patients seen within recommended triage time		Waiting time percentile (minutes)	
		Number	%	Median	90th
1 Resuscitation: immediate: within 2 minutes	804	794	99	0	0
2 Emergency: within 10 minutes	9,183	6,785	74	7	23
3 Urgent: within 30 minutes	39,038	20,948	54	27	134
4 Semi-urgent: within 60 minutes	54,064	31,549	58	48	156
5 Non-urgent: within 120 minutes	7,053	6,035	86	38	142
<b>All categories</b>	<b>110,142</b>	<b>66,111</b>	<b>60</b>	<b>33</b>	<b>142</b>

**Table 5: Tasmanian ED waiting times for patients subsequently admitted**

Triage Category	Presentations Total	Episode length percentile (minutes)		Presentations waiting less than 8 hours	
		Median	90th	Number	%
1 Resuscitation: immediate; within 2 minutes	660	240	672	547	82.88
2 Emergency: within 10 minutes	5,071	336	888	3,570	70.40
3 Urgent: within 30 minutes	14,237	400	991	8,882	62.39
4 Semi-urgent: within 60 minutes	7,238	401	994	4,544	62.78
5 Non-urgent: within 120 minutes	372	293	660	302	81.18
<b>All categories</b>	<b>27,578</b>	<b>384</b>	<b>962</b>	<b>17,845</b>	<b>64.71</b>

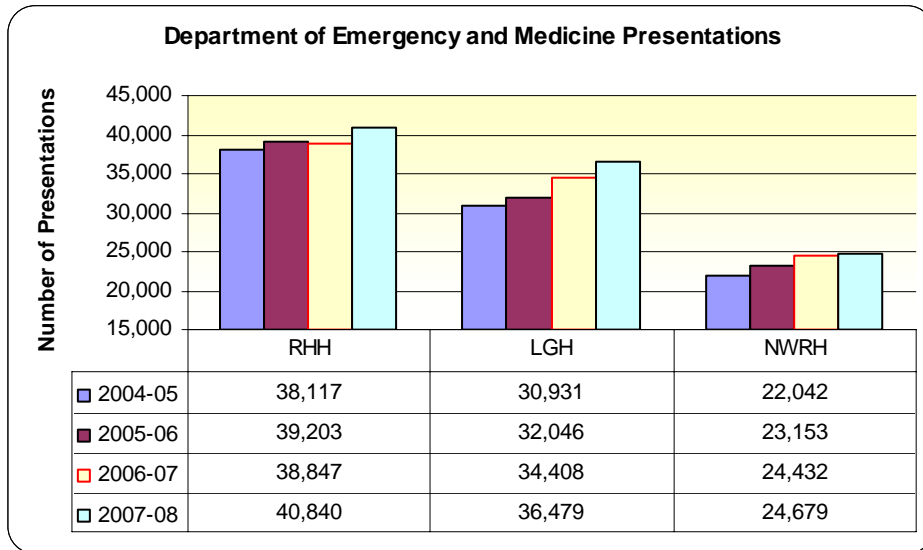
Pressure on Tasmanian public EDs is increasing as evidenced by rising demand, ambulance ramping, long waits for service and long treatment times in emergency departments.

### **Tasmania's Emergency Department Performance – an Overview**

The number of presentations at the State's public hospital EDs has been increasing (Figure 1). There were 101,998 presentations in the twelve months to 30 June 2008, which represents a four and a half per cent increase statewide over the previous year.

Between 2006-07 and 2007-08, ED presentations at the RHH have increased by 5%, at the LGH by 6% and at the NWRH by 1%. Since 2004-05, presentations have grown by 7% at the RHH, by 18% at the LGH and by 12% at the NWRH.

**Figure 1: Total ED Presentations by Hospital (including patients who did not wait)**



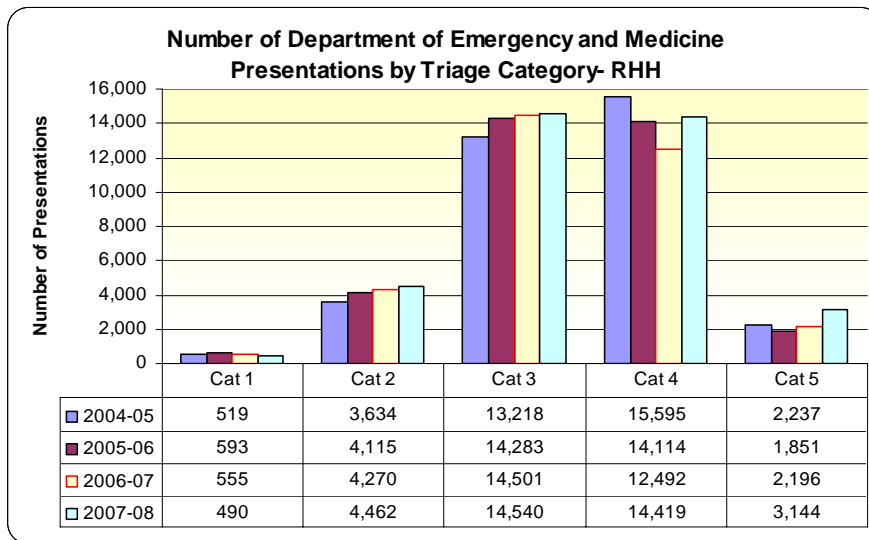
### Primary Care Type Presentations at the Emergency Department in the Three Major Hospitals

#### RHH

When examining presentations by triage category, the RHH shows demand growth in categories 2 and 3, decreasing attendances for category 4 and increasing demand for category 5. Hobart has a high availability of GP services with good GP out of hours services and with private EDs at two private hospitals. Growth is likely to be due to the ageing of the population and increasing chronic illness. The after hours care trial conducted a few years ago in Hobart confirmed that referral patterns in Hobart were generally appropriate with patients mostly self-referring to the appropriate service (GP or ED). If the availability of private hospital EDs, GPs or GP out of hours services should change, then referral patterns may also change and strong growth in category 4 and 5 presentations at the RHH could then be expected. One of the private EDs in Hobart is currently under serious threat of closure.



