South Western Sydney Area Health Service

Ambulatory Care

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Foreword

There are a number of important issues facing South Western Sydney Area Health Service (SWSAHS) that we need to consider. There is ongoing demand for health services, new technologies, new drugs and new approaches to care including the provision of care at many sites (such as home, GP and specialist rooms, hospital, community health centres). These all have major implications for SWSAHS in how we provide services now and into the future.

Ambulatory care in SWSAHS is considered an overall approach to achieving integrated and appropriate care. It is the sum of all the different components of services such as hospital in the home, early discharge programs, shared care programs, outpatient clinics, same day medical and surgical services provided within hospitals, emergency services, care in the community and in General Practitioner and specialists' rooms. It is about ensuring that all these components are part of an overall direction for the Area Health Service.

The challenge for us is that ensuring that with greater choice in the setting where care is delivered, care is integrated, appropriate to the needs of the patient and their carers and of high quality. It is about ensuring that all people within SWSAHS have alternatives to a hospital admission for care. It is about providing appropriate care by the most appropriate person in the most appropriate location.

It means building on the progress that has already been made in SWSAHS in many areas and applying ambulatory care more widely to paediatrics, drug and alcohol, aged care and rehabilitation, mental health and antenatal care as well as areas such as renal medicine, cancer services and diabetes.

The purpose of this plan is to identify issues associated with ambulatory care in SWSAHS and actions that are required to provide an ambulatory service that is efficient, effective, equitable and acceptable to the community of SWSAHS, including staff, clients and their families. This means involving the coordinators and providers of care, the patient, their carers and the broader community in planning, developing and evaluating ambulatory care services.

This plan is an important step in identifying key areas that the Area Health Service needs to focus on to continue to make progress in such an important aspect of our service.

IAN SOUTHWELL
Chief Executive Officer

May 2000

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1. Introduction

The SWSAHS Area Operations Plan (AOP) identifies the need to develop strategies to improve and increase ambulatory care services. The AOP is based on a number of planning principles that bring together the two streams of SWSAHS's purpose of *Better Health, Good Health Care*. A number of these principles relate to ambulatory care and include:

- An emphasis on "service" not beds;
- All services will have a connected prevention strategy, a service at home strategy and a strategy to connect with other providers;
- An emphasis on doing as much as possible of what is currently done on an overnight basis in hospitals on an ambulatory basis; and
- An emphasis on the management of unplanned or emergency demand.

The purpose of this plan is to identify issues associated with ambulatory care in SWSAHS and actions that are required to provide an ambulatory service that is efficient, effective, equitable and acceptable to the community of SWSAHS, including staff, clients and their families.

2. Background

Health care, including care in hospitals is changing. There is a global trend of increasing admission rates and falling bed numbers[1]. This means that there is a need to create flexibility to manage uncertainty and use resources effectively, while maintaining the capacity to cope with seasonal variation in demand for services.

Changing surgical, anaesthetic, diagnostic and pharmacological practice has enabled health systems all over the world to consider managing patients in settings other than hospitals. Changing technology is probably the main force driving the substitution of health care resources. New treatments, procedures and diagnostic techniques allow conditions to be managed in different settings by different staff[2].

SWSAHS has followed this trend as evidenced by declining average length of stay (ALOS) in SWSAHS hospitals as demonstrated in Table 1. Total ALOS declines even more when day only activity is included as day only activity increases as a total proportion of workload and occupancy rates exceed 100%, that is, more than one patient occupies one bed/chair in one day.

Table 1 – Inpatient Length of Stay (days) in SWSAHS

	1996/97 (actual)	1997/98 (actual)	1998/99 (actual)	2001 (forecast)	2006 (forecast)
Tertiary overnight	13.0	11.5	11.6	10.5	9.3
Non tertiary overnight	4.7	4.4	4.4	5.0	4.5

[1] Hensher, M, Edwards, N and Stokes, R. International trends in the provision and utilisation of hospital care. BMJ, Volume 319, September 1999.

[2] Hensher, M, Fulop, N, Coast, J and Jefferys, E. Better out than in? Alternatives to acute hospital care. BMJ, Volume 319, October 1999.

Total ALOS	3.5	3.4	3.3	3.1	2.7

Most major changes that have led to fundamental alterations in the organisation of care have not generally been policy changes. For example, development of effective chemotherapy for tuberculosis led to the closure of thousands of hospital beds and elimination of whole hospitals. Generally policy has focussed on "appropriateness", that is, how to provide alternative care for inpatients who do not strictly need to be in hospital because of current technologies[3].

As well as a number of major technology related changes other change has:

- Been driven by what is able to be managed in settings other than in a hospital bed (eg. nursing home, home, day hospital, outpatient clinic) but not by a philosophy of what is most appropriately managed in what setting;
- Created the perception that the health system is only driven by efficiency objectives;
- Often occurred in an ad hoc manner due to the vision of certain key individuals; and
- Has been accepted as normal practice in some streams of care and in some parts of SWSAHS but not in others.

Ambulatory Care is perhaps better entitled **Appropriate and Integrated Care Delivery** as it ultimately concerns care delivery systems and what is the best or appropriate care delivery method and place in which to manage a particular condition being experienced by a particular patient or community member at that particular time. This means that ambulatory care is not just about efficiency but also quality, effectiveness and equity of access to the best care.

At present Sector Health Services in SWSAHS define ambulatory care differently to each other, but the most common theme is that it is care for people who previously needed to be hospitalised. This definition is reasonable, but limiting. It does not press the question of how care might be best delivered for people who must be hospitalised. SWSAHS's approach to date is limited by each Sector's exclusion criteria. While this is understandable in relation to safety, an inclusive approach would mean that potentially all patients could benefit from an overarching approach of appropriate care delivery.

3. The Framework for Managing the Quality of Health Services in NSW

The *Framework for Managing the Quality of Health Services in NSW* defines quality in health as **doing the right thing, the first time, in the right way, at the right time.**

The Framework is the means by which clinical governance is to be introduced in NSW. Many issues are identified in considering how to improve quality of care further. Some of these include: a focus on quality of clinical care; explicit

[3] Hensher, M, Fulop, N, Coast, J and Jefferys, E. Better out than in? Alternatives to acute hospital care. BMJ, Volume 319, October 1999.

accountability for quality of care; managing the quality of health services; providing an organisational focus for quality activities and reporting; competence of providers, multidisciplinary teams and health care organisations; continuity of care; education and training; information management; and the essential cultural requirement of continuous quality improvement.

The Framework has obvious application to a view of ambulatory care as a process of achieving and supporting appropriate care delivery. The six dimensions of quality are:

- ***Safety*** of health care: A major objective of any health care system should be the safe progress of consumers through all parts of the system. Harm from their care, by omission or commission, as well as from the environment in which it is carried out, must be avoided and the risk minimised in care delivery processes.
- ***Effectiveness*** of health care: Consumers of health services should be able to expect that the treatment they receive will produce measurable benefit. The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome.
- ***Appropriateness*** of care: It is essential that the interventions that are performed for the treatment of a particular condition are selected based on the likelihood that the intervention will produce the desired outcome. Appropriateness of health care is about using evidence to "do the right thing" to the right person, in a timely fashion.
- ***Consumer participation*** in health care: Not only do consumers have a fundamental right to participate in health care delivery, but such input will also have considerable benefit. Consumer participation will enhance acceptability.
- ***Access*** to services: Area Health Service should offer equitable access to health services on the basis of patient need, irrespective of geography, socio-economic group, ethnicity, age or sex.
- ***Efficiency*** of service provision: Health services must ensure that resources are utilised to gain value for money. This can be achieved by focussing on minimising the cost of production of services and by the allocation of resources to provide the greatest benefit to consumers.

The SWSAHS principles of equity, efficiency, effectiveness and acceptability are clearly consistent with these six dimensions.

