

Ambulatory Care Policy and Planning Framework

Consultation paper

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Foreword

Prediction is often held to be a somewhat uncertain science. As health care policy makers, funders, planners and providers, we have the advantage of certainty in our knowledge of changes in the patterns of health and illness which already substantially affect our service delivery systems and will continue to do so for the foreseeable future.

It sometimes seems hackneyed to observe that Victorians generally live longer and healthier lives than ever before. In fact our life expectancy is now arguably the second longest in the world.

At the same time, chronic diseases, including cardiovascular disease, pulmonary disease, diabetes and some forms of cancer, are now commonplace and will increasingly be so within the context of an overall older and healthier population. These diseases are amenable to interventions in every part of the spectrum of health care, particularly prevention, early intervention and management once acquired.

Most people, even with established chronic disease, will be able to be managed within a community setting of care; and it is obviously desirable that hospitalisation for this group of clients is avoided whenever possible.

In addition, much care that previously required a hospital stay, can be provided in a community setting, or done as a day attendance at a health service. This creates an opportunity for otherwise healthy people to receive episodic care in a way that is less intrusive and less disruptive to their lifestyle.

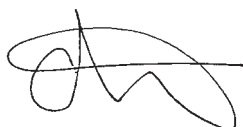
These trends are the genesis of the Ambulatory Care Framework, which seeks to provide direction for health care services to develop high quality, coordinated and integrated person-centred health care.

There are no surprises in this approach; in fact it has been self-evident for some years. Victoria can take pride in its national leadership in developing programs such as the Hospital Admission Risk Program; the Primary Care Partnership Strategy; Hospital in the Home; Post Acute Care; Sub-acute Ambulatory Care; and other initiatives. We should strive for continuing innovation and systematic implementation of already proven strategies.

This framework emphasises the importance of the right care, at the right place, at the right time. It involves a series of challenges, including those about interfaces between private/public; general/specialist; hospital/community; community/home; and effectively managing interface issues at a number of levels.

It will guide the type and location of new facilities and how all facilities may be used to deliver more integrated care for people with chronic and complex conditions.

Effecting such change into the future is both exciting and challenging. All of us have some part to play in reshaping health service delivery in the ambulatory care arena. We look forward to your participation and advice as we move forward.



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Introduction

The Ambulatory Care Policy and Planning Framework (ACF) will provide clear policy directions and an overarching planning framework for ambulatory care service delivery models and facilities in Victoria.

Ambulatory care takes place as a day attendance at a health care facility or at the consumer's home. It encompasses a wide spectrum of health care delivery from primary and preventative health services through to specialist surgical services or tertiary prevention.¹

There is a broad range of ambulatory care services in Victoria, provided in both community-based and hospital settings. These services are funded from various sources, including Commonwealth, state and local governments, insurance agencies, private providers, client fees or a combination of these. Within government funding are multiple programs and funding streams, each with their own funding formulas, eligibility criteria and reporting requirements.

Many factors have influenced service changes in the health system and driven the development and expansion of ambulatory models of care. These include:

- changing population demographics, such as growth, ageing and urban expansion
- increasing health service demand
- continuing advances in technology and clinical practice
- the need to maximise cost efficiencies in health care
- consumer expectations and preferences, such as access, waiting times and a preference for less invasive modalities of treatment
- an increasing focus on population health and the needs of the whole person.

There are also factors that have inhibited further development. If not overcome, these factors are likely to prevent ambulatory care models reaching their full potential. These include:









- poor service integration
- ineffective or complex governance or management arrangements
- resistance to organisational or cultural change
- complex and/or inflexible funding arrangements
- lack of facilities and infrastructure
- size, skills and distribution of the health workforce.

A range of policies and initiatives have tackled one or more of these inhibitors. The PCP Strategy has focused on integration and successfully tackled some of the management and cultural barriers to service coordination.

The HARP has also successfully tackled a number of these areas to the benefit of people suffering from chronic and complex conditions.

¹ Department of Human Services (2003). Directions for your health system: Metropolitan Health Strategy. Metropolitan Health and Aged Services Division, Victorian Government Department of Human Services: Melbourne

The development of the ACF derives its impetus from these initiatives and from a number of other recent major Department of Human Services policy documents that call for health system reform. These include:

-  [Directions for your health system: Metropolitan Health Strategy](#) (920kb, pdf)
-  [Directions for your health system: Metropolitan Health Strategy—Ambulatory Care Services](#) (503kb, pdf)
-  [Directions for your health system: Metropolitan Health Strategy—Ambulatory Care Literature Review](#) (503kb, pdf)
-  [Community Health Services: creating a healthier Victoria](#) (797kb, pdf)
-  [Primary Care Partnerships—Strategic Directions 2004–2007](#) (292kb, pdf)
-  [Improving the Care of Older Persons](#) (345kb, pdf)
-  [Integrated Cancer Services Framework](#) (34kb, pdf)
-  [New directions for Victoria’s Mental Health Services: the next five years](#) (35kb pdf)

These policies state the need to focus future growth on building ambulatory care services in the community as a means of improving equity and access to health care, providing more patient-centred care and improving the efficiency and sustainability of the health system.