**Figure 2: Total ED Presentations by Triage Category at RHH (excluding patients who did not wait)**



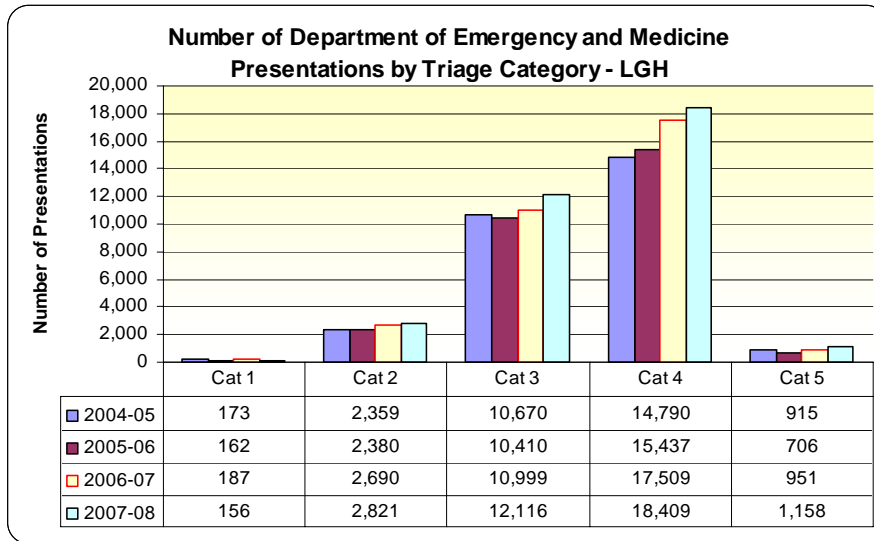
Using an assessment tool<sup>1</sup> that indicates which patients are likely to be primary care patients, it is estimated that in 2007-08, around one in ten of RHH emergency department attendances were primary care cases.

## LGH

The LGH shows strong growth in category 2, 3 and 4 presentations (figure 3). This may reflect the fact that the North has an undersupply of GPs, no private hospital ED and a limited GP out of hours service (restricted to Friday, Saturday and Sunday evenings). Growth in category 4 presentations is probably largely due to the limited availability of GP services in the Launceston area. Again, using the previously mentioned assessment tool that indicates which patients are likely to be primary care patients, it is estimated that in 2007-08 almost 18% of LGH emergency department attendances were primary care cases.

<sup>1</sup> This assessment tool is a modification of the Booz Allen Hamilton assessment tool and was described in the presentation delivered by Kevin Ratcliffe at the Australian Casemix Conference October 2008 entitled *Developments in costing and classification in emergency department activity*.

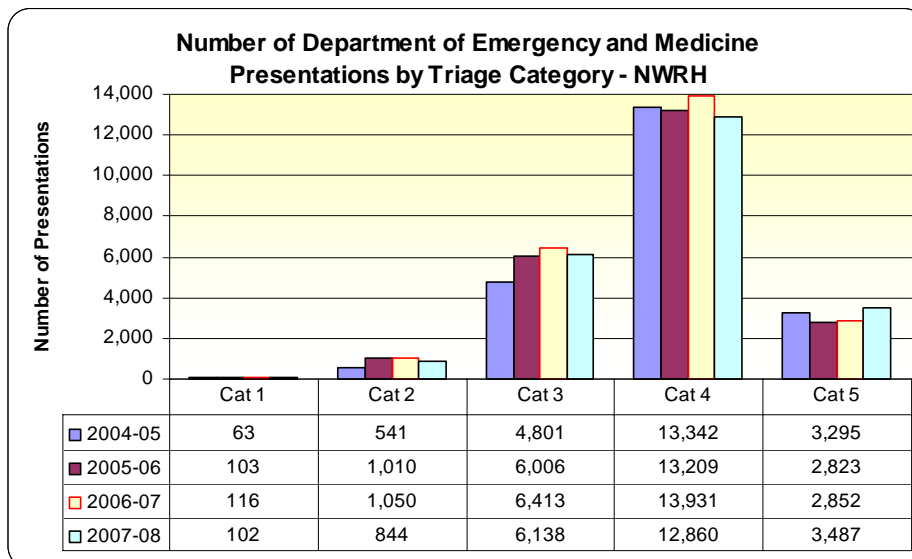
**Figure 3: Total ED Presentations by Triage Category at LGH (excluding patients who did not wait)**



## NWRH

The North West Regional Hospital (Figure 4) shows less growth than the other two major hospitals, although local factors such as the availability of emergency services at the Mersey Community Hospital has produced some year-to-year variation in category 2 and 3 patients. Figure 4 shows the high proportion of category 4 patients at the NWRH compared to the other sites. This is most likely due to the unavailability of private hospital ED services and GP out of hours services and the limited availability of GP services. Again, using the assessment tool that indicates which patients are likely to be primary care patients, it is estimated that in 2007-08, around a quarter of NWRH emergency department attendances were primary care cases.