4. Definitions of Ambulatory Care

There is no clear and accepted definition of ambulatory care. The term ambulatory care has tended to be applied to a range of medical and surgical care that is provided on a day only basis. Generally particular components of care, such as hospital in the home and discharge planning, have been defined. The Commonwealth ambulatory care project is focussing on emergency department and outpatient services.

One definition of **ambulatory care** is care that does not require an overnight hospital admission. Care can be provided in a variety of settings including hospital, out patient and emergency departments, community centres,

ambulatory care centres, the patient's home, the patient's workplace or General Practitioner or Specialist rooms.

Same day surgery refers to a *planned* admission, where the individual undergoes a surgical or endoscopic procedures, requires a local, regional, spinal, general anaesthetic and/or intravenous sedation, a period of post operative observation in a designated areas and is discharged home (or to alternative accommodation) on the same date[4]. The patient requires access to an operating room and a recovery area. Care is therefore provided in hospitals or designated day surgery facilities.

Same day medicine involves the provision of care to prevent admission to hospital, to facilitate earlier discharge from hospital or to provide an alternative site to hospital for provision of the same care. Care can be delivered in a variety of hospital or non hospital settings and may vary over the same episode of care.

Ambulatory care in SWSAHS is defined as the delivery of health care in a variety of settings including outpatient departments, short stay/day only beds, specialists' rooms and the patient's home. This definition encompasses principles of selection criteria, risk assessment and continuous quality improvement. Shared care between general practitioners, nurses, allied health professionals and hospital specialists is the accepted practice. There is shared responsibility for health between the patient, carer and the services allowing for choice in the delivery systems for treatments whether physical, psychosocial or pharmacological.

The **vision** for ambulatory care in SWSAHS is to recognise that <u>all</u> patients can benefit from the concept of ambulatory care and is inclusive rather than exclusive. This does not mean that services such as intensive care, coronary care or immediate post surgical care should be provided in the home, rather that factors that oblige patients to remain in hospital should be examined to see if hospitalisation should continue or alternatives exist.

This vision means applying ambulatory care more widely to include areas such as antenatal care, paediatrics, mental health, drug and alcohol, aged care and rehabilitation and building on the progress that has already been made in SWSAHS in many of these areas.

This approach is consistent with a quality approach of doing **the right thing, the first time, in the right way, at the right time** as well as in the **right location.** That is, appropriate and quality care is provided by the most appropriate person in the most appropriate location. The alternative location is probably the most important aspect of ambulatory care.

This concept is also consistent with a view of ambulatory care as a transition between a number of providers and settings.

[4] NSW Health, What a Difference a Day Can Make – Same Day Surgical and Endoscopic Procedures Policy, May 1999

5. Demand for Day Only Health Services

SWSAHS's population is projected to grow by 13.7% from 731,615 in 1996 to 830,509 in 2006. Population growth and ageing are the two main factors in rising demand for health services.

Categories of activity that can be measured and which are relevant to ambulatory care services include:

1. Day only medical and surgical activity that occurs in a hospital;
2. Non inpatient occasions of service; and
3. Emergency Department (ED) activity.

Outpatient activity currently provided on a privately referred non inpatient basis is not captured in NSW data collections.

Detailed information regarding the estimated potential demand for ambulatory care is provided in Appendix A. The main issues arising from the forecast demand are:

- There is a large increase forecast (71% in the 10 years from 1996-2006) in the demand for day only inpatient services;
- The proportion of day only activity of total workload is estimated to increase from 42% (1996) to 50% (2006);
- An increase in the number of SWS residents treated within SWSAHS would result in an increase of self sufficiency from 69.4% in 1996 to 88.4% by 2006. That is a 91% increase in the workload of day only services in SWSAHS;
- From a base of 1.675 million non inpatient occasions of service in 1997/98 there could be an additional 217,523 NIOOS by 2001 and a further 332,855 NIOOS by 2006.
- Ongoing increases in ED activity. There has been a 10.7% increase in weighted ED attendances in SWSAHS since 1996/97. This is important as EDs are a key entry point into the hospital system. Over the same period there has been a 5.3% increase in admissions from ED to hospital.

By adopting a planning principle that involves all services having an integrated service strategy, this means that potentially all people who utilise services in SWSAHS could benefit from ambulatory care. Linkages between services and provision of appropriate care whatever the setting are required. This involves the following considerations:

- Involving General Practitioners, other service providers and the community in the planning and development of ambulatory care services;
- That there are adequate clinical guidelines and training and professional supports to ensure that patient care is safe and appropriately managed and provided whatever the location;
- A whole of hospital approach including consideration of transitional wards for those who do not meet the current selection criteria for ambulatory care services but who are low dependency;

- Linked discharge and admission policies that acknowledge that patients are entitled to know the time of admission and discharge where possible (allowing for complications and unplanned variations);
- Consideration of optimal admission processes and readily available information on care alternatives;
- Provision of hospital areas for non inpatient services;
- Whether current selection or exclusion criteria are appropriate;
- Communication and information needs of all providers;
- Education and training needs of service providers, carers and patients;
- Implications of multiple sites for service provision; and
- Community support services.

5.1 Demand Management

In view of the change in demand forecast, demand management is an important issue for the Area. There are currently two main pathways for admission to a hospital bed. One is via the Emergency Department (ED) and the other is as a planned admission. Other pathways include:

- The patient having their admission arranged by the GP or Visiting Medical Officer (VMO), and although an unplanned admission, proceeding immediately to the ward or admission to a hospital bed via the Ambulatory Care Ward;
- Admission directly to the ward from outpatient clinics; and
- Rather than admitting the patient, admission can be direct to an Ambulatory Care Program with the "bed" provided in the home with the same care as would have been provided in an inpatient setting.

There are four main objectives in seeking to manage demand:

1. To ensure that ED management can refer to alternative care to avoid admission where this is the appropriate care pathway;
2. To ensure that planned admissions for medicine or surgery achieve the length of stay, as well as quality of care, expected in the health system;
3. To ensure that people who need to be admitted overnight and managed in hospital are discharged into other care in other settings in a timely fashion and that there are options available for post admission care if required; and
4. To ensure that those seeking to arrange, and those accepting admission, are aware of all the options for care that are available.

6. Benefits of Ambulatory Care

Most research has been done into outcomes of hospital in the home approaches although it has been reported there have been methodological limitations in these studies[5]. A number of studies have generally indicated that health outcomes are at least comparable to inpatient care and patient satisfaction may be higher. Recent evidence from a randomised controlled trial suggests that hospital at home can deliver care as effectively as hospital

[5] Sheppard, S and Iliffe, S. Hospital-at-home versus in-patient hospital care. Cochrane Library, 1997.

with no clinically important differences in health status and at similar or lower cost than an equivalent admission to an acute hospital[6].

In regard to efficiency, it is probably harder to confirm that ambulatory care is less costly than hospital care until better costing information is available for non inpatient services. Costs saved are also greatest when an admission is avoided or when many days of care is saved. Care costs at the end of a stay in hospital are at their lowest, so the savings are marginal.

Overall, evidence is generally lacking about whether many of the most frequently discussed alternatives to hospital are noticeably and consistently cheaper than hospital based care[7]. These alternatives include discharge planning, patient hotels, hospital in the home, community or general practice hospitals and nurse led inpatient care. It has been proposed that rather than considering alternatives to hospital as substitutes that aim to reduce admission, these should be viewed as bridges between hospital and home, by means of which the quality of care can be constantly improved[8].

The literature in general also does not indicate the social cost of ambulatory care. For example, the cost of leave from work to provide care or transport, the emotional and physical cost of caring for people at home, the stress that people may feel if patients are not admitted to the "security" of a hospital; and many other social impacts.

There are also issues with current funding arrangements that need to be considered in relation to increasing ambulatory care. As an example, most private health funds do not fund hospital in the home. In addition, the increasing acuity and complexity of community care may not be adequately reflected in the current estimated cost of a non inpatient occasion of service and there may be financial incentives to admit people for care.

