WHAT IS THE FRAMEWORK FOR NON-INPATIENT CARE?

The Framework provides the strategic direction for ambulatory and community care from which specific models of care and service delivery will be developed and implemented as part of statewide policy and Area Health Service (AHS) clinical planning.

The Framework is integral to:

- Service planning by AHS health service planning units
- Central policy planning and development of models of care through the Division of Health Policy and Clinical Reform
- The provision of ambulatory care services to patients in WA.

The Framework is the strategic direction for the expansion of non-inpatient care and will help shape best practice care to provide safe and sustainable, patient focused health care for WA.

WHY IS IT IMPORTANT?

WA is experiencing a disproportionate increase in the demand for health services relative to the growth and ageing of the population. The current over-reliance on hospital-based health care is unsustainable from a workforce, financial and consumer perspective. The consequences of this approach are a limited suite of options for care, which has resulted in:

- Increasing tertiary access block to over 50% on most days year round
- Increasing emergency department demand at 6-8% each year
- Long emergency department, outpatient and surgical waiting times
- Increased length of stay for acute patients.

Additionally, current health care delivery is organised and deployed with inherent inefficiencies. A focus on innovation and the development of a broader range of services will address the following:

- Poor admission and discharge processes
- Fragmented, adhoc care for people with chronic and long-term care needs
- Multiple models of care
Unnecessary referrals and visits to outpatient clinics
- Multi-day stay as the default for surgical and medical care
- Workforce that is predominantly tertiary-centric with narrow clinical roles.

**WHAT DO I NEED TO DO?**

Plan for the further expansion of a range of services that will improve the patient’s journey through the health system where possible by:

- Preventing the need for admission
- Reducing admissions to day case only
- Timely discharge
- Discharge directly from the Emergency Department to the new ambulatory services or home with community supports
- Providing acute care in the patient’s home
- Delivering improved patient outcomes.

**AMBULATORY CARE PROGRAMS SHOULD:**

- Include an initial patient assessment to determine eligibility
- Have admission and discharge criteria
- Be seen as short term initiatives
- Always link the patient back to their general practitioner
- Include the concepts of health promotion, prevention and self-management as much as possible to encourage independence.

**WHAT TARGETS CAN THE IMPLEMENTATION OF NON-INPATIENT SERVICES CONTRIBUTE TO ACHIEVING?**

The WA Health Strategic Intent and Clinical Services Framework require non-inpatient initiatives to be implemented to avoid the need for hospital admissions currently equating to a minimum of 560 beds saved across the metropolitan system by the year 2016/17.

The Area Health Service (AHS) performance indicators will be achieved by the AHS implementing a greater range of non-inpatient services, such as Hospital in the Home, increased same day surgery rates and length of stay reductions. Detailed targets may be found within the current Operational Plan.
WHERE SHOULD I START?

Initial efforts to improve the management of demand and achieve operational targets should be focussed on current best practice high impact changes that deliver results though a non-inpatient approach to care delivery. Case studies and strategies are outlined in the framework and focus on the following:

1. **Improve patient flow by better managing admission and discharge processes** eg. care coordinators in ED, ambulatory emergency care, pre-admission clinics, hospital in the home, post-acute care.

2. **Provide coordinated care for people with chronic conditions and long-term needs** eg. asthma kids program, contracting care.

3. **Redesign and extend healthcare roles to maximise patient engagement and access through patient centred pathways** eg. physiotherapist triage in outpatients for patients with back pain.

4. **Reduce unnecessary referrals and visits to outpatients** eg. clinical priority access criteria for GPs to refer patients to outpatients clinics, discharge criteria for outpatients.

5. **Treat day surgery and day medical procedures as the norm for elective patients to prevent unnecessary overnight hospital stays.**

OTHER ACTIONS THAT WILL HELP:

Providing additional non-inpatient services alone will not achieve the aim of delivering an integrated, patient focused health care system. It also requires:

- An increased focus on prevention specifically addressed in the WA Health Promotion Strategic Framework 2006-2011
- New models of care delivery to demonstrate how to provide care differently
- Clinical service redesign to improve efficiency and effectiveness
- Workforce redesign to better use the limited resources
- Consumer engagement to ensure a patient centred approach and better uptake of new services.
- Ongoing consultation with clinicians and other key stakeholders to gain ownership and support and to foster new and innovative ideas for change.
WHERE CAN I FIND EXAMPLES OF GOOD PRACTICE?

