



PARLIAMENT OF TASMANIA

Select Committee on Transfer of Care Delays (Ambulance Ramping)

Submission by Connected Medical Solutions Ltd.

10 November 2023





Dear Dr Rosalie Woodruff, MP (Chair) and Committee Members,

We thank you for the opportunity to provide a submission to this Inquiry.

Connected Medical Solutions Limited, trading as My Emergency Doctor and Psych2U (based in Hobart), is Australia's leading emergency telemedicine provider.

We support ambulance services, emergency departments, GPs, and patients in the community to access urgent, emergency and ongoing care at the times and places it is needed most. We currently serve Ambulance Tasmania to provide care to patients in their homes and we have the ability to support paramedics in the field. These services reduce pressure on the system, address unnecessary ambulance conveyance and extend the scope of paramedics to help manage more patients *in situ* and avoid emergency department attendance. We also provide support to Royal Hobart Hospital by providing virtual emergency specialists to Dover MPS, helping provide vital care to the community in support of on-site clinicians.

We are a private company that has been able to develop innovative sustainable telehealth-based solutions at pace and scale. These solutions deliver strong clinical, operational and cost outcomes that public health institutions have traditionally struggled to deliver consistently. Established in 2016, we have been recognised by Australian Financial Review in the Top 3 Innovative Healthcare Companies in Australia for 2021, 2022 and 2023. Since our inception, we have led the market and have learned what it takes to succeed in telehealth across the continuum of care and we are directly supporting a reduction in Transfer of Care (ToC) delays.

The solutions we have developed directly address a number of key components of the scope of this inquiry. Specifically, they:

- Reduce Transfer of Care delays;
- Address cost challenges presented by the use of locums, agency staff and other temporary staff arrangements;
- Provide new models of care and technical and clinical innovations to improve the health outcomes for people of Tasmania;
- Address barriers to workforce expansion, to increase supply, accessibility and affordability of specialist clinical services; and
- Facilitate better engagement across local health districts and speciality health networks (Ambulance, PHNs, UCCs, RACFS).

We have a proven track record of delivery that speaks to the efficacy and credibility of our work, that we trust is worthy of your consideration.

We are a proven partner with the Public Sector, and we relish the opportunity to bring our innovative thinking and expertise, and collaborate on the development and implementation of new and more cost-effective models of care. We are very keen to share our unique capabilities and to share our hard-won learnings to better assist the public sector.





The root causes of transfer of care (ToC) delays are multifaceted, systemic and occur across the continuum of care, not just in Emergency Departments where their consequences ultimately manifest.

Subsequently, corrective responses to the real root causes of ToC delays also must be, by definition, examined and applied across the continuum of care. There is no silver bullet. To make a significant impact on reducing ToC delays, a number of corrective responses must be applied contemporaneously.

As the root causes span the continuum of Primary, Secondary and Tertiary Care, Federal and State responsibilities need to be taken into account.

Poor ToC occurs in an Emergency Department when there is poor patient flow through the ED. That is, where there are blockages to admittance from the ED into an inpatient bed or discharge from the ED back into the community (Home or Residential Aged Care Facility). This is called access block. In these cases the EDs become full with patients who occupy the capacity of ED staff. Any new patients arriving via ambulance cannot be attended to by ED staff, and so remain on the ambulance trolley under the care of paramedics, until such time as existing ED patients are moved on to their appropriate destinations. This is the Transfer of Care (ToC) delay. Access Block and ToC delays are commonly heaviest in the mornings.

a) the causes of transfer of care delays, acknowledging Federal and State responsibilities.

Causes of ToC in the Community Setting:

When people in the community (Home or RACF) either cannot access or choose not to access primary care (GPs) they are often directed to, or choose to attend, an Emergency Department for care. Often this may be for issues that could be best attended to in the community setting, if appropriate support was available. More people attending EDs than is necessary or appropriate contributes to access block and ToC delays, whether they attend the ED via ambulance or by other means.

Where there are reductions in GP services, either through practices closing or practices reducing hours of service, patients turn to EDs. The reduction in GP services is felt most strongly in rural or regional areas but can also occur in metropolitan areas. Where GP practices reduce or remove bulk billing, many patients are compelled to attend EDs because they cannot afford the out-of-pocket expense for the GP. Lower socio-economic communities are hit hardest in these circumstances.