**Figure 4: Total ED Presentations by Triage Category NWRH (excluding patients who did not wait)**



## Ambulance Ramping at the RHH

Ambulance ramping is a term used to describe queuing of ambulances at the ED where the ambulance service is unable to transfer patients to the care of the receiving hospital due to unavailability of staff or space to house patients within the ED.

Ramping prevents optimal provision of emergency services and efficient use of ambulance resources. Not only do patients wait additional time for services, but also ramping prevents the emergency response service from being available to attend other cases. Ramping is expensive. Up to 13 hours per day are lost by crews being ramped and the cost to the health system is greater than if patients were queued in the ED.

Ramping represents a failure on the part of the hospital to commence treatment in a timely manner, as patients remain in the care of paramedics rather than becoming the responsibility of the ED despite actually being inside the ED.

For a number of reasons, ramping or queuing of ambulances currently occurs at the RHH ED, but not at other Tasmanian hospitals. Some reasons for ramping at RHH include current models of care, patient flow in the ED, patient numbers and availability of space both within the department and in the ambulance parking bay and increasing patient treatment times within ED leading to access block. The following tables (Tables 6 and 7) show the number of cases of ramping by month since data were first available and the number of hours of ramping in relation to these patients.

**Table 6: All Ramped patients by month RHH**

<b>All ramping events</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Median</b>
2006-07									100	266	342	330	298
2007-08	429	408	315	353	317	309	369	324	342	229	377	350	346

**Table 7: Total Ramped hours RHH by Month**

<b>Total Hours</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Median</b>
2006-07									61	138	189	222	163.5
2007-08	291	236	176	254	160	150	190	210	218	109	258	333	214

While some delays in the hand over of patients may be inevitable, significant delays are not acceptable and action is required to eliminate ramping as far as practicable. Table 8 indicates that the median for 2007-08 is 15.5 patients per month being ramped in excess of two hours. Diversion of patients to other care providers, rapid assessment and transfer to specialised teams, quicker transfer to a hospital bed and overall reduced treatment time in ED may all help to alleviate the problem of ramping.

**Table 8: RHH patients with >2 hours Ramped time**

Over2hrs	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Median
2006-07									6	10	16	25	13
2007-08	29	18	11	28	8	9	13	11	31	9	24	55	15.5

### Waiting Times in Emergency Departments

The activity of an ED includes a number of phases: such as initial contact; assessment; evaluation and initial treatment; and assignment to appropriate ongoing management, either as admitted care or non-admitted care in the department prior to departure.

Data on emergency department activity is available from the DHHS information systems, Emergency Department Information System (EDIS) and the Hospital Patient Administration System. The phases of care have distinct definitions for data collection in these systems.

- Time to treatment: triage to when seen by a doctor or Rapid Assessment Team;
- Treatment time: from when seen by a doctor to departure ready;
- Exit time: departure ready to when the patient actually leaves the ED.

Much of the current reporting on waiting times for ED services is to do with the time to triage and reporting on the total time in the ED. Current reporting systems do not adequately record all the other phases of care.

Performance indicator reporting for long stays in EDs generally focuses on patients eventually admitted to a ward bed, but who have exceed 8 hours in the ED but does not focus on other patients who are not admitted but have long treatment times. ED data requires further development to better document the full process of care provided, and to better identify bottlenecks in care provision. Much of the current discussion focuses on bed block, but bed block only applies for admitted patients who are required to remain in the EDs because a bed is not available.

*The State of our Public Hospitals Report for 2006-07* contains the latest comparative data on waiting times by triage category by State and Territory average. National performance is 99% of category one patients seen within the required time while for category two it was 78%, for category three 65%, category four 66% and category five 88%. Tasmanian public hospital performance is similar to the average national performance and Tasmania ranked equal third amongst States and Territories for the percentage of patients seen within recommended times.