About this paper

Objective

The objective of this consultation paper is to communicate the ACF vision and principles, identify the potential implications of the ACF for the current health service system, and promote broad level stakeholder discussion and feedback.

Key questions and areas for consideration are provided in the 'Principles in context' section. The process for consultation is described below.

The ACF project team and steering committee will review all feedback received from this consultation paper.

Consultation process

Existing knowledge

Existing evidence and previous market research were reviewed to obtain baseline opinions about people's experiences with current health care services, their knowledge of available services and the rationale for choice of service, and the differences between metropolitan, regional and rural preferences.

This information is being used to inform the development of the ACF in relation to service delivery, service types and treatment modality. Further targeted research using established mechanisms of engagement may be undertaken to clarify aspects of the ACF.

Formal consultation based on this document

This document is being broadly distributed using existing communication methods, direct contacts and the Department of Human Services ACF website. Feedback on the document and the issues it raises will be sought through:

- a statewide forum targeting a broad range of key stakeholders
- a series of smaller consultation workshops providing an opportunity for smaller groups of stakeholders to provide detailed feedback
- written feedback on the consultation discussion points contained in this paper and any related issues.

Written feedback on the document can be provided up to and including **Friday 2 September 2005** by:

- email to: acffeedback@dhs.vic.gov.au
- posting written feedback to:
ACF Consultation
Level 11
555 Collins Street
MELBOURNE 3000

Further information about the ACF team, contact details, general project background and related policy links can be found at: <http://www.dhs.vic.gov.au/rrhacs/ambula.htm>

Ambulatory Care Policy and Planning Framework release

The ACF is being developed in parallel with this consultation phase. It is anticipated that, following this consultation, the ACF will be finalised and released in late 2005.

Vision

The Victorian health care system will increasingly deliver person-centred health care in home and community settings, reducing the need for inpatient care and improving the health outcomes of Victorians.

The future of health care services

The delivery of health care will be integrated and coordinated around the needs of people, rather than service types, professional boundaries, organisational structure, program funding or reporting requirements. Health care organisations, in partnership with consumers, will be collectively responsible for people's health outcomes.

Many services currently delivered in hospital inpatient settings will be provided in the community. Community-based health care services will have greater capacity to respond to and meet people's health care needs before they become seriously ill. Community-based health care services will coordinate and deliver the best possible care, informed by people's needs and preferences.

Hospital-based health care services will continue to evolve the way they provide care, further increasing same-day attendances and modifying patient management systems, physical facilities and clinical practice to better suit care on a walk-in, walk-out basis.

Information technology will give the people receiving services and the providers of those services quick and easy access to information. More medical technologies will be available to people in their homes and local communities.

The need for an Ambulatory Care Framework

This vision of the future of health care in Victoria cannot be achieved without a sense of shared purpose and a clear structure to guide the development of an ambulatory care service system. An ACF is needed to provide both a clear policy context and a set of system-wide planning parameters to set the overall strategic direction and identify the practical implications of working towards these policy goals.

The ACF will set out the capacities needed in the ambulatory care service system and help to determine where and how these capacities will be delivered. This paper aims to identify some of the implications at a high level, both as a basis for consultation, and as a first step towards specifying a practical framework for the delivery of ambulatory care services in Victoria.

Principles

The following principles will guide the development of ambulatory care services in Victoria.

People and community

Access to health care will be timely, provided predominantly in community-based settings and informed by patient choice.

- Care will be ‘person-centred’, focusing on the needs of the whole person as these change over time.
- Health care will be provided in community-based settings (including in people’s homes), where it is safe and cost-effective to do so.
- People will have equitable, timely and appropriate access to health care regardless of where they live.

Service delivery

Health care will be evidence-based, will address broad determinants of health and will ensure that information about people’s health care is well managed.

- The delivery of health care will be based on the best evidence available and will be planned on an area basis to meet the needs of defined populations.
- The delivery of health care will incorporate a population-based health approach that recognises the social determinants of health and promotes prevention and early intervention.
- Information about people and the services they receive will be consistently managed and coordinated across health care services to protect privacy and support integrated service delivery and continuity of care.

Capability

Health care will be delivered by a skilled workforce resourced to deliver services in a planned and coordinated way.

- The workforce will be configured to deliver integrated health care.
- There will be a consistent, planned approach to developing the infrastructure for the delivery of integrated health care, including information and communications technology, standard tools and protocols, facilities and equipment.
- One mechanism for integrating health care services will be co-location or clustering within health precincts.

Collaboration

Health care will be based on funding and accountability arrangements that foster a partnership approach.

- The provision of health care will be based on partnerships among levels of government and public and private health care services.
- Funding and accountability arrangements for the delivery of quality health care services will support the provision of the right care, at the right time, and in the right place.

Principles in context

People and community

Access to health care will be timely, provided predominantly in community-based settings and informed by patient choice.

Projected population changes in Victoria, particularly in areas of high population growth, are providing opportunities to deliver expanded services through new facility types closer to where people live. Declining populations in some rural areas are also providing opportunities and challenges in the provision of health service delivery.