The following are considered to be potential benefits of ambulatory care:

- Decreased length of inpatient hospital stay;
- It reflects changing clinical practice and improvements in technology
- Reduced risk associated with overnight hospitalisation;
- Reduced risk of nosocomial infections;
- Provides an integrated continuum of care;
- Inappropriate admissions are prevented, readmissions reduced and chronic conditions more effectively managed;
- Greater patient and General Practitioner satisfaction;
- Contributes to greater continuity of care and shared care with General Practitioners;

[6] Wilson, A, et al. Economic evaluation of hospital at home scheme versus hospital care: cost minimisation analysis of data from a randomised controlled trial. BMJ, Volume 319, December 1999.

[7] Hensher, M, Fulop, N, Coast, J and Jefferys, E. Better out than in? Alternatives to acute hospital care. BMJ, Volume 319, October 1999.

[8] Steiner, A. Intermediate care: a conceptual framework and review of the literature. London: King's Fund, 1997.

- Greater flexibility in the choice of site where care is provided by the provider, carer and patient with improved patient access and less disruption to family and work;
- Home is often the preferred choice for care when it is available on this basis; and
- It is not more costly than an overnight hospital stay.

7. Planning Principles for Ambulatory Care

As part of considering how best to plan ambulatory care within SWSAHS the following planning principles have been identified:

- An emphasis on integration of care between hospital, community and General Practitioners;
- Provision of the most appropriate care by the most appropriate provider in the most appropriate location;
- An emphasis on inclusiveness;
- An emphasis on safety and quality of care;
- An approach that provides Sector flexibility but which has an Area approach to ensure equity of access, consistent levels of service and benchmarking of performance; and
- An approach that engages all staff and the community in improving care available for SWS residents; and
- Recognition of the cultural and organisational change required to maximise integrated care.

8. Models of Ambulatory Care in SWSAHS

Different models of care have developed in each Sector of SWSAHS in response to specific requirements for the service. Detail of each of the individual models is provided in Appendix B. The Integrated Care Minimum Standards developed by SWSAHS are provided at Appendix C.

9. Current Issues

A number of issues have been identified in regard to ambulatory care. These have been considered in relation to the six quality dimensions. In some cases there is obviously overlap between the dimensions.

Safety

- To ensure that care is provided safely in the location where care is delivered there are criteria that exclude people from at home care. These need to be clear and standardised between Sectors. Provision of care without compromising safety for both patients and staff is essential;
- There needs to be confidence that patients can be managed safely and appropriately in the community;
- There are safety and security issues for staff that need to be considered when delivering care in a range of environments. Approaches and requirements should be standardised.

Effectiveness

- Participation by all Sectors in research being undertaken in SWSAHS is supported;
- Staff development including skills development and training is required as part of ongoing training programs. Issues of credentialling of staff to perform additional tasks;
- Awareness of and communication regarding the number of initiatives relating to ambulatory care are required to prevent duplication or to develop links. For example, the Ambulatory Care Information Development Group; the Commonwealth funded Ambulatory Information Infrastructure Project (AIIP); the Nursing Transitional Care Advisory Group; and interstate projects.

Appropriateness

- An Area wide definition of ambulatory care is required while ensuring local flexibility to develop models consistent with local needs;
- Mechanisms to maximise referrals to, and utilisation of, ambulatory care services need to be identified. Issues of discharge, including responsibility for patient discharge and the rights of patients to know when this will occur, as well as the links to admissions, need to be considered;
- There needs to be confidence that complex patients are still able to be managed as required with inpatient stays consistent with the level of complexity;
- Ambulatory care services need to be appropriately managed and organised;
- Need to ensure clinical governance and mechanisms for peer review;
- Need to ensure that there are adequate support systems to provide quality ambulatory care including clinical supervision, consultation advice, regular quality review meetings and communication mechanisms between care providers, including General Practitioners;
- Need to encourage referrals to ambulatory care with confidence that patients can be managed in the community and that care will be appropriately supervised;
- Need to identify strategies to promote “doing the right thing” to the right person in a timely fashion, including in the ”right location”.

Consumer participation

- There needs to be processes whereby the coordinators of patients care can be engaged and support ambulatory care;
- Evaluation processes to be implemented with clinical and patient/carer and other key stakeholders satisfaction indicators. These should be standardised as much as possible while enabling feedback on Sector specific areas or service models;
- Community awareness and acceptance of ambulatory care and its benefits and understanding of its possible drawbacks.

Access

- Commonality of care and equitable access to the same level of care throughout the Area Health Service needs to be ensured;
- Opportunities should be explored to provide the benefits of ambulatory care to all patients, including those who do not meet current selection criteria. For example, step down wards;
- Need to develop consistent selection criteria;
- Review the current agreed Integrated Care Minimum Standards in terms of achieving the intended access to the service.

Efficiency

- Costing models to be considered following review of the Macarthur project;
- Performance indicators need to be developed and standardised including workload and staffing measures. Benchmarking is required;
- Minimum data standards need to be identified and agreed;
- Consideration of implications of referral and funding and billing arrangements;
- Achievement of 2000/01 target of 60% same day surgery as proportion of surgery (currently 42.3%) and 45% of same day activity as proportion of total admissions (currently 34.9%);
- Development of workload measures and standardisation of staffing levels;
- Development of information technology to support effective decision making.

10. Action Plan

An action plan has been developed in relation to each quality dimension and includes the objective, action, short and long term performance indicator, target date and responsibility. Each strategy has also been identified as a high or medium priority.

The following abbreviations have been used in the Action Plan:

DCEO	Deputy Chief Executive Officer
DBS	Director, Business Services
DDP	Director, Division of Planning
DFS	Director, Financial Services
DMCS	Director, Medical and Clinical Services
DNCS	Director, Nursing and Clinical Services
GMs	General Managers

ACTION PLAN

Objective	Action(s)	Performance Indicator (s)		Responsibility	Priority	Progress/ comments
		Short Term By 2000	**Long Term By 2003**			
Safety						
To ensure that care for the patient is provided safely in the location where care is delivered	Standardisation of current minimum acceptance criteria	Common criteria		Advisory Committees and DMCS	High	
	Development of strategies to provide care and increase numbers of patients treated without compromising safety. For example, issue with phone		Strategies developed	Advisory Committees and DMCS	Medium	
To ensure that staff safety and security are maximised	Development of agreed safety protocols	Protocols adopted in all Sectors		DBS	High	
Effectiveness						
To develop common key performance indicators (KPIs)	Identify existing performance indicators for ambulatory care	Audit conducted		Casemix Committee and DFS	High	
	Standardise and implement across all Sectors	KPIs collected in all Sectors	Targets included in performance agreements	Casemix Committee and DFS	Medium	
To support and develop research into ambulatory care	Encourage Sector participation in existing and new research	Identify current research	All Sectors participate in research	GMs	Medium	
To promote staff development and training and enhance skills	Develop training programs	Competency standards identified for clinical staff	Ongoing staff development programs and possible credentialling	GMs and Ambulatory Care Working Party	High	

Objective	Action(s)	Performance Indicator (s)		Responsibility	Priority	Progress/ comments
		Short Term By 2000	**Long Term By 2003**			
To develop support systems for quality ambulatory care	Ensure that support systems include supervision, consultation advice, quality review meetings and communication mechanisms between care providers, including GPs	Systems in place		GMs and Ambulatory Care Working Party	Medium	
To identify appropriate length of stay and admission rates for indicator conditions. (eg cellulitis, pneumonia, DVTs, anticoagulation)	Identify agreed indicator conditions and review on an annual basis to identify further conditions	Conditions agreed	Clinical management guidelines developed	Ambulatory Care Guidelines Committee	High	
	Measure length of stay and admission rates	Length of stay and rates measured	Appropriate length of stay and rates identified	PAS Project and GMs	Medium	
Appropriateness						
To develop Area wide approach to ambulatory care	Adopt SWSAHS definition and identify strategies to promote appropriate care delivery in the appropriate location	All services have adopted policy and strategies developed		GMs	High	
	Identify patient care pathways including discharge to alternative providers and sites for care	Patient care pathways adopted	Targets set	Ambulatory Care Guidelines Committee DCEO	High	
	Measure preventative admissions, that is patients referred to Ambulatory Care direct from GPs or specialists rather than referred to the Emergency Department	Number of preventative admissions		Ambulatory Care Working Party	Medium	