**Figure 5: Proportion of ED patients seen within timeframe - RHH**

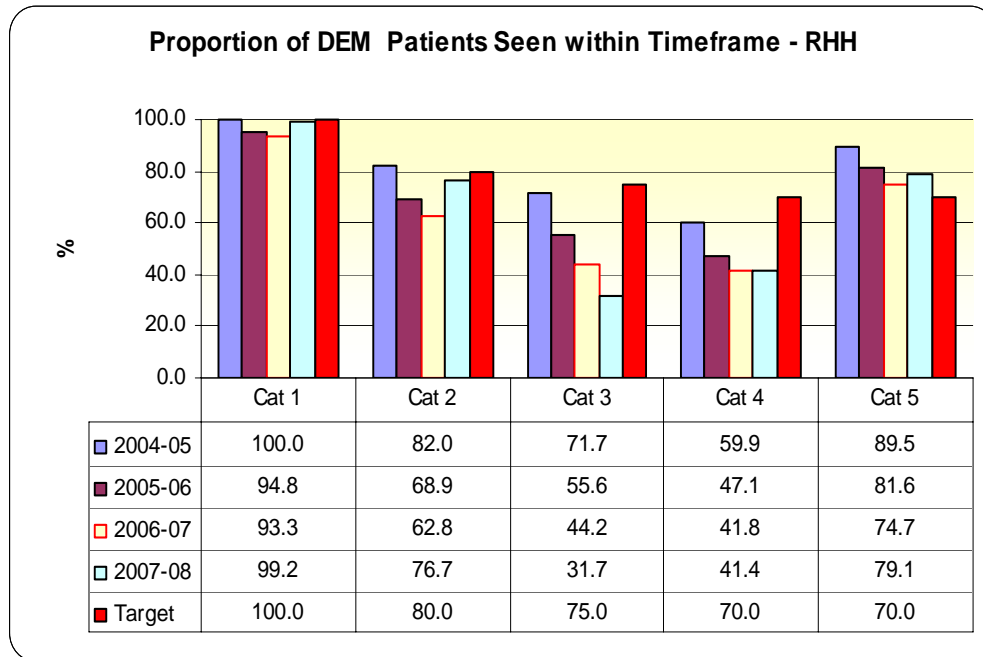


Figure 5 shows the proportion of RHH patients by triage category seen within required times. While the number of category 1 and 2 patients seen within required times are close to the required targets and showed considerable improvement in 2007-08, category 3 and 4 performance is well short of the targets and the proportion of patients seen within required times is decreasing over recent years. Category 5 performance is in excess of the required target and showed improvement in 2007-08 but is still well below the level of performance achieved in 2004-05.

**Figure 6: Proportion of ED patients seen within timeframe - LGH**

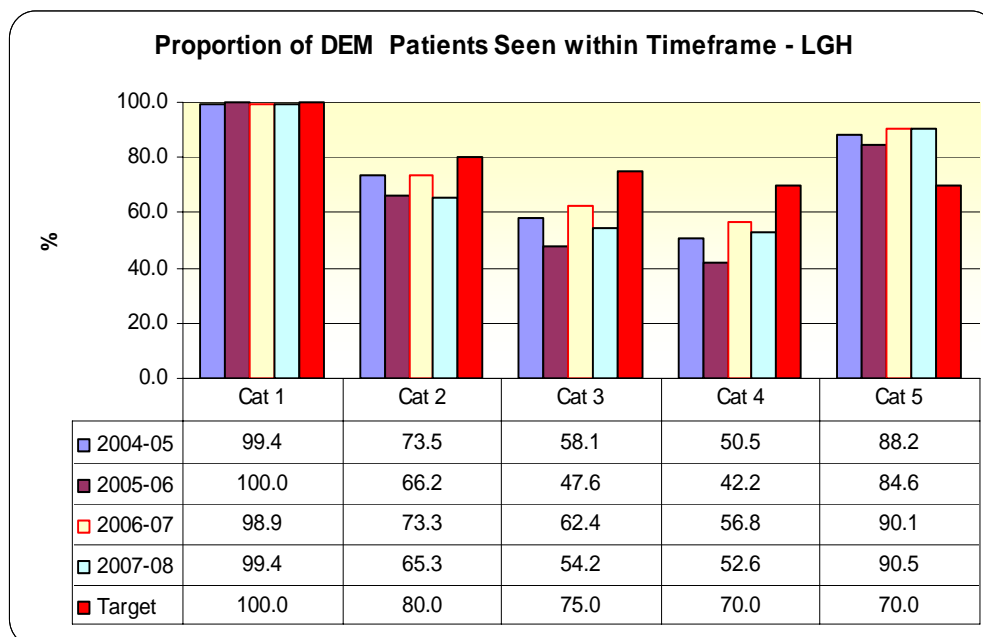


Figure 6 shows the proportion of LGH patients by triage category seen within required times. While the number of category 1 patients seen within required times is close to the required target, performance for categories 2,3 and 4 is well short of the targets

and the proportion of patients seen within required times decreased last year. Category 5 performance is well in excess of the required target.

**Figure 7: Proportion of ED patients seen within timeframe - NWRH**

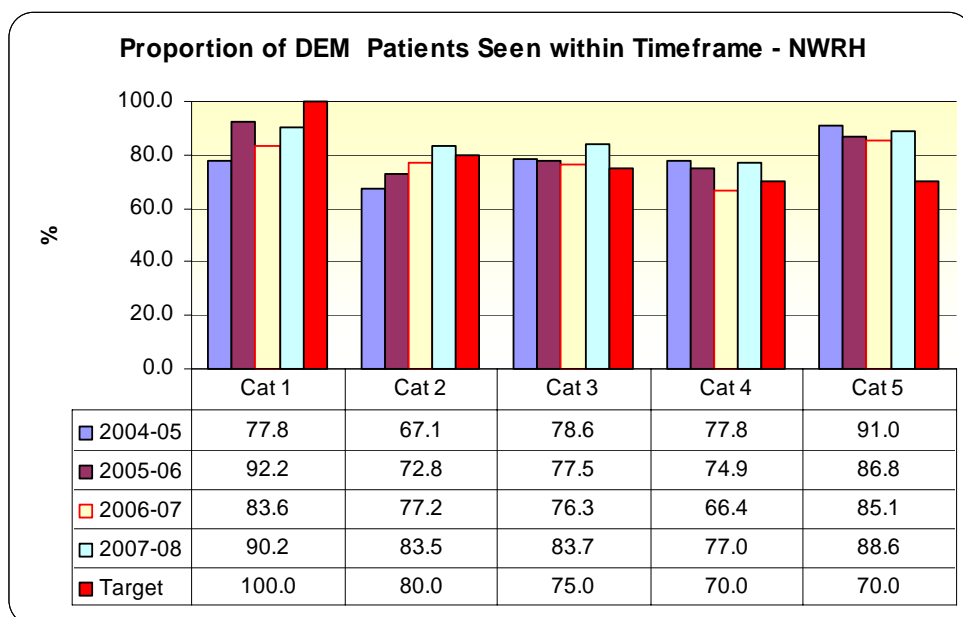


Figure 7 shows the proportion of NWRH patients by triage category seen within required times. While the number of category 1 patients seen within required times is below the required target, performance for categories 2, 3, 4 and 5 is in excess of the targets. The proportion of patients seen within required times improved for all triage categories in 2007-08 compared to 2006-07.