Timely access to health care depends not only on resources being available to meet demand, but also on the flexibility of the service system and, particularly, its capacity to adjust to identified priorities and the needs of local communities.

Care will be 'person-centred', focusing on the needs of the whole person as these change over time.

The ACF recognises that health services and the actions of individuals in addressing health matters are a subset of a broader set of health determinants. Effectiveness of health services is just one of a number of factors that influence wellbeing, others being healthy lifestyles, psychosocial circumstances, economic and social conditions and housing.² Enhanced collaboration between traditional health services and services such as drug treatment and housing will enable the needs of the whole person to be addressed.

Consumer involvement in health care is critical to effective service delivery, planning and evaluation. The achievement of optimum care outcomes is essential for empowering consumers to take control over their own health and be active participants in the health care they receive.

There are a number of ways consumers are presently involved in the planning and delivery of health care, such as health service and PCP consumer committees. However, current governance, service coordination arrangements, organisational structures and funding can be improved to make people the focus of attention. Further developing these arrangements will improve people's experience and outcomes of their health care.

Health care will be provided in community-based settings (including in people's homes), where it is safe and cost-effective to do so.

The major policy direction underpinning the new vision is that health care services will be increasingly community-based. Now, and increasingly in the future, a wide range of health care can be provided safely and effectively without the need for an inpatient stay. Inpatient care will become an option of last resort.

To capitalise on this trend, the ACF needs to provide a pathway for the development of an integrated, community-based service system in which a variety of care, across a range of complexity and specialisation, can be packaged according to the needs of individuals. This includes primary care, secondary specialist consultations, and tertiary interventions such as day procedures and day treatment. Use of modern technologies will reduce the need for hospitalisation and allow further increases in the use of day procedures, day treatment and care and monitoring of health status provided in people's homes. Over time, this will involve substantial changes in the setting of care, the outlook and practice of health care providers, and their relationships with each other.

² Department of Human Services (2003). Integrated health promotion resource kit. Rural and Regional Health and Aged Care Division, Victorian Government Department of Human Services: Melbourne.

People will have equitable, timely and appropriate access to health care regardless of where they live.

Allocation of recurrent resources and capital investment will consider area-based planning. Area-based planning for population health will create a closer fit between service system capacity and the health care needs of local communities. Where services cannot be provided locally, new technologies (such as the use of live video links, remote diagnostics and monitoring) can increase the capacity to undertake consultations and monitor health status without consumers having to travel long distances, which can be of particular benefit in rural areas.

Where it can improve access to services, support more efficient service delivery and better integration between services that need to work together, co-location of services will also be considered (for instance, co-location of General Practice services, specialist clinics, diagnostic services and day procedure theatres within a health precinct).

Pursuing options for certain ambulatory care services to be part of a statewide waiting list management/electronic scheduling system would provide publicly accessible waiting time information and allow people greater, more informed choice.

Development of shared waiting list management systems, priority of access tools and service benchmarking will assist consumers to receive care within clinically appropriate time frames.

Consultation discussion points

- *How can we improve consumer involvement to ensure effective service planning and delivery?*
- *What barriers to 'person-centred' care need to be overcome?*
- *What is required to build stronger integration between primary care and specialist services?*
- *What are the barriers to population health based care?*
- *Which existing ambulatory care services will be able to be provided in community-based facilities? Which ambulatory services must continue to be provided on hospital sites, and why?*

Service delivery

Health care will be evidence-based, will address broad determinants of health and will ensure that information about people's health care is well managed.

The delivery of health care will be based on the best evidence available and will be planned on an area basis to meet the needs of defined populations.

Planning for ambulatory care service delivery would be carried out on an area basis for defined local populations. Evidence of the health care status of populations will be used to identify priorities and influence service planning, capital development and funding allocation. Planning should inform decision making about integrated service delivery and future investment. Local area planning would be carried out within a consistent statewide framework using evidence-based best practice.

The specific service numbers and mix per area will depend on the needs of the local population, the existing service system, facilities, critical mass and efficiency. Area-based planning needs to take account of three levels of catchment:

- planning at the local government area (LGA) level or below
- planning on the basis of PCP catchments or larger sub-regional groupings based on multiple PCP catchments
- planning at the level of Department of Human Services regions.

Designation of planning catchments for the purposes of the ACF should not be taken to imply particular governance arrangements. Rather, these represent a standard approach to defining catchment boundaries that should underpin planning processes.

Planning processes would take into account tertiary services including day treatment and procedures, secondary services such as specialist consultations and diagnostic services, and a range of primary care services, including community-based aged care, mental health and alcohol and drug services. Ambulatory care planning processes will be built on the foundation of established partnerships and will require agencies to extend their existing investments in service and capital planning and decision making about integrated service delivery. Core partners include metropolitan and regional health services, small rural health services, community health services, divisions of general practice (representing local general practitioners—GPs), local government, district nursing services, public and private specialists and other private service providers.

Specific criteria and role delineation of ambulatory services would identify which services could be provided in a community-based setting on a planning area basis. Where appropriate, planning would consider where services should be co-located to improve access, efficiency, or integrated service delivery.