RACF residents present particular challenges that need some focus. RACF residents are aged and frail with multiple co-morbidities and generally chronic health issues. RACFs have a higher concentration of, and higher need for, primary care support. In locations where there is a shortage of GP/Primary care support there is often consequent insufficient monitoring of RACF patients who are forced to attend EDs for care and are most often transported to EDs via ambulance. We note again that Urgent Care Centres (UCCs) do not provide chronic disease management or





preventative health services. This group of 'frequent flyers' are supported better in the community and are some of the highest-risk patients affected by ToC delays. Increasingly, lack of GP/primary care support is preventing patients from being admitted back to empty beds in RACFs. A patient in a hospital bed is therefore exitblocked in the hospital and cannot be discharged until a GP can accept them. This further stymies flow in the hospital and manifests in the ED where new patients continue to present and ToC deteriorates.

Responses to ToC causes in the Community

Medicare Urgent Care Clinics (UCCs)

The Federal Government has launched a program to address primary care shortages by funding the establishment the Medicare UCCs. UCCs will normally comprise a practice of GPs and nurses with training in urgent care. The practices need to be located near other services such as imaging and pathology that operate at similar hours to the UCC practice. The UCCs' hours of operation generally vary from site to site.

The three UCCs in Tasmania operate 7 days a week, through the following hours:

- Launceston Medicare UCC: 2 pm to 8 pm
- Hobart Medicare UCC: 4 pm to 10 pm
- Ochre Health Medicare UCC Hobart: 12 pm to 8 pm

The intent of the Medicare UCCs is to help reduce pressure on EDs and make it easier for people to see a doctor or nurse when urgent but non-life-threatening care is required.

Limitations of the UCC Model

Critics point out that the UCCs will have little or only modest impact on reducing ED pressure and ToC delays because:

- The staffing for UCCs sometimes consumes GP resources that were already in the community, without adding net GP capacity to a region.
- They won't be able to see people for things like chronic disease management or preventive health procedures, which are especially important for a vulnerable ageing population (RACF patients especially)
- They only support walk-in physical attendance. They do not support telehealth, limiting vital access.
- While they provide extended hours of care, they do not provide late evening or overnight support when many of the most complex urgent care cases arise.
- They are generally not located near the rural or regional centres which have the greatest restrictions on primary care access.





How MED Addresses the Limitations:

MED addresses primary care shortcomings through:

24/7 FACEM on Demand for UCCs

MED provides telehealth FACEMs on demand 24/7 providing much-needed support, particularly after hours. MED can provide adjunct telehealth support to UCCs, extending their capacity and hours of access.

PHN After Hours Support

MED works with a number of Primary Health Networks to provide ondemand after-hours care for people in the community in Victoria and NSW. Through MED, patients can access FACEM support for urgent and emergency consultations where they are otherwise unavailable. Most cases are resolved *in situ* and result in better, faster support for the patient and reductions in ambulance transfer, ED presentations, access block and ToC delays.

RACF Support:

MED supports a number of RACFs across Australia with 24/7 FACEM ondemand or GP services. Easy timely access to regular support means that most patients can be cared for *in situ*. This leads to better health outcomes for the patient and material reductions in the use of ambulance transfers and ED presentation, which in turn reduces access block and ToC delays.

Where communities access MED telehealth services we see:

- 89% of patients managed *in-situ* (Home, RACFs);
- 2,800 emergency presentations and 360 ambulance trips avoided;
- Alleviating the burden on local hospitals and emergency services;
- Financial savings of around \$1 million over 18 months, equating to a remarkable \$118 saving per patient.

MBS Support for Telehealth:

The Federal Government introduced MBS telehealth items for GPs on a temporary basis in response to the COVID-19 pandemic, and since June 2023, has made them permanent. To be eligible to access MBS telehealth requires the patient to have an established relationship with a GP, where the patient has received at least one face-to-face service with the GP or GP Practice in the 12 months preceding the telehealth attendance.





Limitations of MBS Support for Telehealth:

While telehealth has the potential to deliver high-quality virtual access to care where physical access to care is not possible or is difficult, the current MBS structure has limitations that restrict patients' access to telehealth services:

- Practices may not have access to telehealth equipment;
- Medical practitioners may not be trained to perform telehealth consultations;
- Patients who cannot access a physical GP to have a face-to-face interaction in a 12-month period, cannot access Medicare rebates for consults performed by the doctor through telehealth. This creates unnecessary risk and financially penalises the most vulnerable and least supported patients, particularly in regional and remote areas, where a face-to-face interaction simply cannot occur because of the absence of GPs.