Objective	Action(s)	Performance Indicator (s)		Responsibility	Priority	Progress/ comments
		Short Term By 2000	**Long Term By 2003**			
To identify a "leader" for each of the Sector services	Identify an ambulatory care medical director/coordinator in each Sector	Medical director/coordinator identified/ appointed		GMs	High	This is not a line management role for all services that involve ambulatory care
	Identify requirements and processes for medical governance and implementation of guidelines	Consultation with GPs and other clinicians has occurred	Requirements identified	GMs	Medium	
To maximise referrals to, and utilisation of, existing services	Identify any issues related to referral of patients to the service	Issues identified		GMs	High	
	Develop strategies to improve referrals and increase the numbers of patients treated on an ambulatory basis and identify other suitable areas	Strategies developed	Numbers of patients referred increased by >10%	DMCS and Area Advisory Committee	High	
	Pilot programs or evaluate current programs in areas such as mental health, paediatrics, antenatal care, drug and alcohol and rehabilitation	Pilots undertaken and evaluated	Specific targets identified for each speciality	GMs	High	
Consumer Participation						
To standardise current survey and evaluation tools	Implement standard survey and evaluation tools in all Sectors	Tools adopted in all Sectors		DDP	Medium	
To engage coordinators of patient care in supporting and promoting ambulatory care	Identify "champions" for ambulatory care	Champions identified		GMs	High	
	Include GPs and clinicians in the planning and evaluation of ambulatory care	Included in planning processes		DDP/GMs	High	
	Conduct an annual workshop involving key stakeholders in ambulatory care services	Workshop conducted		DDP	High	

Objective	Action(s)	Performance Indicator (s)		Responsibility	Priority	Progress/ comments
		Short Term By 2000	**Long Term By 2003**			
To engage the community in development, planning and evaluation of ambulatory care services	Develop a community participation strategy	Strategy developed		DDP	Medium	
Access						
All SWS residents able to access the same level of ambulatory care services	Develop consistent minimum selection criteria for SWS	Selection criteria consistent		DMCS/DNCS	High	
	Review the current agreed Integrated Care Minimum Standards	Review conducted		DMCS/DNCS	High	
	Ensure that the service's performance meets the intention of the Minimum Care Standard of Service	All services meet standards		GMs	Medium	
Efficiency						
To identify the costs of ambulatory care occasions of service	Review the outcome of the Macarthur Ambulatory Database Development project which includes an activity based costing component	Outcome reviewed		DFS and Casemix Committee	Medium	There is no accepted classification tool for ambulatory care services in NSW. This is a statewide requirement
To develop minimum data standards	Review current data collections	Audit conducted		Casemix Committee	High	

Objective	Action(s)	Performance Indicator (s)		Responsibility	Priority	Progress/ comments
		Short Term By 2000	**Long Term By 2003**			
	Develop a minimum data set	Minimum data set developed	Information collected by all Sectors available as a data set	Ambulatory Care Working Party	High	Suitable local workload measures will need to be identified, recognising that there are currently no NSW classifications
To develop a methodology to standardise workload measures	Identify and agree appropriate workload measures for clinical groups for all Sectors	Workload measures identified		Ambulatory Care Working Party with support from Casemix Committee	High	Work done by Fairfield Dir Com Health to be noted
To undertake benchmarking	Develop an agreed process to implement benchmarking following development of standard performance indicators and workload measures		Benchmarking undertaken of performance	DFS	Medium	
To achieve day surgery target of 60% of all surgery on day only basis by 2000/01	Identify areas that need particular strategies to achieve target	Targets for procedures in Day Surgery policy achieved		DCEO	High	
	Identify areas performing well and review reasons for good performance	Processes identified and rolled out where possible		DMCS/DNCS	Medium	
To achieve same day target of 45% of all admissions as same day by 2000/01	Identify areas that need particular strategies to achieve target	45% of all admissions same day		DCEO	High	

Objective	Action(s)	Performance Indicator (s)		Responsibility	Priority	Progress/ comments
		Short Term By 2000	**Long Term By 2003**			
To roll out Sector models of care to all of SWSAHS	Identify current models that work well in Sectors	Review conducted and models evaluated	Roll out of models	DMCS	High	
To maximise revenue opportunities	Investigate revenue opportunities such as transfer of inpatient casemix payment or Health Insurance Fund payment to private payments	Revenue opportunities investigated and identified		DFS	Medium	
To have information systems that enable effective decision making and facilitates ambulatory care	To identify information requirements	Information requirements identified		Ambulatory Care Working Party	Medium	Other IT&M initiatives relate to this strategy
	Progress implementation of a unique patient identifier and the ability to track patient and exchange information across different providers and different care			PAS Project	Medium	

Appendix A

DEMAND FOR DAY ONLY HEALTH SERVICES

SWSAHS's population is projected to grow by 13.7% from 731,615 in 1996 to 830,509 in 2006. Population growth and ageing are the two main factors in rising demand for health services.

Categories of activity that can be measured and which are relevant to ambulatory care services include:

4. Day only medical and surgical activity that occurs in a hospital;
5. Non inpatient occasions of service; and
6. Emergency Department activity.

While forecasts of inpatient activity to 2001 and 2006 assume an increase in the proportion of day only activity, there are not methodologies for estimating the increase in non inpatient and emergency activity. Estimates of the increase in this activity has been based on population growth, rates of change forecast for inpatient services and the rates of increase in the services themselves.

Outpatient activity currently provided on a privately referred non inpatient basis is not captured in NSW data collections.

By adopting a planning principle that involves all services having an integrated service strategy, this means that potentially all people who utilise services in SWSAHS could benefit from ambulatory care.

Day Only Medical and Surgical Activity That Occurs in a Hospital

NSW Health's Activity Projections Plus Interventions (APPI) model predicts a 4% per annum growth in acute inpatient activity from 1996 to 2001. This is due to a range of factors including population growth and ageing and trends in acute service provision.

Demand in this context refers to the requirement for health services from the community based on models which consider trends from current and past service utilisation, population growth and ageing and anticipated changes in the provision of services. SWS resident's demand can be met through access to services provided within SWSAHS, by other Area Health Services or interstate.

It should be noted that this represents a forecast of the future activity based on a number of assumptions, including no change in the current flow of patients and trends in acute services utilisation.

Interpreting these forecasts requires some cautionary notes. The forecasts are based on observed trends from 8 prior years of data. Regression analysis is a statistical method of predicting forward but it does not by itself design the future.

Table 1 - Forecast Total Demand for Day Only Services by SWS Residents (Episodes of Care)

Demand for Day Only	1996	2001	2006	% Change
Day Only	56,972	76,803	97,336	71%
% of overall workload	42%	47%	50%	+8%

Source: NSW Health Activity Plus Interventions Model

Table 2 - Changes in the Workload of Day Only Services in SWSAHS (Episodes of Care)

Year	Demand	Supply	Capture	Outflow	Inflow	Self-Sufficiency
1996	56,972	45,675	39,536	17,436	6,139	69.4%
2001	76,803	67,855	59,423	17,380	8,432	77.4%
2006	97,336	87,088	76,357	20,979	10,731	88.4%

Source: NSW Health Activity Plus Interventions Model

This forcast would see an increase of 91% in the workload of day only services in SWSAHS if more people are treated locally. It is apparent that there are significant implications of the forecast for day only services. While the day surgical component of this increase does require that the patient have access to an operating room and recovery area, there will be a combination number of hospital and non hospital sites for the provision of day medical services.

Non Inpatient Occasions of Service

There are a number of issues associated with the activity and cost data for non inpatient occasions of service. Overall the information is more dated and probably does not reflect the actual cost of providing more acute services. It is anticipated that a number of projects, including the Australian National Sub Acute and Non Acute patient (AN-SNAP) classification, will result in more accurate information regarding non inpatient services.