A service delivery framework would classify and cluster existing services and define the minimum criteria required for each cluster. This classification would provide consumers and service providers with a clear understanding and set of expectations about the role and capability of each cluster. The framework would also specify expectations regarding the level of integration between services and other measures of quality such as evidence-based best practice for managing specific conditions.

Appendix 1 provides a possible classification schema. As this schema notes, for reasons of complexity, catchment size and functional interdependence, there are a range of services for which planning implications should be considered on a regional basis. This implies a need for coordination across PCP catchments in rural and some metropolitan areas to support planning at a regional level. Department of Human Services regional offices will need the capacity to facilitate this. Similarly, some services need to be planned around population catchments at LGA level or smaller. Area-based planning needs to work across these three levels. It also needs to consider the impact on health services and other agencies whose catchments do not necessarily align with LGA, PCP or department regional boundaries.

The delivery of health care will incorporate a population-based health approach that recognises the social determinants of health and promotes prevention and early intervention.

Service planning will incorporate a population health approach that analyses within each planning area:

- burden of disease
- social determinants of health
- implications of ambulatory care sensitive conditions data
- current and projected demographic profile.

Other service planning parameters would include:

- current and predicted service demand and supply
- viability of service provision
- quality of service provision
- strategic priorities and alignment with government policy
- existing infrastructure (including fabric, equipment, information and communications technology (ICT), workforce and other capacity issues).

To support local planning, regional and statewide capacities would need to be in place to commission research, gather and analyse existing data and disseminate findings.

Improving the health outcomes of people requires access to early identification, health promotion and prevention approaches. Enhancing these health support services across the system would balance the investment in the spectrum of ambulatory services, which range from highly specialised clinical services to self-management approaches. Investment should also build on the community's capacity for secondary prevention, that is, early detection and prevention of illness. This could include mobilising resources and providing services that respond in appropriate time frames to maximise and maintain people's capacity to self-manage and function within their community.

Information about people and the services they receive will be consistently managed and coordinated across health care services, to protect privacy and support integrated service delivery and continuity of care.

Ambulatory care services will provide acute and primary episodic care through to intensive coordinated services.

In the first instance, the ACF will develop and incorporate existing services and new programs for specific disease and patient groups, such as cancer services. Over time, the ACF will encourage innovation and development of models of ambulatory care.

ICT will need to provide system-wide capacity for linking and sharing people's health care information to support integration and continuity of care.

Building on HealthSMART and HealthConnect, Victoria can establish centralised shared services that support integration and consistency in service delivery. This will save money as it reduces duplication of effort (for example, through the use of common client data and sharing of intake and assessment data) and fragmentation of information management. In this environment, enrolled consumers with chronic and complex needs could have a summary record available to all health care services (with consent), including the statewide telephone triage service.

A universal electronic referral capability could also be established allowing referrals to and from all types of services in all locations in Victoria. Electronic referrals could be linked to statewide centralised scheduling and waiting list management systems and to detailed client records and event summary information.

Consultation discussion points

- *What mechanisms are needed to effectively plan for integrated ambulatory care services at a population level?*
- *How might the current range of population-based planning approaches be re-cast in light of the needs of the ambulatory care system? (Consider PCP, Primary Care and Population Health Advisory Committees and local government roles.) How could area-based planning be integrated with other planning requirements (for example, metropolitan health service strategic plans)?*
- **Appendix 1** *provides an example of a potential schema for classifying ambulatory care services. How useful is this schema for guiding planning of ambulatory care services? How could it be improved?*

Capability

Health care will be delivered by a skilled workforce resourced to deliver services in a planned and coordinated way.

The workforce will be configured to deliver integrated health care.

New workforce models will need to support the delivery of new models of care and the effective, efficient operation of new service configurations. Workers in the new health workforce will need to be flexible and multi-skilled to deliver care in community and home based settings. A range of staff will be needed to deliver services in the highly specialised hospitals of the future. Effective coordination of care across multiple settings will also be required.

As health care technologies change and develop, the way in which people receive their health care outside of hospital will also change in scope and sophistication. This will require new skills, capacities and ways of working, as well as the development of new workforce roles.

There will be a consistent, planned approach to developing the infrastructure for the delivery of integrated health care, including information and communications technology, standard tools and protocols, facilities and equipment.

Capital investment will enable the expansion of community-based ambulatory models of care. Co-location of services could create efficiencies by bringing together a critical mass of services and reducing the infrastructure and administrative services required.

As noted, the development of systemic information management capacities is critical to integrated health care. A core capability will be the development of a 24-hour statewide telephone triage service that would provide a first point of contact with the health care system. The service would use computerised decision support systems to provide people with information and advice about their health care and appropriate health care options. The service could also provide the first point of contact for people with chronic and complex needs and provide them with additional support through outbound recall and reminder calls.

Consistent staff development, information management and information and communications technology can deliver a standard approach to managing people's care as they move through the system (including standardised hospital admission and discharge procedures, which would support a streamlined transition between acute and primary health care settings).

A mechanism for integrating health care services will be through co-location or clustering within health precincts.