MED strongly urges that MBS provisions for telehealth remain as permanent arrangements and further proposes that changes to the MBS to allow rebates for telehealth, without first requiring a physical GP visit, would provide immediate access to care for those in underserved regions.

Ambulance Services

An ambulance is not required for all people who call the ambulance service.

The access to ambulance services for the community is primarily through the 000 call service. For the vast majority of callers to 000, an ambulance dispatch or indeed a visit to an ED, is well in excess of the level and urgency of care that they require. To ensure clinically appropriate and efficient use of important ambulance resources, a triage of ambulance calls is usually provided by nurses who assess if an ambulance and ED is or is not the most appropriate clinical pathway for the caller.

If an ambulance is dispatched to a patient in the community, the in-field paramedics may be able to make an additional assessment of the need to transfer to an ED. Some patients will be best supported by a GP. Some may need to go to an ED but not immediately or by ambulance. Diverting patients away from ambulance transfer and an ED presentation, where diversion is the clinically appropriate pathway, can contribute to reducing access block and ToC delays.

Limitations:

- There are limitations to the clinical assessment abilities of both triage nurses and in-field paramedics when in doubt they will always defer to sending patients to an ED;
- Consequently, some patients are sent to ED when it may not be clinically necessary;
- If there are limited GP practices the patient will revert to an ED support in any case.





How MED Helps address the limitations:

Specialist Emergency Doctors (FACEMs) with higher-order clinical skills can more accurately and safely assess which patients need not be transported by ambulance. Using FACEMS for Secondary Triage and for guidance for in-field paramedics reduces unnecessary ambulance transfers and in turn directly reduces access block and ToC delays.

MED provides a 24/7 Virtual Secondary Triage assessment by FACEMs to ambulance services in Tasmania, Victoria and NSW. Our FACEM triage and infield paramedic support results in a significant reduction in unnecessary ambulance transfers, allowing ambulances and paramedics to remain available for the most urgent cases:

- For infield paramedic support >70% of consultations were managed *in situ* (representing avoided ED presentations and ambulance trips);
- 96% of ambulance dispatches are avoided.
- Estimated \$4.1m achieved in savings for the first year of secondary triage program.

Causes of ToC In the ED:

Staff shortages can further compromise the clinically effective and efficient operation of an ED. Many hospitals with EDs struggle to maintain a stable 24/7 medical roster to support the patient load they receive. In larger centres there may be a shortage of FACEMS or senior advance trainees (Registrars). In rural or regional settings there may be a shortage of Career Medical Officers or Critical Care trained GPs. Shortages most commonly occur for overnight and weekend shifts.

In worst-case scenarios, shortages of medical coverage require the ED to be closed and the hospital to be put on ambulance bypass. In the best-case scenarios junior doctors carry the load. The absence of Senior Doctor support inevitably leads to slower and more expensive decision-making (more tests), and the consequent slower patient flow blocks the ED, contributing to access block and ToC delays.

Patients presenting to EDs are triaged into categories T1, T2, T3, T4 or T5 according to clinical urgency, where T1 is the most urgent and T5 are the least urgent. Generally, T1 and T2 patients are most likely to be admitted to the hospital and consume a higher order of clinical support. T3, T4 and T5 are most likely not to be admitted. A material number of T3-T5s could have been treated in a primary care setting, it sufficient resources were available. Using scarce, highly skilled and more expensive ED resources to manage T3-T5 patients slows the management of T1-T2 patients. In blocked EDs, the average length of stay for both admitted and non-admitted patients increases, causing access block and ToC delays.

Patients for whom the decision to admit or discharge is unclear (usually T3) perennially block EDs while the disposition decision is determined. In response, many hospitals choose to establish Short Stay Units or wards (SSUs) to move these undifferentiated patients for further management, thus freeing up the ED bed.





Hospitals regularly revert to using locum doctors to fill short roster gaps. Locums are always significantly more expensive, stressing already under siege public health budgets, and sometimes of variable clinical quality.

How MED Helps: ED Waiting Room Service

A significant number of T3-T5 patients are suitable for telehealth support. MED can deliver a 'waiting room service' for these low acuity patients. MEDs FACEMs can provide disposition decisions and clinical oversight of these patients much faster than they would have been seen. This also frees up the onsite ED staff to better support the more critical T1-T2 patients. Where a MED waiting room service is in place, we have seen the average length of stay of both admitted and non-admitted patients in the ED reduce by half which increases available bed stock and directly reduces ToC delays.