Care needs to be taken in drawing comparisons from the information in Table 3 as it reflects particular Sector arrangements for some services, for example, mental health.

Table 3 - 1997/98 Activity and Cost Data for SWSAHS Non Inpatient Services

Service	*Emergency OOS*	*Emergency Diagnostics OOS*	*Emergency Services $'000*	*Ave cost per OOS*[1]	*Mental Health OOS*	*Mental Health Services $'000*	*Ave Cost per OOS*
Bankstown	30,679	24,031	$2,309	$75	19,892	$3,174	$160
Campbelltown	32,452	16,817	$2,022	$62	17,429	$373	21
Camden	11,811	3,574	$824	$70	0	0	0
Fairfield	27,395	13,692	$2,053	$75	429	0	-
Liverpool	52,508	29,555	$6,082	$116	51,562	$6,452	$125
Wingecarribee	17,137	28	$934	$54	5,675	$820	$144
Total	**171,982**	**87,697**	**$14,244**	**$75**	**94,987**	**$10,819**	**$114**

Service	Outpatient OOS	Outpatient Diagnostics OOS	Outpatient Services $'000	Ave cost per OOS	Primary & Comm Based OOS	Primary & Comm Based Services $'000	Ave Cost per OOS
Bankstown	80,610	31,718	$9,059	$81	117,158	$7,807	$67
Campbelltown	113,888	10,366	$5,742	$46	98,297	$8,770	$89
Camden	12,751	6,108	$1,399	$74	36,320	$3,879	$107
Fairfield	45,933	26,060	$3,274	$45	272,261	$11,788	$43
Liverpool	363,165	41,907	$22,259	$55	102,571	$20,332	$198
Wingecarribee	11,781	81	$1,962	$165	36,706	$2,891	$79
Total	**628,128**	**116,240**	**$43,695**	**$59**	**663,313**	**$55,467**	**$84**

Service	Rehab & Extended Care OOS	Rehab & Extended Care $'000	Ave cost per OOS	Total OOS	Total $'000	Ave Cost per OOS[1]
Bankstown	54,090	$8,811	$163	358,178	$31,160	$93
Campbelltown	15,648	$287	$18	304,897	$17,194	$60
Camden	14,574	$1,454	$100	85,138	$7,556	$93
Fairfield	9,581	$2,140	$223	395,351	$19,255	$50
Liverpool	49,012	$6,528	$133	690,280	$61,653	$93
Wingecarribee	5,469	$624	$114	76,877	$7,231	$94
Total	**148,374**	**$19,844**	**$133**	**1,910,721**	**$144,049**	**$81**

1. Emergency Diagnostics Occasions of Service (OOS) not included in the calculation of average cost per OOS.
Source: 1997/98 NSW Public Hospital Comparison Data

Given the rate of increase for Emergency Department activity has been very high, this data has been excluded when estimating the potential additional NIOOS. Planning models have forecast an annual growth rate of 4% for inpatient services, however this has not been achieved with growth rates of between 1-2% per annum. However, if a 4% per annum increase occurred in relation to NIOOS then by 2001 there would be an additional 217,523 NIOOS by 2001 and a further 332,855 NIOOS by 2006.

Emergency Department Activity

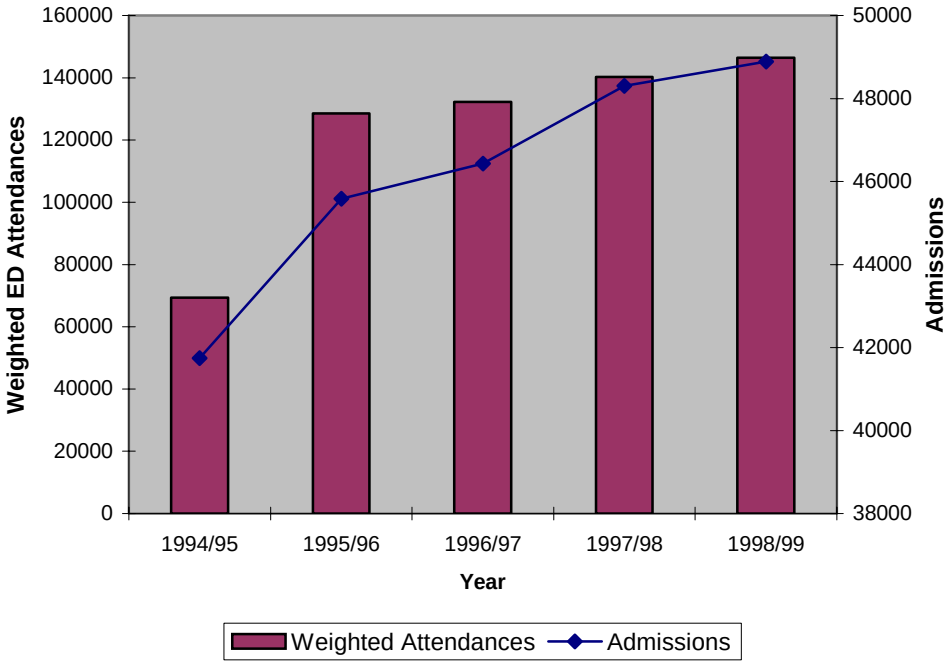
There has been a 10.7% increase in weighted ED attendances since 1996/97. This is important as EDs are a key entry point into the hospital system. Over the same period there has been a 5.3% increase in admissions from ED to hospital. This would suggest that some of this growth in attendances is appropriate as the patient has gone on to be admitted.

There are some variations across the Sectors. Weighted ED attendances have increased at Liverpool (17.3%), Bowral (22.1%) and Campbelltown (12.1%) with associated increases in admissions (Liverpool 15.1%; Bowral 28.4% and Campbelltown 7.8%). There has been reductions in both attendances and admissions at Camden (-5.1% and -11.1% respectively). Attendances have increased at Fairfield (3.4%) and Bankstown (7.4%) while admissions have decreased (-1.2% and -3.6% respectively).

Th variation in the Macarthur Sector is related to the changes in inpatient beds and decanting at Camden and therefore shifts of activity to Campbelltown.

Of total hospital admissions in 1997/98 and 1998/99, 37.9% and 38.5% were from ED. As a statewide benchmark, generally about 33% of total admissions are from the ED.

Trends in Emergency Attendances and Admissions 1994/95-1998/99



Source: EDIS and HOSPAS. Note that 1994/95 ED weighted attendances is not a full financial year (from 9 -6 months) with the implementation of EDIS into those sites. Bowral and Camden as a result have no data available

Appendix B

SECTOR HEALTH SERVICES AMBULATORY CARE SERVICES

Bankstown Health Service

Definition:

Ambulatory care was defined as a patient that could have been treated in a hospital but who is now treated at home.

Service Management and Service Delivery Models:

The service commenced in 1994. The model involves a hospital based Medical Director, a hospital based unit and nursing staff. Referrals are made to Primary Health Nurses (PHN). Medical support includes the Unit Director, a resident medical officer assigned to the unit and a General Practitioner who attends rounds daily. Nursing support includes ambulatory care registered nurses, community nurses and Nursing Home nurses.

Referrals are from emergency, Visiting Medical Officer's (VMO) rooms, GPs, wards with Bankstown Hospital and other hospitals.

Care provided includes:

- Intravenous antibiotics;
- Infective conditions such as cellulitis, pneumonia, pyelonephritis, would infection, osteomyelitis and febrile neutropenia;
- Anti-coagulation conditions such as deep venous thrombosis, pulmonary embolism, atrial fibrillation, valve replacement, transient ischaemic attacks and angina pectoris.

Selection criteria include:

- Must have telephone connected or access to a mobile phone;
- Client/carer has sufficient understanding of the program to enable communication and interpretation of adverse events;
- Responsible person present during intravenous treatment and 30 minutes after;
- The patient must be compliant with treatment;
- Adults only considered;
- Known substance abusers screened for suitability;
- Client is clinically stable;
- Maximum of three visits a day provided.

