# Heath System Response



VICTORIA State Government | Department of Health

# How the Health System Response is used

## Health System Response purpose and scope

The Health System Response (HSR) has been designed to provide the Victorian health system a **strategy to maintain high-quality COVID-19 and non-COVID-19 care**, including elective activity, during periods of high demand.

## How the Health System Response will work

The HSR has **four Stages**, ranging from Stage One to Stage Four, reflecting the **level of demand on the system**, that will be applied at a state level.

Assigned to each Stage are a **series of levers**, separated into local and central. **Local levers will be applied at a health service level**, with local decision making determining both the timing and extent of their implementation. **Central levers are applied by the Department of Health** to ensure operational consistency and to provide a systemic way to addressing increased demand.

## How the Health System Response will be utilised

Department of Health and health sector operational leads will **monitor key system demand metrics** to determine the level of stress on the overall health system.

A **two-step decision process** will be used. The **first step will involve a matrix style approach**, where COVID-19 admissions are mapped against a process which categorises workforce constraints. The **second step is a qualitative and quantitative risk assessment**, using a range of supplementary information and metrics available to the Department of Health regarding demand on admitted, emergency and ambulance services.

If it is determined that the level of demand necessitates a change in Stages, the Department of Health will **enact and communicate the decision to health service CEOs**. Health services will be required to communicate any change in stages to their staff, so that appropriate changes in practice and service provision can be made.

The Department of Heath will **continue to monitor the demand on the system** and make further judgements and decisions as appropriate

# Health System Response matrix

The first step in determining which stage the HSR is in, is to utilise the **HSR matrix**.

Under this approach, **COVID-19 hospitalisations are mapped against workforce constraints** to determine the level of pressure within the health system.

The second step is a **qualitative and quantitative risk assessment**, using a range of supplementary information and metrics available to the Department of Health regarding demand on admitted, emergency and ambulance services.

| | 0-400 COVID-19 hospitalisations | 401-800 COVID-19 hospitalisations | 801-1400 COVID-19 hospitalisations | 1401-2000+ COVID-19 hospitalisations |
|---|---|---|---|---|
| None to low workforce constraints | Stage One | Stage One | Stage Two | Stage Three |
| Moderate workforce constraints | Stage Two | Stage Two | Stage Three | Stage Four |
| Severe workforce constraints | Stage Two | Stage Three | Stage Four | Stage Four |
| Critical workforce constraints | Stage Three | Stage Four | Stage Four | Stage Four |

# Health System Response Levers

| | Response levers | Stage One | Stage Two | Stage Three | Stage Four |
|---|---|---|---|---|---|
| Local levers | **Workforce** | Maintain non-surge models of care, if possible<br>Support existing staff to work to top of scope<br>Consider scaling with alternative volunteer & non-clinical staff<br>Face to face or telehealth appointments to occur as per routine arrangements | Implement cross-care models, where possible<br>Consider changes to shift length to maximise workforce availability<br>Redeployment to urgent needs<br>Expand telehealth arrangements where clinically appropriate to support acute care delivery, | Consider moving to extended team-based models, based on local need, in consultation with unions<br>Consider leave cancellation<br>Increase telehealth utilisation to support workforce efficiencies, including the utilisation within inpatient settings | Extended team-based models, where necessary in consultation with unions<br>Leave cancellation<br>Maximise utilisation of telehealth in all forms of service provision, where it improves workforce efficiencies and is clinically safe to do so. |
| | **Emergency Care** | Consider virtual EDs, implement scalable triage matrix | Use triage matrix to scale back on less urgent cases where possible; utilisation of existing funded modular ED units | Continue scaling back care where possible; central load management and balancing<br>Re-purposing existing facilities adjacent to ED, if possible | |
| | **Ambulance** | **Unlikely utilisation of:**<br>Additional surge stand up<br>Additional APOT/HASM crews<br>Rapid offload at services | **Possible utilisation of:**<br>Additional surge stand up<br>Additional APOT/HASM crews<br>Rapid offload at services | **Likely utilisation of:**<br>Consideration of additional grid changes<br>Additional surge stand up<br>Additional APOT/HASM crews<br>Rapid offload at services | **Probable utilisation of:**<br>Consideration of additional grid changes<br>Additional surge stand up<br>Additional APOT/HASM crews<br>Rapid offload at services |
| | **Private Hospital Support** | Business as usual - Day-to-day management of demand variance within existing HSP system (including standing arrangements with private hospitals) | Public health services prioritisation of elective activity, including deferring of non-urgent activity.<br>Health services exhaust all options available to load balance and share activity across the HSP, including initiation of all pre-escalation actions | DH authorises HSP Public-Private Pandemic Support Plan enactment.<br>Plans activated based on local decision making and completion of all pre-escalation actions. | Prioritisation and load levelling of emergency surgical categories and services based on capacity. |
| Central levers | **COVID Positive Pathways** | Intake assessment for vulnerable and priority populations<br>Use of community health providers for intake linked to HSP services for escalations. Fortnightly sector huddle to manage model and demand | Intake assessment for vulnerable and priority populations<br>Use of community health providers for intake linked to HSP services for escalations. Weekly sector huddle to manage model and demand | Pivot model to expand intake assessment to include clinical P1 within 24hrs.<br>Load levelling where required to maintain equity across the state. Use of third-party providers for intake assessment to support community providers, if available<br>One-three times weekly huddles with the sector to manage capacity and demand | Model expanded to support additional load levelling across the state for intake assessment for P1 cases within 24hrs.<br>Utilisation of third-party providers for intake assessment and medium pathway, supporting community providers .<br>Medium pathway support to include patients on home oxygen to allow for rapid discharge<br>Daily huddles with the sector to manage capacity and demand |
| | **COVID-19 Streaming Model** | Tier 1/2 sites designated via HSP as per local demand. Most optimal sites are prioritised as Tier 1. Sites employ a localised response to operating COVID-19 wards | All public and private acute hospitals become Tier 1 streaming sites. Health services exempted from this where infrastructure and clinical capability risks cannot be mitigated | | All public and private sites become Tier 1 streaming services sites. Health services exempted where clinical capability risks cannot be mitigated |
| | **HSRC operating model** | Planning in place to stand up HSRC, should a movement to Stage Two be required | **Health Service Response Centre - system coordination function stood up**<br>Providing system-level policy, advice and coordination through thrice-weekly COO/AV meetings | **Health Service Response Centre scaled model stood up**<br>COO/AV meetings move to daily. | **Health Service Response Centre – surge model stood up**<br>Co-location with AV |
| Central lever (regional application considered first) | **Emergency Management Response** | Health-service level monitoring to determine whether a local emergency management response is required, such as activating a Code Yellow (workforce issues), with notification to DH. | | System monitoring to inform consideration of local or regional emergency management response. | Consider a coordinated Code Brown response |