Australian:

National Institute of Clinical Studies (NICS) has established an emergency care Community of Practice (CoP) for clinicians, health managers and health care professionals involved in the delivery of emergency care, so that they can share their knowledge and expertise to help close evidence-practice gaps and improve patient care.  [www.nhmrc.gov.au/nics/asp/index.asp](http://www.nhmrc.gov.au/nics/asp/index.asp)

Mental Health Patient Flow Program – ensures direct admissions from community based mental health services to reduce the number of planned and unplanned ED presentation (Victoria).  [www.southernhealth.org.au](http://www.southernhealth.org.au)

3-2-1 Process – improves care at every stage of the ED journey to ensure rapid access to tests and decisions, hastening admission /discharge (NSW).  [www.archi.net.au](http://www.archi.net.au)

Asthma Case Management – care planning and case management of frequently attending patients. Reduction in the number of planned and unplanned ED presentations/admissions and better self- management of signs and symptoms (Victoria).  [www.rch.org.au](http://www.rch.org.au)

International:

Ambulatory Breast Surgery – discharge on the same day (or within 23hrs) of mastectomy. Reduced infections and complications of surgery with high patient satisfaction and uptake. Marked reduction in LOS and cost of provision of care (UK)  [www.kch.nhs.uk](http://www.kch.nhs.uk)

Acute Respiratory Assessment Service – providing acute care in the home for uncomplicated exacerbations of COPD. Expert nurses support the patient and GPs to manage the acute episode at home.  [www.nbt.nhs.uk](http://www.nbt.nhs.uk)

Ambulatory Emergency Care – improving access and support for emergency patients to ensure only those patients who really require admission are admitted. Significant reduction in the rate of admission from ED.  [www.institute.nhs.uk](http://www.institute.nhs.uk)

Community Matron Program – case management & care planning for patient with chronic/long term conditions who frequently attend ED. Reduction in the number of unplanned ED presentations, admissions and LOS.  [www.dh.gov.uk](http://www.dh.gov.uk)

Rapid Access Clinics - chest pain/heart failure outpatient clinics reduce the need for emergency presentations by providing GPs with guaranteed access to specialist care for their patients.  [www.18weeks.nhs.uk](http://www.18weeks.nhs.uk)

Direct Access To Diagnostics for Allied Health and GPs - ensures direct access to services and diagnostics to prevent a presentation to ED and continued management in the community sector.  [www.18weeks.nhs.uk](http://www.18weeks.nhs.uk)
Nurse-Led Community Deep Vein Thrombosis Service - allows GPs to refer patients with a suspected Deep Vein Thrombosis (DVT) to the community walk-in service, following agreed criteria. The next phases of the service include all management of warfarin treatment being transferred to the community anticoagulation service at the treatment centre, and eventually the whole DVT pathway, including definitive diagnosis by ultrasound scan, will take place in the community. Avoids an emergency department presentation and an admission. www.dh.gov.uk

Community Support Assistants - additional semi-skilled staff who can undertake some basic nursing care in the home, increasing the reach of the services and ensuring the appropriate nursing skills are utilised where most required. www.healthcareworkforce.nhs.uk

Generic Support Worker - working alongside health care workers to empower patients. Expands the reach of the chronic disease teams and ensures that skilled staff are employed where they are most needed. (WHO recommendation: Innovative Care for Chronic Conditions). www.healthcareworkforce.nhs.uk

Dementia Care Development - equipping staff to provide better care to for patients with dementia. Ensure a standard of care for all dementia patients regardless of location. www.healthcareworkforce.nhs.uk

Care Technician Role - training of health care assistants to perform annual reviews of patients with conditions such as Diabetes. Working with GPs and other community providers, this role ensures compliance with best practice in the management of long-term conditions and assists primary care staff to undertake targeted intervention as required. www.healthcareworkforce.nhs.uk

Expanded Nurse Roles - training nurses to do endoscopic work and anaesthesia ensuring that patients do not have to wait for extended periods of time to access routine diagnostic and surgical care. This also includes a role for endoscopy assistants and coordinators. www.healthcareworkforce.nhs.uk

Cash For Care - gives patients purchasing power and allows them to make decision on type and quantity of social and support services they want. Reduction in the number of services used and feedback to services to change the types of service they provide. www.dh.gov.uk

Patient Opinion - Web site where patients can share their experience of being in hospital. Patient stories are sent automatically to the relevant manager who can then respond to feedback on the site. Information is exchanged and the opinions of the patients are obtained at the strategic and micro level. www.patientopinion.org.

USEFUL REFERENCES FOR FURTHER INFORMATION


B Leff, L Burton, S Mader, B Naughton, J Burl, S Inouye, W Greenough, S Guido, C Langston, K Frick, D Steinwachs & J Burton, ‘Hospital at Home: Feasibility And Outcomes Of A Program To Provide Hospital-Level Care At Home For Acutely Ill Older Patients’ 2005 Annals of Internal Medicine 143, 798-808.


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Withdrawn March 2015


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