Strengths of the service include the integration between hospital and community service, high utilisation by VMOs and GPs and the in hospital unit allows flexibility. Some issues involve the reliance on a medical director, the scope of treatment provided, there is limited referral times to PHNs (up to 1500 hours Monday-Friday) and are reliant on other nursing services in Central and Western Sydney Area Health Services.

Episodes of care are recorded as non inpatient occasions of service.

An outpatient rehabilitation service commenced in February 2000 and will provide rehabilitation in the home.

Communication Systems:

Systems include fax and phone with GPs; community nurses carry mobile phones and pagers; daily ward rounds; and the community liaison nurse has daily visits.

Integrated Care Minimum Standards:

The service does not currently comply with the standards.

The hours of service are:

In hospital unit – 0800-2000 Monday to Friday; 0900-1730 Saturday and Sunday with after hours on call. PHN – 0800-2230 seven days with after hours access via mobile phone

Evaluations or Quality Activities:

Patient satisfaction tools are used.

Equity of Access:

All patients in the Bankstown Local Government Area (LGA) are eligible subject to the selection criteria.

Brochures are currently being printed in other languages.

Future Initiatives:

Pilot program with GPs for management of cellulitis, pyelonephritis and deep venous thrombosis. Involvement in day surgery and outpatient rehabilitation.

Fairfield Health Service

Definition:

Refers to the management and treatment of patients in the home environment, who would have in the past required prolonged hospitalisation.

Service Management and Service Delivery Models:

The service commenced in December 1998 with 8 beds allocated in Fairfield Hospital and a PHN coordinator available. Program support was provided from the General Practice Unit, senior medical officers in emergency, the Fairfield Division of General Practice, Hospital Executive and the Ambulatory Care Committee.

Following a restructure of community health nursing services in August 1998 a three monthly rotation of a PHN from each of the generalist PHN services to the ambulatory care program commenced and this provided opportunities to upskill PHN's proficiency and skills in the management of acute clients in the community. In December 1998 the programs name was changed to the Acute Care Outreach Service (ACOS).

The aim of ACOS is:

- To facilitate the early discharge of patients from the hospital;
- To provide a continuum of optimal health care from hospital to home; and
- To provide a quality and efficient care of acute care clients in the community.

Key benefits are:

- Direct referrals, avoiding delays;
- Effective use of priority resources;
- Decrease length of stay in hospital;
- Reduced risk of nosocomial infections;
- Reduced risk of accidents/incidents in hospital;
- Skilled community nursing staff;
- Improved networking;
- Decreased waiting lists;
- Increased patient flow.

Referrals are from emergency departments, Specialist rooms, GPs, hospitals and Nursing Homes via GPs.

Any condition requiring acute care service or extra monitoring at home, including post acute cardiac conditions, LMWHs and Warfarin management, septic arthritis and osteomyelitis and diabetes. Care provided includes:

- Monitoring of vital signs, oxygen saturation, peak flows and pathology follow up and results;
- Management of subclavian and Hickmans catheters, portacaths and PICCs and midline catheters;
- Cannulations:
- Daily venous access;
- Education and support including physiotherapy for existing clients and health well being and promotion.

Referral criteria include:

- All referrals assessed and are at the discretion of the admitting medical officer or VMO;
- Client discharged into the Fairfield LGA. Out of area clients are referred to the discharge planner;
- Client must have a telephone at home;
- Client must have family or other support;
- GP informed of client referral to ACOS; and

- Client informed of the program and how it operates.

Staffing includes a coordinator, two PHNs, a discharge planner and a physiotherapist.

ACOS episodes of care are counted non inpatient occasions of service.

Communication Systems:

The patient's GP is informed by the PHN on admission, day of discharge and fax and after hours and week-end referrals are notified the following morning. Crisis contact numbers are provided to clients. This includes ACOS contact numbers, the after hours advice line to Fairfield Emergency Department and the emergency number. The discharge planner is a pivotal link in the system,

Integrated Care Minimum Standards:

The hours of service are:

0830-2100 Monday to Friday; 0830-1700 Saturday, Sunday and public holidays.

Hours of service are flexible with access from 0700-2100 Monday to Sunday.

Evaluations or Quality Activities:

A Quality Improvement project was the basis for the changes in December 1998 and the establishment of ACOS. Clinical indicators are being collected and include:

Equity of Access:

All patients in the Fairfield LGA are eligible subject to the ACOS criteria.

Future Initiatives:

To include an occupational therapist as part of the ACOS team, to have allocated beds and a medical officer.

Liverpool Health Service

Definition:

Transitional care is defined as a continuum of care model with the ability to manage patients appropriately in a variety of settings with access to alternative care settings in an effective and timely manner. Transitional care involves the transfer of care from hospital to community and back when necessary. It is alternative model of care to acute inpatient services. Ambulatory care at Liverpool is a concept within transitional care and provides for services that previously required inpatient care and are now provided in a community setting.

Service Management and Service Delivery Models:

Liverpool Health Service (LHS) has an organisational structure that is divided into Clinical Divisions. Each Clinical Division offers programs to facilitate transitional and ambulatory care. A focus of LHS for the development of these programs has been to build closer ties with the community. This facilitates a shared management plan for a patient. In this way services have been re-engineered and/or developed to maximise the utilisation of existing expertise and human resources.

Assistance for family/carers is achieved in a variety of programs. Close links are established with the sector PHNs with the establishment of the **Primary Health Nurse Liaison** rotation in the Division of Medicine. The **Aged Care and Assessment Team (ACAT)** and **the Brain Injury Unit (BIU)** offer services in the community to patients and carers and enable timely and appropriate admission to hospital as required.

Shared care programs have been established with GPs for specific conditions eg, diabetes, antenatal care and in mental health.

Outreach Programs include Stomal Therapy, Neonatal and Family Support, Domiciliary Midwifery, Paediatric Home Care and case management for neurology patients especially patients with Multiple Sclerosis. The Clinical Nurse Consultant, Surgery offers support to community staff and carers in the management of patients in the community with a tracheostomy.

Early discharge programs and follow up support have been facilitated with close links to the community eg. the post-Coronary Artery Bypass Graft Discharge Programs, the management of DVT's and administration of intravenous antibiotics.

Links with **community organisations** are established eg. Homecare, community options and community aged care packages are used extensively to ensure the care needed is provided in the most efficient and effective manner.

Outpatient Services are operational across the organisation and provide for ambulatory care of patients. Examples of outpatient clinics include Dermatology, Diabetes and the Chest clinic. These clinics provide review and care where previously patients may have been admitted to hospital.

Renal and cancer services are provided as **inpatient and outpatient services** with transition between the models of care as required. The renal service includes clinics, CAPD and dialysis as outpatient services, inpatient beds and a **hospital in the home service utilising a renal case manager**. The Cancer Therapy Centre provides for the outpatient management of cancer patients with some and inpatient beds also provided.

Ambulatory Day Care Services are established with a unit in the Clinical Building. Services provided by this unit include: the administration of antibiotics and blood transfusions/products; the management of patients

following renal biopsy and lumbar puncture; venesection; pleural/peritoneal aspiration; and the administration of Methyl prednisolone and Introgram.

Day Only and Day of Surgery admissions are provided through the Perioperative Unit.

Communication System:

Communication with GPs is via discharge summaries. DOCFACS is under development and this will inform the GP via fax transmissions of patient admission/discharge and patient movement. The Division of Surgery has developed an electronic discharge summary system that will go to trial in April 2000.

Communication with PHNs is enhanced by the appointment of the Primary Health Nurse Liaison Nurse, a rotation position between the Community and the Division of Medicine.

Other mechanisms of communication are: multi-disciplinary case conferences, special projects, and shared resources eg. Aged Care Assessment Team and Brain Injury Unit. Letters to other health care providers is another important method of communication

There is also the General Practitioner Liaison Committee and the Aged Care Liaison Committee.

