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NSW HEALTH

AMBULATORY CARE
- an ED's best friend

Dr Nick Collins
FRACGP
Director, Macarthur Ambulatory Care Service (MACS)

Ambulatory Care – the synonyms….

Hospital-in-the-home (HITH)

Community Acute/Post-Acute Care (CAPAC)

Acute Community Outreach Service (ACOS)

The list is endless….

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Macarthur Region:

- 50km south-west of Sydney CBD
  - Campbelltown, Camden and Wollondilly LGAs
- population approaching 250,000
  - growing at about 5% pa
- low socio-economic status
  - private health insurance rate 8%

- Health Service
  - Campbelltown and Camden Hospitals
    - 300 acute/rehab beds
    - both have EDs
    - combined ED presentations
      - 2006 >40,000pa
      - 2007 increasing by about 25%

- Active local Division of General Practice
  - GP FTE 1:>1500 patients

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A brief local history:

1990s part of SWSAHS
- -Area initiative to develop ambulatory care services
- -sectors determined local implementation
- -Macarthur transformed its Surgical Outreach Service into MACS

2007 part of SSWAHS
- -Clinical stream structure
- -Network of services with different administrative structures
- -Paediatric Service 'budded' from MACS in 2003
- -MACS retains in-patient status: it is a 'virtual ward'
  - nursing 0700 – 2200 365 days/yr (12 FTE)
  - GP (extended skills) registrar 0800 – 1630 Mon-Fri
  - 1 FTE Staff Specialist
  - co-opted allied health

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Clinical Pillars of Ambulatory Care

1. Hospital substitution (HITH)
   - -entire episode
   - -supported discharge
2. Medical out-patient (Day Hospital)
3. Hospital avoidance
   - -chronic/complex disease management
4. Disaster management
5. Host to external services

(Modified from Wilson et al *AHR* 2001)

…but how does this help our Emergency Department?

Pillar 1

Substitution of traditional in-patient stay:

- rapid response to ED
  - joins 8am handover round
  - Registrar/Staff Specialist reviews patients in ED
  - out-of-hours by phone; Dr-Dr referrals
  - regular meetings with A/Director ED
- diversion through MACS
  - GP and specialists familiar with process – phone call only
  - provide patient with time to present
  - communication a priority
  - no interference with usual primary care management
- supported discharge from in-patient wards
  - alleviate bed-block
  - attend patient flow meetings
  - receive info from spotters
  - recruit vs refer
  - teams can admit to MACS

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Case study: Elsie

70F frail; surgical correction of syringomyelia; recurrent episodes of vomiting requiring monthly attendance at ED for IV fluids and antiemetics; commonly admitted for 1 or 2 days (under different physicians) but often spending entire stay on ED trolley.

MACS takes over care early 2000; case conference with GP and husband; agree to present to MACS for IV fluids during working day plus parenteral antiemetics/steroids; rapid response prompted by husband's phone call

IV access deteriorates: switch to home-administered s/c fluids with twice-daily nursing visits

Benefits: patient-centred care; avoid nosocomial infection and other adverse events; GP liaison; carer satisfaction.

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Case studies: Ray, David and Janice

Patients referred during weekend of May 5/6 2007:

43M with bursitis/cellulitis of elbow/forearm; referred by ED for cephazolin/probenecid; notified of Gram positive cocci in one BC bottle after 24hrs; patient reviewed by nursing staff – clinically well; BC contaminant; patient discharged day 4

34M with cellulitis right leg; wc 13; referred by ED CMO for daily cephazolin with probenecid; treatment completed in 5 days

70F with second episode AF in two weeks; overnight stay in ED; reverted SR; referred by Med Reg for supervision of warfarinisation/clexane; INR not quite therapeutic; remains in SR

Pillar 2

Medical outpatients (Day Hospital)

- Patients referred for infusions and transfusions
  - blood products
  - monoclonal antibodies
  - steroids
  - bisphosphonates
- Procedures
  - elective LP
  - paracentesis
- Consultation
  - esp elderly/RACF patients unable to access rooms

Case study: Jacqueline

53F; HHT and bronchiectasis; regular ED presentations for breathlessness and anaemia; stay of 1-2 days under different physicians; out-patient specialist involvement

Review of casenotes; discussion with GP; seemed to require fortnightly attendance

GP performed FBC every 2 weeks; MACS x-matched and transfused if required; gave IV antibotics if required; regular GP liaison

Still required ED attendance for catastrophic ENT and GI bleeds

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Pillar 3

Hospital avoidance

Chronic/complex disease management

- Less common with move to clinical streaming
  - Cardiac, Heart failure, Respiratory all now have Liaison Nursing positions reporting to specific clinical stream

- Still support some services:
  - Gastroenterology: elective/semi-elective PEG tube changes
  - Urology: difficult catheters/first SPC changes

Pillar 4

Disaster Management

- Venue for temporary ED overflow
- Venue for patient review
  - MACS unit located next to ED by design in 'new' wings of both Camden and Campbelltown Hospitals
- MACS Staff can accelerate ward clearance
- Reconfigure Emergency Access
  - Pandemic planning (designated fever hospital)

Case study: Causing a stink

Eight workers in a packing shed notice an odour. During time of anthrax scares; some members of workforce develop respiratory, eye and upper GI symptoms; Ambulance Service notifies ED; disaster plan activated

All eight patients arrive in ED; immediate transfer to MACS where ED nursing and designated ED senior medical staff attend.