MED has implemented a Waiting Room Service in Broken Hill NSW where we see results that directly impact ToC delays:

- MED manages T3-T5 patients, freeing local hospital staff to manage T1-T2;
- 60% of patients are seen by MED within 30 minutes of being triaged, well ahead of Australian Triage Scale targets;
- Patients are discharged well within the 4-hour target;
- ED Average Length of Stay reduced by 50% for non-admitted and admitted patients.

How MED Helps: Overnight Board Rounds:

Where there are shortages of senior medical cover in an ED, MED can provide FACEMS via telehealth to work alongside on-site ED nurses and Junior Medical Offers. Delivering up to three virtual board rounds per night with onsite staff, MED FACEMs provide much-needed leadership, plus clinical and operational decision-making. With MED FACEM oversight, the department can operate at night with the same specialist expertise available during the day. By making more effective and timely diagnosis, treatment and disposition decisions, the ED functions better and is less blocked in time for the morning shift. This has a material impact on reducing ToC, improving patient flow and supporting staff morale.

We support overnight Board Rounds at Horsham and Wangaratta hospitals in Victoria and are in active discussion with a Sydney metropolitan public hospital. Where MED has supported EDs with overnight Board Rounds we see results in the order of:

- 31% of treatment plans were changed, minimising clinical and operational risks;
- 14% reduction in ED unnecessary investigations/pathology tests;
- 29% of admission decisions were changed to discharge decisions;
- Junior doctors provided feedback of feeling supported through the rounds.





How MED Helps: Short Stay Unit Management

SSUs can provide relief for ED bed blockages. Unfortunately, SSUs also need medical leadership and are often subject to the same issues of medical roster shortages as identified for EDs. In these cases, SSUs may be closed or may just become the next blockage point in patient flow, which will ultimately backup to the ED causing ToC delays.

Similar to our ED solutions, MED is able to provide FACEMs on Demand virtually to assist in disposition decisions, patient management and discharge. We have supported Short Stay Unit at Goulburn Valley Health.

Causes of ToC in the Inpatient Setting

Regularly, patients in regional locations require higher order ED or inpatient care that cannot be supported by their local hospital or healthcare facility. When they no longer require the higher-order care they can return to local facilities to complete their care journey. Where local facilities struggle to maintain a full or stable medical roster, patients often stay unnecessarily in the large hospitals until a doctor can be found to admit them locally. This contributes to access block and ToC delays and denies access to tertiary inpatient services to other patients.

Additionally, patients in inpatient wards who need to be discharged to RACFs are sometimes blocked because there are no GPs to admit for care at the RACF. Inpatients who cannot be moved block the transfer of ED patients into inpatient wards and are a significant contributor to access block and ToC delays.

How MED Helps: Virtual Admitting Service (VAS) & Transfer of Care

Working with on-site medical staff, MED provides virtual GPs to accept admittance of patients, manage transfer of patients from larger hospitals and manage ongoing inpatient care through to discharge. Freeing up the bed at the larger hospital directly contributes to better patient flow and reduces access block and ToC delays at those hospitals. MED provides VAS services to a number of sites across Australia and is in active discussion with two centres in Tasmania.

How MED Helps: GP support for RACFs

As articulated earlier, MED provides virtual FACEM on Demand and GP support for RACFs. This allows the RACF to safely accept a patient discharge from the hospital, freeing up the inpatient bed and relieving ToC delays.

(e) measures taken by other Australian and international jurisdictions to mitigate transfer of care delays and its effects;

We have already discussed the Federal Government program of UCCs sufficiently in this document. Similarly, we have also sufficiently articulated models such as FACEM on Demand, Ambulance Secondary Triage, Virtual Board Rounds and Waiting Room Management etc, which are all in use across state jurisdictions right now.

We wish, however, to comment on state-based approaches to virtual care.





Most states have or are progressing models of virtual care that consider urgent and emergency care. We believe that while most have merit most also have significant shortcomings that need careful consideration. Some models focus attention on urgent care but then leave material gaps in emergency care. Some provide virtual services but still leave significant gaps in overnight medical coverage. Some state-based services inadvertently overlap with PHN services, consuming the patients and costs that the Federally funded PHNs are supposed to cover. Some services contemplate the state 'doing it all' but lack the expertise to effectively manage complex virtual workforces at scale. The establishment cost of these services is significant, as is their operation, because real-time care it is not simply a case of doctors on a video call—it is an entirely different operational model, with much complexity, where the cost-per patient can blow out considerably if not managed deliberately.