Integrated Care Minimum Standards:

The Ambulatory Care Unit is open 0700 - 2100 hours Monday to Friday and 0900 - 1730 hours Saturday and Sunday.

Primary Health Nurses access is available 0700 - 2200 hours seven days a week with intake from 0900 - 1630 hours.

The Cancer Therapy Centre is open 0800 - 1830 hours Monday - Saturday and after hours on-call. Hospital in the home is available 24 hours a day, seven days a week as an on-call service.

Renal services: CAPD are available 0830 - 1700 hours Monday - Friday and after hours on-call. Satellite Dialysis is available Monday - Saturday 0730 - 2100 hours and after hours on-call. Hospital in the home is available 24 hours per day, seven days a week on an on-call basis.

Evaluations or Quality Activities:

- Patient Satisfaction Survey
- Review of Inpatient Length of Stay
- General Practitioner Liaison Committee.

Equity of Access:

All patients of LHS are eligible for services within the **t**ransitional care and ambulatory care programs.

Future Initiatives:

- Further development of DOCFACS technology will allow for the trauma presentations to hospital to be notified to GPs.
- Case management of complex medical patients in the community and acute setting to actively manage patients in their home and reduce presentations to the Emergency Department and readmission.
- Further initiatives for the early discharge of surgical patients utilising the resources of the community.
- Following the trial, review and evaluation of the electronic surgical discharge summaries, the system will be rolled out to all those sub-specialities who participate in surgical audit. It is envisaged that surgical audit/electronic discharge summaries will be rolled out to other surgical units in SWSAHS.

Macarthur Health Service

Definition:

Ambulatory care is the delivery of health care in a variety of settings including outpatient departments, short stay/day only beds and the patient home.

This definition encompasses principles of selection criteria, risk assessment and continuous quality improvement. Shared care between GPs, nurses, allied health professionals and hospital specialists is the accepted practice.

Service Management and Service Delivery Models:

Principles

There is also a shared responsibility for health between the patient, carer and the services allowing for choices in the delivery systems for treatments whether physical, psychosocial or pharmacological.

Ambulatory Response Team

This component involves the follow up of patients by the Ambulatory Care Service (ACS) who have been treated in the emergency department and discharged but who may still be at risk. This is aimed to prevent patients representing at ED with the same problem.

Hospital in the Home

This involves care being provided by the ACS for a period of 3-5 days.

Supported Discharge

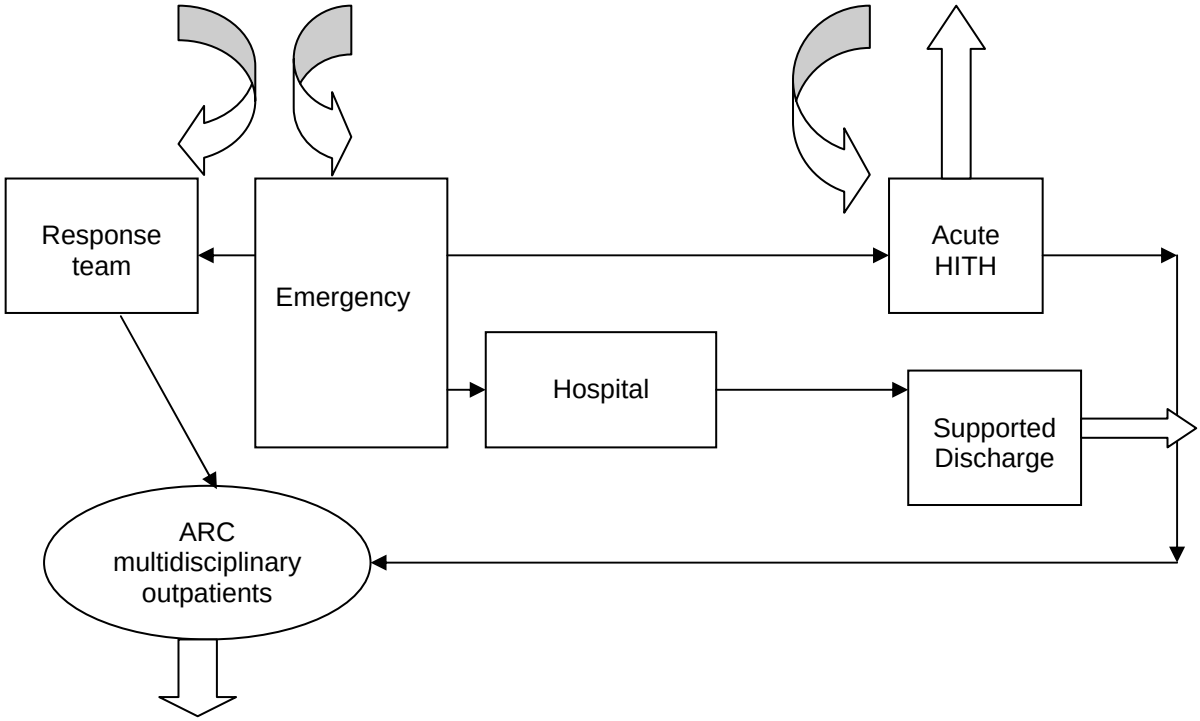
This involves patients being discharged from hospital and managed at home by the ACS for a period of 10-15 days. It is not an extra period of care added to the usual hospital stay, but is aimed at replacing inpatient stay with care in the community. That is, a change in the setting for patient management. This could involve care for neurological rehabilitation, fractured neck of femur and total knee and hip replacements. Rehabilitation would also be more directed and goal focused and involve the patient managing in their usual environment.

Once the patient is able to leave the home, care would be provided in usual settings such as day hospitals.

Ambulatory Assessment, including day hospital

It is proposed that this component of the model would involve the patient being admitted for a day on an elective basis with assessment and development of a care/management plan by all necessary disciplines.

The components of the model include:



Partnerships With Other Stakeholders

Partnerships with GPs, hospital staff, PHN and carers and patients are essential.

Currently 80% of care is delivered in the patient's home and 20% in the hospital environment.

Referrals are from GPs (50%), emergency department (25%), Hospital (15%) and specialists (10%).

Episodes of care are recorded as non inpatient occasions of service. Privately referred non inpatients are bulk billed.

Communication Systems:

Systems include: hospital daily ward rounds, case conferences, phone/fax/e-mail, video conferencing, use of digital camera and ambulatory monitoring.

Integrated Care Minimum Standards:

The service does not currently comply with the standards.

The hours of service are:

In hospital unit – 0800-2000 Monday to Friday; 0900-1730 Saturday and Sunday with after hours on call. PHN – 0800-2230 seven days with after hours access via mobile phone

Evaluations or Quality Activities:

These activities include:

- Patient and GP satisfaction;
- Variation in clinical and process indicators;
- Development of a minimum data set;
- Research activities; and benchmarking.

Equity of Access:

All patients in the Macarthur Sector are eligible with attention to NESB and ATSI and special needs patients. Staff have flexible site of delivery of care, shared care and staff awareness and development.

Future Initiatives:

Participation in costing studies.

Wingecarribee Health Service

Definition:

The transitional care program (TCP) provides a more intensive level of care than that available through other community services. The client/patient is the central focus of the program with achievement of integrated care an important goal of TCP. **Appropriate care** is given by the most **appropriate provider** in the most **appropriate location**.

Service Management and Service Delivery Models:

The TCP was developed in response to a community liaison project and an unplanned admission survey that identified a number of issues.

The TCP commenced as a nursing based program but has been extended to offer other services in the home. These services are physiotherapy, occupational therapy, social work and nutrition. These services operate Monday to Friday with the exception of social work which will offer a weekend service as soon as recruitment is finalised.

Two overall outcomes from implementation of the TCP are:

1. Reducing length of stay; and
2. Eliminating unnecessary admissions.

Advantages of the program are:

1. Better service both in terms of hours and numbers of staff;
2. More efficient discharge process;
3. Better utilisation of available resources;
4. Organisational integration; and
5. Removal of cross sector barriers.