### Delayed discharge from the Emergency Department

There is evidence of increasing time spent by patients in emergency departments. The number of cases waiting more than 8 hours has increased over time in the ED, particularly at RHH, whereas the LGH has always had a large number of these cases.

Unless the ED is set up for short stay patients, patients who experience long periods being treated in the ED without being discharged home or to a ward have a less comfortable experience and may also experience adverse events and lower quality care. There is also a considerable cost to the system. The direct cost of nursing care alone is estimated at over \$400 for each occasion of service.

It is an inefficient use of resources to keep patients in an ED at far higher daily cost than when admitted to a ward. It costs twice as much to care for a patient for each day in the ED compared with a medical or general surgical ward.

Table 9 shows the patients staying longer than 8 hours in emergency departments. While the majority of patients are subsequently admitted, there are a significant and increasing number of non-admitted patients also staying longer than 8 hours.

**Table 9: Patients experiencing over 8 Hours treatment time**

Hospital	2003-04	2004-05	2005-06	2006-07	2007-08
RHH	2,033	2,623	4,544	5,253	6,464
LGH	3,258	3,107	4,429	3,277	5,247
NWRH	443	698	623	952	1,339
<b>Total</b>	<b>5,734</b>	<b>6,428</b>	<b>9,596</b>	<b>9,482</b>	<b>13,050</b>

**Admitted Patients**

Hospital	2003-04	2004-05	2005-06	2006-07	2007-08
RHH	1,965	2,536	4,202	4,735	6,259
LGH	3,066	2,925	4,168	3,170	5,071
NWRH	345	500	486	748	1,125
<b>Total</b>	<b>5,376</b>	<b>5,961</b>	<b>8,856</b>	<b>8,653</b>	<b>12,455</b>

**Non-Admitted Patients**

Hospital	2003-04	2004-05	2005-06	2006-07	2007-08
RHH	68	87	342	518	205
LGH	192	182	261	107	176
NWRH	98	198	137	204	214
<b>Total</b>	<b>358</b>	<b>467</b>	<b>740</b>	<b>829</b>	<b>595</b>

**Bed Block**

Bed block is measured by comparing the time the patient is ready for departure to the time when the patient actually leaves the ED to go to a bed. The proportion of cases that exceed a reasonable time is the most reliable measure available to represent bed block or time delay to a bed.

This delay may be due to a lack of available beds, delays in the admission process, delays to allocate a bed or a mismatch between the times patients leave hospital and the times when patients need a bed. An example would be an inefficient medical ward where patients may be discharged after midday even though other patients requiring admission present well before midday.

The data in Table 10 indicates that bed block is a major issue at the RHH and the LGH but is less of an issue at the NWRH. The situation showed some improvement at the RHH in 2007-08 but bed block at the LGH is on the increase. The large increase in patient numbers at the NWRH waiting more than 4 hours for a bed after being departure ready, from 6 in 2003-04 to 290 in 2007-08, indicates that bed block is an emerging issue at the NWRH.

**Table 10: Patients waiting more than 4hours for a bed after being departure ready**

	2003-04		2004-05		2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%	No.	%	No.	%
<b>RHH</b>	1,619	16	1,958	18	2,823	26	2,949	28	2,008	18
<b>LGH</b>	475	7	352	5	567	8	1,002	15	1,330	20
<b>NWRH</b>	6	0	8	0	31	1	130	3	290	6

### Summary

Emergency Departments at public hospitals in Tasmania have experienced an increased workload and there are significant patient management issues arising from this increased activity. The following section examines the strategic directions required to address these issues.



## Strategic Directions

The previous section identified a number of problem areas. Solutions to improve current emergency department performance fall into three areas:

- Diversion of patients who can be better treated elsewhere to reduce the load on emergency departments;
- Improved patient management within emergency departments
- Improved hospital patient flows to allow the EDs to transfer patients requiring admission to the wards by freeing up hospital beds.

### Diversion

Diversion involves directing patients who do not need emergency department care to more appropriate service providers. Diversion is most effective when non-emergency type patients do not present at the emergency department but have access to more appropriate care as an alternative to presentation at an ED. Some practical examples include:

- Diversion of primary care patients to GP practices;
- Diversion of older patients to transition care/other; and
- Community case management of patients with chronic illness.

### Improved ED capacity and performance

Solutions in this area address both the physical facilities and staffing within EDs and the patient management protocols and procedures within emergency departments to maximise the overall efficiency of the department and address internal ED blockages caused by external factors. Some initiatives which may improve overall ED performance include:

- Activity based funding for ED activity.
- Innovative workforce models in ED
- Improved patient management in ED
- Short Stay Units in ED.