The ACF will provide opportunities to co-locate and integrate centre-based services, outreach and office-based programs, including all relevant Department of Human Services programs together with Commonwealth government, local government, non-government agencies and private providers.

Health precincts are community hubs of local ambulatory care services designed to enable local accessibility and serve as a 'first port of call' for a range of health services tailored to meet local needs.

The service configurations for health precincts will require detailed planning and will be supported through the development of a service delivery framework. This will take into account the interdependence of services and the requirements for sufficient critical mass to ensure efficient, safe and effective service delivery.

Choice of locations for ambulatory care services will depend on a number of factors including site availability, the mix of existing services on existing sites, the capacity to attract private services, local population characteristics and need profile, availability of workforce, accessibility by the general public and capacity for future expansion. In rural areas the focus will be on how ambulatory care services can be delivered through existing facilities.

Consultation discussion points

- *What needs to be done to ensure that there is an appropriate workforce available to support the expansion of community-based ambulatory care?*
- *Under the ACF, capital planning would be done on a geographical basis, for defined populations. What are the implications of this for partnering between agencies?*
- *What are the most important capabilities to focus on? What can be achieved quickly? What will bring the most benefit?*

Collaboration

Health care will be based on funding and accountability arrangements that foster a partnership approach.

Service planning and delivery on a partnership basis will require new models of corporate and clinical governance and mechanisms for increasing transparency and building trust between partners. As one of these partners, the Department of Human Services will continue to review options for funding flexibility and new measures of accountability that reduce barriers to partnering and integration and create incentives for innovation.

The provision of health care will be based on partnerships among levels of government and public and private health care services.

There are currently many examples of the private and public sectors collaborating in informal ways. For example, within public hospitals the private and public sectors exist alongside one another, with senior specialists who provide services in the hospital also running private practices. Some community health services include GPs working alongside as co-located private providers.

In an ambulatory care service system, public-private partnership will be instrumental to achieving person-centred health care. Health precincts in particular will require public and private providers to work together in a 'virtual organisation', delivering integrated services.

Funding and accountability arrangements for the delivery of quality health care services will support the provision of the right care, at the right time, and in the right place.

Funding models are integral to service delivery and supporting change. The current multiplicity of funding responsibilities and models across governments and programs has led to fragmentation, duplication and inefficiency in service delivery, which can be a major barrier to achieving continuity of care.

Implementation of the ACF will require funding and program changes to improve service flexibility and coordination. Funding flexibility is particularly important for services provided to the chronically ill where episodes of care in hospitals will occur during ongoing care in the community or at home.

New funding arrangements that support integration (such as arrangements that support a partnership approach for resource allocation based on population needs) and new systems that are administratively responsive to an integrated service system are also required. New systems should also feature funding and service accountability using common data sets and reporting tools.

Consultation discussion points

- *How can changes to existing relationships, service coordination, organisational structures and funding facilitate a more person-centred ambulatory care system?*
- *How can funding models support service integration, flexibility and coordination?*
- *What kind of incentives can be put in place to encourage innovation, increase transparency and build trust?*
- *How can the ACF foster new or improved public-private partnerships?*
- *What is required to support a 'virtual organisation' between co-located public, private and not-for-profit providers?*

Appendix 1—A possible classification of ambulatory care services

Models of care	Types of services (as described in Appendix 2)	Planning considerations
Ambulatory Medical and Surgical Acute Chronic and Complex Care Frail Aged Care Urgent Primary Care Services generally requiring larger catchments for effective delivery characterised by higher levels of one or more of complexity, specialisation, technology and clinical risk.	<ul style="list-style-type: none"> • Same day medical and surgical • Outpatient services • SACS—specialist assessment and rehabilitation services (specialist) • Palliative care services (specialist) • Aged Care Assessment Services • Mental Health—CATT, MSTT • Case management—chronic/complex unstable • Emergency departments • Ambulance/transport services • Emergency primary care centres (such as walk-in centres) 	Planning for these services should be: <ul style="list-style-type: none"> • based on PCP catchments • coordinated to support planning for services at a regional level in rural areas and for very large catchments. Functional dependencies should be considered in planning facilities and models of care, recognising optimal requirements for effective and efficient services—for example, theatres, diagnostics, pharmacy and procedure areas.
Specialised Ambulatory Care Chronic and Complex Care Management Rehabilitation Services generally requiring a medium-sized catchment for effective delivery characterised by moderate levels of one or more of complexity, specialisation, technology and clinical risk.	<ul style="list-style-type: none"> • Dental • Renal dialysis • Hospital in the Home • Mental health—Adult, Aged, CAMHS, PDRSS • Post Acute Care • Primary maternity services • SACS—rehabilitation (non-specialist) • Palliative approach • Case management—aged care, chronic and complex (stable) 	Planning for these services should: <ul style="list-style-type: none"> • be based on PCP catchments in both rural and metro areas • also consider needs at an LGA level in metro areas.
Routine Ambulatory Care Maintenance and Support Promotion and Prevention Services that can generally be effectively delivered on a small catchment basis characterised by lower levels of one or more of complexity, specialisation, technology and clinical risk.	<ul style="list-style-type: none"> • General practice—routine and chronic and complex • Community health and HACC nursing and allied health • HACC planned activity groups (PAG) and home care • Counselling • Community health—health promotion 	Planning for these services should: <ul style="list-style-type: none"> • be based on PCP catchments in both rural and metro areas but also consider needs at an LGA level • also consider needs at a sub LGA level in metro areas.