Partnerships with community health, hospitals and the Division of General Practice are integral.

Selection criteria include:

- Resident of Wingecarribee Shire;
- GP acceptance;
- Client must be assessed prior to entry into the TCP. This can be performed by medical officers in their rooms, in the patient's home or in hospital;
- Treatment must be of an intermittent routine and require 1-2 times per day. IV antibiotics can be delivered 3 times a day and any other clients such as palliative care can have 4-5 visits a day;
- Client must have understanding of treatment regimes and reliable and compliant with treatment; and
- Access to a telephone.

Clinical exclusions include:

- Administration of blood or blood products; and
- Administration of cytotoxic drugs.

Types of conditions that are suitable for the TCP subject to the selection criteria include: cellulitis; osteomyelitis; tonsillitis; deep venous thrombosis; pulmonary embolus; multiple sclerosis; chronic airway limitation; pneumonia; heparin prophylaxis; pyelonephritis; wound infections; and meningitis.

Treatments provided include: medications; personal care; wound dressings; physiotherapy; urethral/supra public catheters; intravenous fluid hydration or medications; gastrostomy tube changes; venepuncture; and telephone screening.

Communication Systems:

The TCP coordinator provides a communication link for hospital wards, allied health, emergency department, other acute facilities, GPs, community health services and aged care facilities.

There is a TCP working party, policy group and team meeting.
Integration is achieved by:

- Integration is achieved through a tiered approach by the organisation from the Sector Executive down through the various teams;
- Handovers;
- Specific projects;
- Rotation of staff from one are to another; and
- General Manager sessions.

Integrated Care Minimum Standards:

The service does not currently comply with the standards.

The hours of service are:

0830-2200 Monday to Sunday with an on call service for palliative care clients. Hours can be varied to meet client needs and staff are able to commence earlier if treatment 3 times a day is required. A checklist is provided for the after hours manager to assist in providing the most appropriate response.

Evaluations or Quality Activities:

These include:

- Satisfaction surveys;
- Data collection on length of stay, treatment provided, referral source and diagnosis; and
- DRG comparison.

A project officer has been appointed in October 1999. Extensive evaluation has already been undertaken and establishment of a database is well under way.

Equity of Access:

All patients in the Wingecarribee Shire are eligible subject to the selection criteria.

Future Initiatives:

While the current service commenced as a nursing based program, it has been extended to social work, occupational therapy, physiotherapy and nutrition. Paediatrics and drug and alcohol are the main areas currently being considered for extension of the program.

Appendix C

INTEGRATED CARE MINIMUM STANDARDS

Hours of Service:	7am to 9pm x 7 days per week
Referral Hours:	10am to 5pm x 7 days per week
Visits per day:	As needed with maximum of 3

All acute/post acute services requiring home visits to be community rather than hospital based with the exception of the Domiciliary Midwifery program which requires practicing competent midwives to provide the service. However staff will be transportable/interchangeable between hospital and community as the needs determines.

The provision of home/community visit programs will be Area wide with the expectation that all patients who live within any SWSAHS local government area will receive the same level of care and be included in the program of the sector in which they live, or can be most effectri9velyt be provided a service from, irrespective of which hospital they were treated at.

Client Types:

No specific restrictions other than those requiring more than 3 visits per day.

Restrictions:

No specific restrictions. Clinical judgement, combined with appropriate consultation between the members of the care team, patients and carer(s) to be the determinant of the suitability of the patient for home care.

Triaging:

The triaging of patients in Emergency Departments is an essential component of the integrated care model, the aim being to prevent unnecessary admission to inpatient settings.

Staffing:

Appropriately qualified nursing staff commensurate with the assistance required, supported by specialist nursing staff, allied health staff, general practitioners, medical specialists involved in the case and other support staff. Suitable arrangements required for the provision of medications (pharmacist input) on an individual basis. The number of clients able to be seen by a staff member each shift should be determined by the casemix load.

Equipment:

Equipment loan pools will be able to provide for the needs of all clients treated in the home. Intersector networking should be undertaken to determine the best way of providing equipment which is not commonly needed so that such equipment does not sit on shelves unused in one sector, whilst another sector is not able to provide the same.

Education:

All staff involved in home/community care require education to ensure that they have competencies required for the service. This includes all participants.

Safety:

OH&S standards must be in place and the general safety of patients and staff must be addressed as would be the case in an inpatient or outpatient setting. Communication systems, incident management, manual handling policies are required.

Quality Assurance:

Quality improvement projects must be undertaken on a regular basis to ensure continuous quality improvement within the integrated care model. External review of the service should be undertaken as part of the appropriate sector accreditation system. Patient rights and responsibilities as well as service values and provision must be made available/known to all patients.

Carers:

Carers must be involved in the giving and receiving of information, education, satisfaction feedback and all other relevant aspects of the care of patients in the community setting.

Documentation:

The long term aim is one medical record per patient. The immediate need is for all documentation to provide for the essential requirement that all referrals between inpatient, outpatient and community/home settings provides the patient, carer(s) and health care team members with the information necessary to provide continuity of care across a seamless system.

Appendix D

AMBULATORY CARE WORKING PARTY

Membership

Name	Position	Organisation
Ms Nel Buttenshaw	Manager, Operations	SWSAHS
Ms Jennifer Collins	General Manager	Macarthur Health Service
Ms Cathryn Cox	Deputy Director, Division of Planning	SWSAHS
Mr Colin Froud	Deputy CEO	SWSAHS
Dr Wendy Harmer	Deputy Director, Area Medical & Clinical Services	SWSAHS
Ms Dianna Kenrick	Director, Community & Allied Health	Fairfield Health Service
Ms Debbie Killian	Director, Community & Allied Health	Bankstown Health Service
Ms Shauna Lee	Nurse Unit Manager, Ambulatory Care Unit	Bankstown Hospital
Ms Joan Lowe	Director of Nursing	Bowral Hospital
Ms Janelle Mullholland	Nurse Manager, PHNs	Hoxton Park Community Health Centre
Ms Debra Parsons	Acting Nurse Unit Manager, Ambulatory Care Unit	Bankstown Hospital
Ms Sue Whitby	Area Patient Flow Committee Representative	Nurse Director, Division of Surgery, Liverpool Hospital
Mr Tim Wills	Director, Division of Planning	SWSAHS
Dr Stephen Wilson	Director, Ambulatory Care	Macarthur Health Service
Dr Nick Zwar	GP Academic Unit	c/- Fairfield Hospital

Terms of Reference

1.	To advise on and support action to implement the progression of transitional care services and models within SWSAHS.
2.	To develop and advise on communication on transitional care services to key stakeholders.
3.	To advise on the development of collaborative partnerships with key stakeholders including health care providers.
4.	To advise on strategies to develop appropriate transitional care services and models to meet the needs of SWS residents.
5.	To advise on strategies to achieve increased equity of access according to need to comprehensive transitional care services for SWS residents.
6.	To advise and act upon strategies to: • Improve continuity of care and ensure appropriate planning, management and coordination of services, including working and consulting with other bodies (external/internal) on issues of mutual concern; and • Create a corporate culture that will foster the provision of an integrated and networked transitional care service.

7.	To identify and promote current evidence-based best practice to provide the highest quality services, and advise and act upon strategies to ensure uptake of best practice.
8.	To advise on which are valid and appropriate health outcomes performance indicators for transitional care services, from existing collections, and identify additional indicators where required, and advise on strategies for standardisation of management information systems for their collection and the employment of appropriate information technology to address SWSAHS Key Challenges, and facilitate the collection and reporting of performance indicators to the Quality, Outcomes and Priorities Committee.
9.	To advise on strategies to foster research into transitional care, in research areas which addresses the particular needs of the population of SWS, and facilitate action to encourage such research.
10.	To identify opportunities and advise on strategies to promote SWSAHS transitional care services to other Area Health Services.
11.	To provide advice to the SWSAHS Board on matters as requested and those considered requiring further progression via the Quality, Outcomes and Priorities Committee.