### Improved patient flows

Solutions in this area aim to improve the overall patient flow within hospitals to free up inpatient beds so that patients awaiting admission within the emergency department can be moved to an inpatient bed on the wards. Possible initiatives include:

- Emergency medical units
- Improved bed management practices
- Improved discharge planning

## State Funded Initiatives

A number of State funded initiatives have already been introduced to address ED demand and performance issues and hospital patient flows. Work to date has focused on improvements to physical facilities and staffing by hospital and each hospital has undertaken a number of initiatives to address ED access block. Initiatives are outlined below for each strategic direction.

### Diversion

1. A Hospital Aged Care Liaison Team (HALT) was established at the Launceston General Hospital in April 2007 through the Council of Australian Governments (COAG) Long Stay Older Patient (LSOP) initiative.

Key objectives of the program are to reduce:

- length of stay of admitted older patients;
- avoidable admissions of older patients and
- re-admissions of older patients.

A comprehensive Risk Assessment and Care Coordination (RACC) team under HALT – LSOP initiative is being established in order to improve the older person's access to multidisciplinary assessment and discharge risk screening, and appropriate ongoing assessment and care planning. This will include assessment and care co-ordination from the ED, as well as in the patient's home following, or to prevent an ED presentation.

The RACC processes will improve patient flow through the ED, preventing avoidable admissions and readmissions, and encouraging early care and planning in the acute environment. Not only will this improve patient flow, but will ultimately improve outcomes for frail older people by enabling hospital avoidance and care provision in an environment appropriate to their needs.

2. An Elder Care pilot implemented at the NWRH revealed that just over 18% of category 3, 4 and 5 patients who presented to ED were over the age of 65 years. However, 38% of this group were admitted with 33% of Cat 1, 2, patients aged over 65 years. Furthermore, the most likely indicator for admission was either that the person was living alone or caring for someone else.

Having identified this risk, the NWRH has established an Elder Care project in the ED which ensures there are Social Workers present more frequently and that there are agreed protocols between the ED staff and Social Work staff for when referrals are made. This ensures significantly more supports are put in place to assist those living independently and those who are caring for others.

3. To supplement the Elder Care program the NWRH is implementing a Transition Care Program to ensure older patients are supported with packages of care in their homes to avoid hospitalisation. The NWRH will introduce 10 packages into the area in 2008-09.
4. The implementation of reform processes in Mental Health Services will have a positive impact on reducing the level of hospitalisation of mental health consumers

including presentations through Departments of Emergency Services. This has included the establishment of multi disciplinary community based care, the introduction of assertive case management and an increased range of supported accommodation options in the community sector. In addition the commencement of the 24 hour Mental Health Helpline to provide immediate expert clinical advice, triage and appropriate service referral is likely to have an overall sustainable positive impact upon reducing DEM presentations for mental health conditions.

### **Improved ED capacity and performance**

1. In 2006, the Government committed \$12 million over 4 years for the development and expansion of the LGH Emergency Department in acknowledgment of the demand pressures facing LGH. The redevelopment of ED and the review and reengineering of the ED models of care are tangible responses to the overcrowding in LGH ED.
2. The LGH has also increased nursing staff from 41.77 FTE in 2004 to 56.3 FTE in 2008, and plans to expand its medical workforce ahead of the planned opening in 2010. The LGH has already commenced an aggressive recruitment campaign to fill the existing medical vacancies and to identify potential staff for the expanded service. The LGH plans to bolster medical staffing immediately by recruiting GPs, career medical officers, locums and qualified overseas specialists.

### **Improved patient flows**

1. The LGH is developing an Acute Medical Unit (AMU) to provide appropriate treatment more quickly to patients, as well as a flexible 8-bed short stay capacity to enable those patients who do not need immediate admission to be monitored appropriately rather than taking up treatment bays. Both these strategies are designed to improve patient flows.
2. The RHH has recently moved into a new and expanded emergency department with an attached short stay unit. Furthermore it has implemented and maintained a contemporary system of “streaming” triaged patients into the following groups:
  - Category I Trauma and Emergency patients who are seen immediately by emergency staff;
  - Other patients for treatment and inpatient admission;
  - Patients that are expected to have a short emergency stay of up to 24 hours who are admitted to the Emergency Short Stay Unit before being discharged and returned to the community;
  - Patients who are assessed, treated and discharged back to community within 4 hours; and
  - Patients with low acuity who are seen in Clinic and returned to community in 2 hours.
3. Patients returning to the community are assisted by:

- The Aged Care Evaluation Team, who comprehensively evaluate aged care patients' needs and refer this group of patients on to appropriate services either within the RHH or to primary care providers.
  - The Mental Health Nurse Liaison Service situated in ED
4. Other ED Initiatives to ensure timely assessment and treatment include:
- A total of 15 ED pathways/protocols in place with nurse initiated treatments to streamline care delivery – for example Asthma protocol
  - Nurse initiated x-rays – and expansion to nurse initiated pathology and pain management
5. At the NWRH 45% of the patients who attend the ED are triaged as category 4 or 5. Generally these patients are not admitted and do not require urgent care but given their numbers, they fill up the ED and wait a long time for treatment.

To address this the NWRH plans to create a fast track process for category 4 and 5 patients where people are seen on a first come, first serve basis rather than wait for all more urgent cases to be seen. A dedicated team of nurses will reduce the length of wait and number of non- urgent patients in the ED and free up consultant staff to respond to the more urgent patients in triage categories 1, 2 and 3.

Particularly in winter months although not restricted to these months, NWRH wards are full and the demand for additional beds from the ED can be very difficult to meet. If beds do not become available then patients who need admission are left to wait (managed by nursing staff) in the ED or in day rooms in the wards. This is not satisfactory.