The groupings above were identified by considering each service on the basis of three factors:

- ‘complexity’ of the service (based on complexity of interventions, specialisation, level of technology and/or level of clinical risk)
- the average size of the general population catchment to which each service is delivered (based on current numbers of service delivery sites)
- the level of functional interdependence between services (the extent to which one service’s needs closely link with another to support effective service delivery).

It is proposed that a schema of this sort be used to define the core components of an ambulatory care service system and to support planning for the delivery of services on an area basis for defined populations.

Appendix 2—Definitions of ambulatory care services

Aged Care Assessment Services

Aged Care Assessment Services assess the needs of frail older people and facilitate access to available care services appropriate to their needs. A comprehensive assessment by an ACAS may result in ACAS approving the person for entry into a residential aged care service or packaged care (Community Aged Care Packages or Extended Aged Care in the Home Packages) or a referral to other community-based services, for example, those provided by the HACC program or a range of medical or health services.

Alcohol and drug services

These include:

- Counselling, consultancy and continuing care (CCCC)—a range of services and supports appropriate to the needs of clients who have alcohol and drug use problems.
- Continuity of care—seeks to ensure that clients get continuous care when moving from one service type to another.
- Youth outreach—an outreach service provides assessment, support and ongoing case coordination to young people (up to the age of 21) with alcohol and drug problems, in their own environment.
- Dual diagnosis—the Dual Diagnosis initiative was set up to support the development of better treatment practices and collaborative relationships between drug treatment and mental health services.
- Pharmacotherapy (Methadone Regional Outreach Worker and Specialist Methadone Service)—methadone regional outreach workers engaged in the rural regions to support and enhance the role of trained GPs in encouraging, recruiting and retaining opiate dependent persons in treatment.
- Outpatient, Home-based and Rural Withdrawal—provided to clients who have a withdrawal syndrome that can be appropriately managed without admission to a residential service.

Ambulance services

Emergency ambulance services are available to all Victorians who are seriously ill or severely injured due to accident or illness. In Victoria, emergency ambulance services are provided exclusively by the Metropolitan Ambulance Service (MAS), Rural Ambulance Victoria (RAV) and the Alexandra and District Ambulance Service. In addition to their primary role as providers of emergency ambulance services, MAS, RAV and Alexandra also provide non-emergency patient transport services when certified by a doctor.

Case management

Components of case management include assessment, planning, linking of resources, consultation with families and service providers, and crisis intervention as required to specific target cohorts such as aged, disability and the chronically ill. The terms ‘case management’ and ‘care management’ are used interchangeably.

Case management service types include:

- Aged care
Individually planned and coordinated packages of community aged care services targeted to frail older people living in the community who require management of services because of their complex care needs, for example, Community Aged Care Packages (CACPs) and the HACC Linkages program.
- Chronic and complex care—unstable/admitted
Refers to people with a chronic or complex condition who have had one or more hospital admissions related to their condition in the previous 12 months. This category includes clients of the mainstreamed Hospital Admission Risk Program.
- Chronic and complex care—stable/non-admitted
Refers to people with a chronic and complex condition who have not been admitted to hospital in the previous 12 months. This includes clients of multidisciplinary chronic disease management teams in community health services.

Community health services

Agencies in receipt of Victorian Community Health Program funding that also deliver a wide range of other primary health and support services to meet local community needs. This definition includes community health centres and primary health units or divisions of rural and metropolitan health services.

Service types in community health services include:

- allied health
- nursing
- primary medical
- dental
- health promotion
- counselling

Counselling

- Level 1. Adjustment problems

Adjustment to specific problems of living that cause tolerable distress and that will remit over time, for example, grief, divorce, loss, changed life circumstances.

- Level 2. Focal problems

Specific mental health needs responsive to evidence-based interventions, for example, panic attacks, post traumatic stress disorder, episodic depression, problem drinking.

- Level 3. Severe/complex/disabling

People at high risk of harm to self or others (severe) and/or difficult to engage or unresponsive to Level 1 and 2 interventions (complex) and/or with enduring and serious mental health disability.

Dental

Public dental services provide a range of programs including:

- School Dental Service (SDS)—provides regular dental care for all primary school children
- Youth Dental Program (YDP)—provides regular dental care for concession cardholders and their dependants in Years 9 to 12, and for school leavers younger than 18 years of age.
- Early Childhood Oral Health Program (ECOHP)—targets preschool aged children most at risk of dental disease.
- Community Dental Program (CDP)—provides emergency, general and denture services to concession cardholders and their dependants.
- Specialist Dental Care—is provided at the Royal Dental Hospital. The hospital also provides domiciliary (home visiting) service for people who find it difficult to leave their homes, including residential facilities.

