Queensland Health

Reform Planning Group

Stakeholder Consultation: Written Submission - ACEM

The Reform Planning Group ('Group') was established for a limited time period to prepare advice to the Director-General of Queensland Health and the Deputy Premier and Minister for Health and Minister for Ambulance Services on system-wide reform activities for Queensland's health system arising from the COVID-19 pandemic. Reform activities will focus on preventing ill health and delivering better value for our patients, our workforce and our public health system.

As part of the Group's engagement and consultation across the Queensland health system, short written submissions are being sought in the form of **two (2) key questions**.

*Please provide your responses to the questions in the space provided (a **500 character limit** applies to each question).*

Question One: In response to the COVID-19 pandemic, a number of changes were implemented with how many health services are delivered. Of these changes, which do you think should be adopted on an ongoing basis, and why?
As the peak professional organisation for emergency medicine, the **Australasian College for Emergency Medicine (ACEM)** is responsible for the training of emergency physicians and the advancement of professional standards in Australia and New Zealand. ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to an emergency department (ED). The spread of COVID-19 necessitated a reassessment of ED core business and rapid changes to models of care to direct patients to the right place for the right care, in the right timeframe while managing and/or avoiding possible exposure to respiratory infections. This included streamlining front-of-house assessment to enable patient cohorting based on infectious risk; diverting ED presentations to non-ED clinics or telehealth consultations; admitting to inpatient units directly; and generally facilitating rapid transit through EDs[1]. Community and outpatient services have introduced pre-notification and pre-booked acute care consultations, and visitor management and screening has been introduced across all services. As a result, clinically stable patients have been able to access the care they need directly, without the ED acting as a gatekeeper or experiencing long delays waiting for access to specialty inpatient services. These streamlined pathways have also increased cooperation between specialties, and increased awareness of the value of EDs in caring for high acuity patients. For a multitude of reasons, the pandemic initially reduced overcrowding in many EDs however many are already seeing a rapid return to previous levels of overcrowding and access block. ED

[1] Rojek AM, Dutch M, Camilleri D, Gardiner E, Smith E, Marshall C, et al. Early clinical response to a high consequence infectious disease outbreak: insights from COVID-19. Med J Aust. 2020;212(10):447-450

overcrowding has been implicated in rapid transmission of infection in previous epidemics[2,3] so failing to address these issues is not only harmful for patients, but clinicians as well and will lead to lower efficiency and staff burnout. In recovering from the pandemic, there can be no going back to the previous situation of overcrowded EDs and over-capacity hospitals.

A public health imperative exists to learn from this pandemic and ensure EDs can provide high quality and safe care. In response to the COVID-19 pandemic ACEM recommends the following ongoing changes are adopted on an ongoing basis:

- PPE utilisation for both patients and staff, and isolation of potential cases until risk of infection has been ruled out;
- ED redesign to enable necessary infection prevention and control mechanisms. For example, physical distancing in all working and waiting areas and ambulance ramping/awaiting offload areas, and enhanced numbers of negative pressure isolation rooms and single rooms;
- Models of care that enhance patient flow and avoid access block, such as maintenance of critical illness pathways (e.g for ST-Elevation Myocardial Infarction (STEMI), trauma, stroke, febrile neutropaenia), streamlined pathways for common, stable admissions, and expedited admissions with ED consultants having admitting rights for all inpatient areas, and inpatient teams undertaking admissions on the wards; and
- Use of telehealth or virtual models of care for EDs, residential aged care facility (RACF) "in-reach" programs, Hospital in the Home (HITH), inpatient teams, primary care and other providers.

[2] Cass D. Once upon a time in the emergency department: a cautionary tale. Ann Emerg Med. 2005;46(6):541-543.

[3] Low DE. SARS: lessons from Toronto. In: Institute of Medicine (US) forum on microbial threats; Knobler S, Mahmoud A, Lemon S, et al. (Eds). Learning from SARS: preparing for the next disease outbreak: workshop summary. Washington (DC): National Academies Press (US); 2004. Available from: https://www.ncbi.nlm.nih.gov/books/NBK92467/

Question Two: What new opportunities for change have arisen out of the COVID-19 pandemic that you/your organisation would like to see pursued as part of long-term health system reform, and why?

As a result of the COVID-19 pandemic, rapid health system transformation has taken place with implementation of solutions advocated for two decades to reduce overcrowding and improve access to emergency care[4,5,6,7]. Post COVID-19, the following actions are recommended by ACEM as part of long-term reform:

An environment where staff and patients are safe from harm:

- ED redesign to allow for proper management of isolation, pandemic responses (including additional space for physical distancing in all staff and patient areas), and streaming/cohorting of patients according to infectious risk.
- ED operations allowing for enhanced disinfection protocols; screening/control of visitor numbers; appropriate PPE measures (including supply, provision, and training), non-essential clinical support replaced by tele or videoconferencing, outdoor meetings or working remotely; diversion and escalation strategies to eliminate crowding in ambulance bays, waiting rooms, and all patient clinical areas.

An environment where experiences of receiving and delivering care are positive:

- Models of emergency care that enhance patient flow and avoid access block and ED crowding, including reserved care for patients who are physiologically unstable, require urgent assessment and treatment for a potentially high-risk condition or can benefit from the specialised care and skills only provided in the ED; improved pathways to definitive care for low-acuity patients; expedited inpatient admissions, with ED consultant admitting rights for all inpatient areas; provision of telehealth advice to smaller EDs, pre-hospital providers, and RACFs to reduce avoidable ED presentations; implementation of advance care plans and end of life care at home or in community facilities.
- New access measures that go beyond the National Emergency Access Target (NEAT)of 4 hours and actively promote patient flow and quality care at the local and jurisdictional levels.

Emergency care is of high quality and improves the health of our communities

- Emergency care as part of an integrated and co-ordinated system providing efficient care to the community, including:
    - community solutions for care and for people experiencing homelessness and those facing housing insecurity, poverty and overcrowded households
    - a strategy for care of vulnerable patients including older people, those with mental health challenges, and those with disabilities who rely on home carers to access healthcare, while enabling the goal of people safely remaining at home
    - community-based care for chronic disease management with sustainable case coordination and streamlined access to reviews with specialists when required

[4] Forero R, Young L, Phung HN, Hillman KM, Mohsin M, Bauman AE, Ieraci S, McCarthy SM, Hugelmeyer CD. Access block in NSW hospitals, 1999–2001: does the definition matter? Med J Aust 2004;180(2):67-70.

[5] Cameron PA, Joseph AP and McCarthy SM. Access block can be managed. Med J Aust 2009;190(7):364-368.

[6] Richardson DB. Association of access block with decreased ED performance. Acad Emerg Med 2001;8:575-576.

[7] Derlet RW, Richards JR. Overcrowding in the nation's emergency departments: complex causes and disturbing effects. Ann Emerg Med. 2000;35(1):63-68.

- community-based care for minor illness and injury presentations
- continual development of and investment in telehealth or virtual models of care, residential aged care facility “in-reach” programs, and, care close to home to increase hospital avoidance

- EDs and healthcare systems monitor the impact of system changes in order to identify and respond to unintended consequences, such as delayed access to time-critical interventions or increased mortality, and to identify additional opportunities to streamline care.

Please email your completed submission to: reformplanning@health.qld.gov.au