All patients recover to be discharged within 8 hours: culprit eventually discovered……

….a can of rotting onions!!

Pillar 5

Host to external services

from within Area Health Service (AHS)

eg sexual assault acute clinical and counselling service

external to operation of AHS

eg Macarthur GP After-Hours Service

Rene Pennock CEO will speak next

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Quality Assurance

- Variance (rather than adverse event, error etc)
  - self reporting system; anonymous
  - simple dropdown menu on software programme
  - monthly review of data
    - casenote review by team
    - issues then referred to main team meeting
  - fixed, catered protected meeting time
  - GP and community reps
  - prompt review of clinical and process issues
  - also allows for benchmarking, complaints, IIMS review, satisfaction surveys

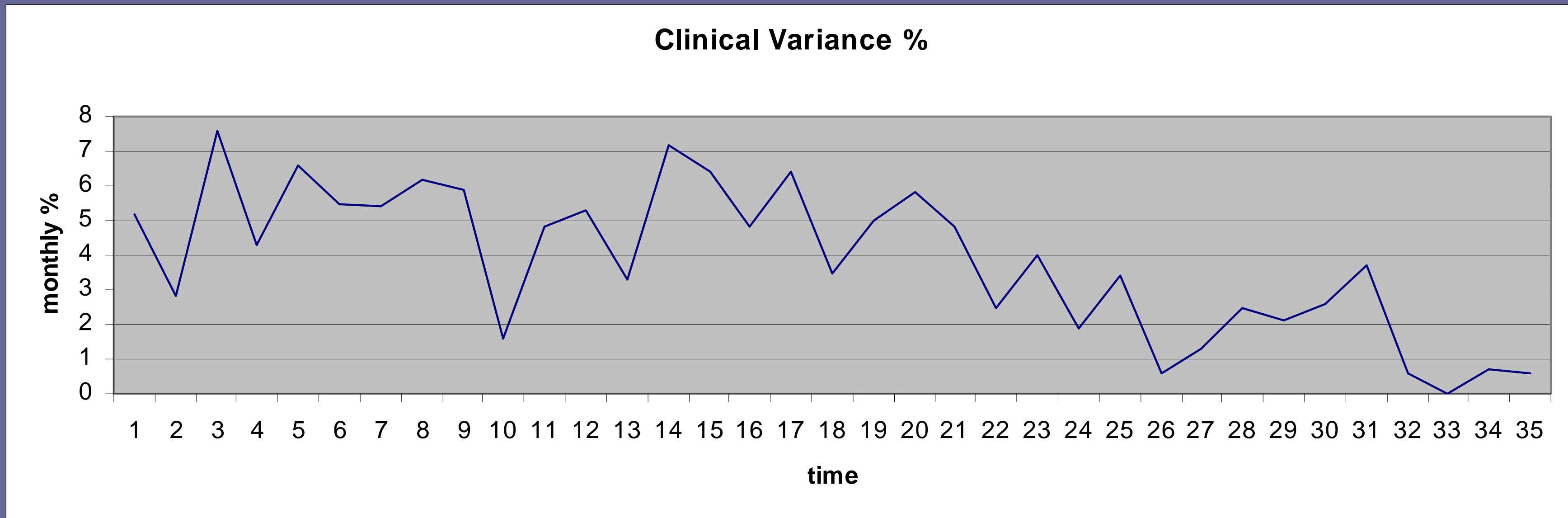
What quality indicators can we use to show effectiveness of a HITH programme?

ACHS sets an agenda including unexpected staff callouts and phonecalls.

Real issue is number of patients needing higher level of care

- return to MACS unexpectedly
- return to ED unexpectedly (2005 n = 3 = 0.2%)
- return to MACS/ED and require admission (2005 n = 18 = 1.0%)
  - and return to programme
  - and do not return to programme (2005 n = 10 = 0.5%)

AMBULATORY CARE – an ED's best friend



Graph of MACS clinical variance/no of referrals expressed as % vs time in months (1= May 2003; 35= March 2006)

Risk Management

Clinical

- All patients are referred by a doctor to a doctor
- Assessment includes clinical, functional and social aspects
- Referral supported by nursing review
- Treatment supported by evidence-based guidelines
- Verbal consent supported by signed service agreement
- Clear and comprehensive QA processes

OH+S

- Environmental checklist for all patients requiring home visit
- No opiates
- Minimal visits in darkness
- Security support for high-risk situations

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Current issues for debate:

Hospital outreach vs GP inreach

Specialist vs Generalist services: which side are ED?

Administrative recognition: inpatient vs outpatient vs CAPAC

Do you need all five ‘pillars’ to run an effective service?

How can you fund a service?

Best friend?

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Best friend?

Needs to be close

Best friend?

Needs to be close

Needs to be available

Best friend?

Needs to be close

Needs to be available

Needs to be reliable

Best friend?

Needs to be close

Needs to be available

Needs to be reliable

Needs to be able to share troubles

Best friend?

Needs to be close

Needs to be available

Needs to be reliable

Needs to be able to share troubles

Needs to be there for the long haul

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FRACGP
Director, Macarthur Ambulatory Care Service (MACS)
nicholas.collins@sswahs.nsw.gov.au