Emergency department (ED)

Public hospital emergency departments provide urgent care to patients with life threatening or serious health problems. EDs also provide care to patients with less serious conditions, however, patients with urgent medical needs always take priority.

Emergency primary care centres

A general practice clinic working on an extended hours basis (open on evenings and weekends) specialising in minor injuries and other urgent primary medical care treatment. Such clinics would generally have practice nurse support, observation facilities and access to diagnostics (pathology and radiology).

General practice

General practice is part of the Australian health care system and operates predominantly through private medical practices, which provide universal unreferral access to whole person medical care for individuals, families and communities. General practice care means comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health.³

Home and Community Care (HACC)

The HACC Program funds services that support frail older people, younger people with disabilities, and their carers. They are a range of basic support services that enable people to stay in the community and live as independently as possible. Local governments, the Royal District Nursing Service, Community Health Services, public hospitals, community and voluntary organisations provide HACC services.

Services funded by the HACC Program include:

- Planned Activity Groups (PAG)
- Home care/Home help
- Property maintenance
- Personal care
- Respite
- Allied health services
- Home based nursing

Hospital in the Home (HITH)

Hospital in the Home is the provision of hospital care in the comfort of the person's own home. Patients are regarded as hospital inpatients and remain under the care of their treating doctor in the hospital. Patients may be able to receive all their hospital care in the home or may have a stay in hospital and then receive HITH in the latter part of their treatment. HITH is available to public patients from the 43 participating public hospitals across the state.⁴

Maternity care

Primary maternity care (and some secondary consultation) is provided in the community and ambulatory care settings. *Future directions for Victoria's maternity services*, (June 2004) provides a framework for increased access to primary maternity care.

Mental health⁵

Victorian public mental health services provide comprehensive specialist treatment for people with serious mental illness and/or psychiatric disability. Components include inpatient, community residential and ambulatory services.

Services are age-specific:

- Adult Mental Health Services for people aged 16–64;
- Child and Adolescent Mental Health Services for children and adolescents up to the age of 18 years; and
- Aged Persons Mental Health Services for people aged 65 years and over.

Ambulatory clinical services provide:

- Crisis assessment & intensive treatment on an outreach basis, including determining whether hospitalisation is needed e.g. Crisis Assessment and Treatment Teams (CATT);
- Community treatment & support including assessment and case management, usually appointment based e.g. Continuing Care Teams (CCT), dual diagnosis (mental illness and substance misuse);
- Intensive outreach community treatment & support eg Mobile Support and Treatment Teams (MSTT); and
- Services to assist primary health services treat and support people with less serious mental disorders.

Psychiatric Disability Rehabilitation and Support Services (PDRSS) provide psychosocial rehabilitation for people with a psychiatric disability that assists them to develop skills that will improve their quality of life and independence.

3 Definition of General Practice in Australia, RACGP Online <http://www.racgp.org.au/document.asp?id=6234>

4 Source: Hospital in the Home web page <http://www.health.vic.gov.au/hith/>

5 Source: Victoria's Mental Health Services <http://www.health.vic.gov.au/mentalhealth/services/adult/index.htm>

Ambulatory Psychiatric Disability Rehabilitation and Support Services provide:

- Centre-based programs e.g. psychosocial rehabilitation day programs; and
- In-home programs e.g. home based outreach support, supported accommodation, and planned respite.

Outpatient services

Medical and other services provided by a qualified facility where an overnight stay is not required, such as specialised care, pre and post hospital care and other medical and allied health services.

Palliative care

Care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient and their carers/family⁶.

Victorian palliative care services provided on an ambulatory basis include:

- community based palliative care
- special needs services
- grief and bereavement services.

Post acute care (PAC)

A service provided to people after a hospital admission or emergency department presentation. It provides time-limited, individually tailored packages of supportive care to assist people to recuperate in the community.⁷

Pre-admission

Pre-admission assessment is essential for elective surgical patients. Benefits of pre-admission assessment include:

- accurate information is obtained about the patient, therefore identifying potential risks
- decreases in patient cancellations
- patients are more informed of their surgery
- decreases in late preparation for elective surgery.

Renal dialysis⁸

The maintenance dialysis program can be undertaken in the home, at a satellite centre or in hospital. Maintenance dialysis is distinguished from acute or intensive care dialysis because it is an ongoing life maintaining procedure. The different dialysis modalities are haemodialysis and peritoneal dialysis.

Same-day medical and surgical

Admitted hospital patients who attend for a procedure, intervention or surgery without an overnight stay.

Sub-acute Ambulatory Care Services (SACS)

Sub-acute ambulatory care is non-admitted, goal-orientated, time limited, individualised interdisciplinary care that aims to help people who are disabled, frail, chronically ill or recovering from traumatic injury to regain and/or maintain optimal function, and to allow people to maximise their independence and return to (or remain in) their usual place of residence.

The core services include rehabilitation (specialist and non-specialist) that can be delivered in centre-based or home-based settings and specialist assessment services that include: cognitive dementia and memory services (CDAMS), continence clinics, falls and mobility clinics, pain management clinics, wound management clinics and movement disorder clinics.