In order to address this issue the NWRH has focused on two aspects of the patient pathway, these are *Push and Pull*.

The NWRH believes that the historical approach of trying to push patients out of ED to the wards and out of the wards to the community, or aged care facilities does not work. The reason for this is that in the *push* scenario it is highly probable that the destination to which the patient is pushed is unlikely to accept them and will therefore try and push back to avoid taking the patient. Examples of this are: beds not being made up until the previous patient has left the building rather than transferring the patient into a safe discharge waiting area, aged care facilities not taking patients on Fridays.

The strategy to address this issue of bed block is to create a *pull* scenario so that patients are sought from the wards by the community services, from the ED by the wards.

6. To build on the initiatives already introduced, Tasmania has recently conducted a study of patient flow issues at the Launceston General Hospital and the Royal Hobart Hospital. The results of this study have been used to formulate initiatives to improve patient flows within EDs and within the hospital more generally. The specific proposals suggested for the implementation plan are largely based on the findings of this study.

## **The National Partnership Initiative and Tasmania – the joint way forward**

Tasmania will use National Partnership funding to build on existing initiatives and to apply a statewide strategic framework to new initiatives while still taking account of the differences between individual sites.

The following pages outline Tasmania's proposed implementation plan and the suite of evidence-based programs designed to reduce the pressure on emergency departments at public hospitals across Tasmania. Discussions have been held with a number of stakeholders, including the CEOs of the Area Health Services in Tasmania in developing this plan.

## Taking Pressure off Public Hospitals – Implementation Plan

### Targets of Schedule D

- 3. By 2012-13, 80% of emergency department presentations are seen within clinically recommended triage times as recommended by the Australasian College of Emergency Medicine**
- 4. By 2013-14, 95% of Hospitals with an ED report to the non-admitted emergency department care national minimum data set collection**

### The Tasmanian Plan

The health system in Tasmania is currently undergoing two major reform processes, the introduction of Area Health Services and the implementation of the Integrative Services Plan. This Implementation Plan is designed to complement this reform process and to promote our strategic objectives of:

1. Supporting individuals, families and communities to have more control over what matters to them.
2. Promoting health and wellbeing and intervening early when needed.
3. Developing responsive, accessible and sustainable services.
4. Creating collaborative partnerships to support the development of healthier communities.
5. Shaping our workforce to be capable of meeting changing needs and future requirements.

Tasmania is striving to achieve these objectives, in relation to emergency department care, by pursuing an agenda of improved performance, accountability and transparency.

The Plan addresses the need for improved service integration between community care, emergency departments and hospital inpatient services to ensure the right services are provided in the right setting and that there is continuity of care across service settings and improved information exchange to support this continuity of care.

This Implementation Plan allows the Area Health Services (AHS) to tailor their emergency department reforms to local community needs. It provides incentives for improved patient care.

Tasmania intends to distribute the funding under a combined population share and performance incentive model. The AHSs will receive 80% of funding based on their population share in the following proportions:

- Southern AHS, including Royal Hobart Hospital – 49.4%
- Northern AHS, including Launceston General Hospital – 28.3%
- North West AHS, including North West Regional and Mersey Hospitals – 22.3%

Funding will be provided to the AHSs after they have submitted action plans and had these plans approved by the Department of Health & Human Services (DHHS).

For each the four years of the plan, 20% of the funding will be set aside to provide performance incentives. Each AHS will have a nominal funding pool and will win a proportion of this depending on how well it met its stretch targets for the preceding year. Any unallocated funds each year will be used for overall system improvements designed to reduce the pressure on public hospitals, such as the purchase of equipment. A top slice of \$200,000 (\$50,000 per annum) will be retained centrally to undertake audits of performance reporting.

The draft performance indicators are outlined in the following Tasmanian Implementation Plan. They will require further refinement and the addition of the stretch targets and benchmarks as appropriate. As the data collection processes are refined, more performance indicators may become available.

The hospitals will need to apply for funding under the following funding streams within the broad areas of diversion, emergency department performance and hospital patient flow. The streams for funding are as follows: -

Diversion

1. Support for aged complex and chronically ill people outside hospitals;
2. The third door program;

Emergency Department Performance

3. Minor capital works and equipment enhancements;
4. Data and reporting enhancements;
5. Work practice changes within emergency departments;

Hospital patient flow

6. Establish medical emergency units;
7. Improved hospital patient flow initiatives; and
8. Bed management systems.

Funding for streams 4 and 8 may involve the purchase of statewide systems and so may be expended on a statewide basis rather than at the individual area health service level.



Funding streams will be allocated as follows:

	<b>Initiative</b>	<b>Allocation (\$ million)</b>
Diversion	1 Support for aged complex and chronically ill people outside hospitals	3.0
	2 The third door program	0.6
ED Performance	3 Minor capital works and equipment enhancements	2.5
	4 Data and reporting enhancements	2.0
	5 Work practice changes within emergency departments	2.3
Hospital Flow	7 Establish medical emergency units	3.0
	8 Improved hospital patient flow initiatives	1.0
	9 Bed management systems	2.0
	Performance audit	0.2
<b>Total</b>		<b>16.6</b>

Funding levels are indicative only and may vary according to the action plans received from Area Health Services.