As Tasmania contemplates its own approaches to virtual care, we suggest that seeking counsel from private organisations, like MED, that have proven innovative solutions would benefit the Tasmanian Department of Health and the people of Tasmania. We would welcome any such opportunities to share our experience and insights.

(f) further actions that can be taken by the State Government in the short, medium, and long term to address the causes and effects of transfer of care delays; and

We submit that state and federal health departments can make greater use of telehealth triage services to ease the chokepoints that are driving transfer of care delays.

As we have shown, the root causes of ToC delays are multifaceted, systemic and occur across the continuum of care, not just in EDs where their consequences ultimately manifest.

To adequately address them, a series of coordinated responses is required, including but not limited to:

- Greater use of telehealth services (GP and emergency) in RACFs;
- Greater usage of telehealth secondary triage consultation for 000 ambulance;
- Greater use of telehealth triage for in-field extended care paramedics (ECPs);
- Use of telehealth services for UCCs; RACFs and PHNs;
- Use of Virtual Board Rounds in hospitals to support junior doctors and nurses overnight and on weekends to deliver better clinical and operational performance;
- Use of Waiting Room services in EDs to manage T3-T5 patients.

In closing, we hope that the innovative models we have, our ability to implement them and make them stick, and our proven track record and positive outcomes pique some interest.

Health services that look for inspiration and innovation in the same places they have always looked, are unlikely to find and deliver the sustainable, effective, efficient breakthrough solutions they crave.





Unfortunately, Public Healthcare can be a difficult setting to incubate good ideas. Over decades there have been countless pilot initiatives that are announced and start with great promise, but fail to deliver.

We believe that we offer a unique set of capabilities, experience, and learnings, that if allowed to be shared collaboratively with Tasmanian Department of Health, could make a material difference to the people of Tasmania.

Yours Sincerely,

Bill Maiden

CEO, Connected Medical Solutions Ltd t/a My Emergency Doctor

About My Emergency Dr

Our services are delivered to over 220 facilities across Australia, including but not limited to: 58 Hospitals; 43 Urgent Care Centres; 55 Residential Aged Care Facilities; four Public Health Networks and three State Ambulance Services.

With a heritage in Emergency Medicine, we have expanded our clinical capabilities to include GPs, Psychiatrists, Psychologists and we are currently working to add Geriatric, Neurology and Cardiology specialists to our roster. We have over 150 APHRA registered FACEMS working in Australia and overseas providing "follow the sun" always-on access to specialist doctors, meaning our emergency departments can function as truly 24-hour operations. Our shift duration can be as low as two hours, which means we can provide a more reliable and more flexible roster for Health Care Providers and for our clinicians. The fractionation of working patterns makes it possible to better match the demand for health care (which peaks and troughs through a 24-hour period) to the capacity to deliver care. By matching supply and demand, costs are better aligned with activity and service levels need not deteriorate in periods of increased activity, which is the legacy of the current system when rostering in 10-hour blocks.

Our services do not replace existing Health Provider services, but rather seamlessly work within existing services, specifically tailored to each site, filling critical resource and capability gaps. They are designed to be always available 24/7 but only used when needed. Our model allows us to scale quickly to meet any variability in demand. Our ability to provide variable cost services where fixed costs services are traditionally used delivers much higher cost efficiency and flexibility. For clarity, these are not locum services. Our services are always on, always available.

Our 24/7 model means that Local Health Districts, Public Health Networks and Residential Aged Care Facilities have full certainty of the availability of medical support for all sites as on-site staff become more challenging to find. Our services prevent the need to bypass smaller hospitals, a response which increases the load on secondary and tertiary referral hospitals.





We give Health Providers full control of service delivery, with higher confidence and strong risk management in a more cost-effective manner. The cost of our virtual service delivery is comparable to physical staff rates and significantly better than locum rates.

We have a clinical governance model that is market-leading and more robust than some utilised in public health services. All of our services are video recorded and are regularly case-audited. This means we can deliver a consistency of clinical quality and throughput that is sometimes difficult to achieve in a public setting.

Don Berwick of the Institute for Healthcare Improvement said, "Every system is perfectly designed to achieve exactly the results that it gets." Our virtual integrated eco-system of care supports Public Health by:

- Increasing patient access to care;
- Reducing risk;
- Increasing clinical quality;
- Increasing operational performance;
- Driving better staff and patient satisfaction; and
- Offering better cost effectiveness