6 Source: VAED, 14th Edition. 1 July 2004

7 Source: Victoria's Post Acute Care Program <http://www.health.vic.gov.au/pac/index.htm>

8 Source: Victorian Maintenance Renal Dialysis Program <http://www.health.vic.gov.au/renaldialysis/index.htm>

Glossary

Ambulatory care

Care that takes place as a day attendance at a health care facility or at the consumer's home. This umbrella term incorporates: primary, secondary and tertiary level services, services provided to individuals or populations, services provided on a same day basis and acute episodic or longitudinal care.

Ambulatory care sensitive conditions

Conditions for which hospitalisation is avoidable through prevention and early intervention delivered in ambulatory settings.

Area-based planning

Planning of health care services for local populations in defined catchment areas.

Burden of disease

The burden of disease is the health and socioeconomic cost of a given medical condition on a society.

Chronic and complex conditions

A chronic condition is continuous or persistent over an extended period of time and not easily or quickly resolved. Amongst Australia's national health priorities are chronic conditions that are our greatest burdens of disease: asthma, cancer, cardiovascular disease, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.⁹ A complex condition typically involves co-morbidities and psychosocial factors.

Co-located

Health services sharing geographic facilities.

Community-based settings

These are settings located within the local community.

Diagnostic services

Diagnostic services are provided to patients for testing and screening of illness and injury. These services broadly include imaging and pathology.

Early intervention

A process used to recognise warning signs for health problems and to take early action against factors that put individuals at risk.

Evidence-based practice

Evidence-based health care is the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Consultation with the client is implicit in the process.

HealthConnect

HealthConnect is a network of electronic health records that aims to improve the flow of information across the Australian health sector. It involves the electronic collection, storage and exchange of consumer health information via a secure network and within strict privacy safeguards.

Health precincts

Health precincts bring together, in the one area, a range of health and health related services to create a community hub for service delivery. The range of services available will be flexible, reflecting the needs of local communities.

Health promotion

Health promotion is the process of enabling people to increase control over, and improve, their health. Health is seen as a resource for everyday life, not the objective of living. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. The fundamental conditions and resources needed for good health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.¹⁰

9 Commonwealth Department of Health and Ageing: <http://www7.health.gov.au/pq/nhpa/>

10 Better health channel, Ottawa Charter for Health Promotion http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Ottawa_Charter_for_Health_Promotion?open

HealthSMART

This is Victoria's Whole-of-Health Information and Communication Strategy. HealthSMART aims to improve patient care, reduce the administrative burden on health care professionals and ease the costs associated with updating technical infrastructure within the public health care system by adopting a more standardised approach to information systems.

Integrated care

Care that is coordinated and connected across the continuum of services and amongst providers in all sectors and levels.

Metropolitan Health and Aged Care Services Division

This division is responsible for the full range of health and aged care services in metropolitan Melbourne. It also has statewide policy and program responsibility for acute, sub-acute, ambulance and mental health services.

Person-centred

Delivery of health care configured around the needs of the person.

Population health

Population health is the health of groups, families and communities. Populations may be defined by locality, biological criteria (age or gender), social criteria (socioeconomic status) or cultural criteria (ethnicity).

Prevention

There are three types of prevention: primary, secondary and tertiary prevention. Primary prevention is an active, assertive process of creating conditions and or personal attributes that promote the wellbeing of people. Secondary prevention is early detection and intervention to keep initial problems from becoming more severe. Tertiary prevention is the effort to rehabilitate those affected with severe disorders and return them to the community.

Primary Care Partnerships (PCP)

A PCP is a voluntary alliance of service providers that work together to improve health and wellbeing in their local communities. In Victoria, more than 800 services have voluntarily come together in 31 PCPs (catchments) across the state to progress reforms.

Remote diagnostics and monitoring

Remote patient monitoring (RPM), a subset of telemedicine, includes devices and software that enable health care providers and educators to diagnose, consult with, monitor, treat and educate patients remotely.

Rural and Regional Health and Aged Care Services Division

This division is responsible for the full range of health and aged care services in rural and regional Victoria. It also has statewide policy and program responsibility for aged care, primary and community health, dental health and public health and drugs.

Self-management

Involves engaging in activities that protect and promote health, monitoring and managing of symptoms and signs of illness, managing the impacts of illness on functioning, emotions and interpersonal relationships, and adhering to treatment regimes.

Service coordination

Service coordination aims to place consumers at the centre of service delivery, ensuring that they have access to the services they need, opportunities for early intervention and health promotion and improved health outcomes.

Service planning

Planning that is undertaken periodically with the aim of providing an effective and efficient health service.

Social determinants of health

Social determinants of health are factors in society or in our living conditions that affect our health throughout life, for better or for worse.

Telephone triage

The provision of basic medical assistance and preliminary diagnosis over the phone by a trained medical practitioner using an approved resource, often called a protocol.

Virtual organisation

Virtual organisation arrangements consist of networks of workers and organisational units, linked by information and communication technologies, which flexibly coordinate their activities and combine their skills and resources to achieve common goals but without traditional hierarchical modes of central direction or supervision.