Role of the States	Key deliverables for States implementation plans	Timing	Cost	Expected effects on Performance Benchmarks
<a href="#">1. Implement hospital diversion strategies</a>				
<b>Provide additional support for aged complex and chronically ill people who are at risk of emergency department presentation and hospitalisation through improved assessment and early intervention</b>	<p>Establish an outreach team to support Nursing homes, GPs and other community services who identify 'at-risk' complex and chronically ill people who may need specialised multidisciplinary team input to assist them to remain in their place of residence, rather than requiring hospitalisation.</p> <p>Implement improved case management for patients with chronic conditions.</p>		\$3.0m	<p>Reduction in preventable or inappropriate presentations at emergency departments</p> <p>Reduction in attendances for selected chronic illnesses (asthma, diabetes etc.)</p>
<b>The Third Door</b>	<p>The Third Door is a program that allows patients to be directly admitted for inpatient or outpatient care without first being assessed or treated in the emergency department, thereby recognising that some patients can be more effectively treated in other settings.</p> <p>Patients with chronic conditions, cancer and renal patients are particularly suited to this type of model of care. The advantages are that:</p> <ul style="list-style-type: none"> <li>the patients are often known to the unit or team</li> </ul>		\$600,000	<p>Reduction in non emergency presentations at emergency departments</p>

Role of the States	Key deliverables for States implementation plans	Timing	Cost	Expected effects on Performance Benchmarks
	into whose care they are directly transferred; and <ul style="list-style-type: none"> <li>• the clinicians in the unit or team are skilled in looking after the patient's condition.</li> </ul>			

Role of the States	Key deliverables for States implementation plans	Timing	Cost	Expected effects on Performance Benchmarks
<a href="#">2. Improve emergency department performance</a>				
<b>Minor capital works upgrades</b>	This involves minor upgrades within emergency departments where minor capital works will resolve issues that are causing delays and contributing to poor patient flow.		\$2.5m	Increase in the proportion of patients being treated in clinically appropriate periods of time.
<b>Improve data consistency, accuracy and transparency in reporting</b>	Develop protocols and processes to: <ul style="list-style-type: none"> <li>improve emergency department data collection and coding;</li> <li>improve transparency in reporting; and improve data auditing (\$200,000 to be retained centrally for data audit).</li> </ul> Some additional data items are required to improve patient flow in EDs. The 3-2-1 model of care would require additional data to implement and to monitor performance.  For more effective patient management, emergency department data needs to be linked to admissions data, primary care data and outpatient data to improve reporting and management of episodes of care.		\$2.0m  plus  \$0.2m for performance audit	

Role of the States	Key deliverables for States implementation plans	Timing	Cost	Expected effects on Performance Benchmarks
<p><b>Implement work practice changes within emergency departments</b></p>	<p>Trial innovative workforce models in ED and explore process improvements to better utilise current workforce.</p> <p>E.g. Implementation of a 3-2-1 model of care to break down a patient's journey through the emergency department into three brackets of time:</p> <ul style="list-style-type: none"> <li>• 3 hours for the DEM to examine a patient, undertake investigations, commence initial treatment and determine whether the patient is likely to be admitted;</li> <li>• 2 hours for specialty inpatient teams to consult with a view to admission; and</li> <li>• 1 hour for inpatient wards to be ready to take over the care of the admitted patient and move the patient from the DEM to the ward.</li> </ul>		\$2.3m	<p>Increase in the proportion of patients being treated in clinically appropriate periods of time.</p> <p>Reduction in the proportion of patients spending more than 8 hours in an emergency department.</p>

Role of the States	Key deliverables for States implementation plans	Timing	Cost	Expected effects on Performance Benchmarks
<a href="#"><u>3. Better patient flows throughout the hospital</u></a>				
<b>Develop Emergency Medical Units</b>	An Emergency Medical Unit (EMU) is a designated ward within a hospital which accepts admissions for general medical conditions. The clinical management of EMU patients is jointly managed by emergency department and medical physicians. The expected length of stay in EMU could be up to 4 days.		\$3.0 m	Increase in the proportion of patients being treated in clinically appropriate periods of time.  Reduction in the proportion of patients spending more than 8 hours in an emergency department.
<b>Improved patient flows</b>	Improve patient flow through hospitals by actively managing key factors affecting patient throughput including: <ul style="list-style-type: none"> <li>• admission and discharge protocols and programs including effective discharge planning;</li> <li>• other barriers to the efficient operation of the hospital; and</li> <li>• development of new services such as Hospital</li> </ul>		\$1.0m	Increased proportion of patients being treated in clinically appropriate periods of time.  Reduction in the proportion of patients spending more than 8 hours in an emergency department

Role of the States	Key deliverables for States implementation plans	Timing	Cost	Expected effects on Performance Benchmarks
	in the Home.			
<b>Improved bed management practices</b>	<p>Develop a whole of hospital bed management plan that takes account of predictable peaks in emergency demand such as at weekends and during winter and patterns of elective surgery, with the broad objective that overall hospital throughput is smoothed so that emergency patients are not subject to excessive waits and elective patient procedures are not cancelled unreasonably.</p> <p>Efficient use of beds also requires accurate, transparent data collection with rapid feedback to clinicians.</p>		\$2.0m	<p>Increased proportion of patients being treated in clinically appropriate periods of time</p> <p>Reduction in the proportion of patients spending more than 8 hours in an emergency department</p>

<sup>i</sup> Jackson, N.O., *Comment on latest ABS Release (Dec 2004) – Population Growth Positive but Slowing*, <http://taspop.tasbis.com/webapps/site/588/widgets/1396/news/news-more.html?newsid=6273>, University of Tasmania, Hobart, 2005.