

Ambulatory Care Services In Victoria

**Development of a policy and
planning framework**



SUMMARY PROJECT BRIEF

1.0 Introduction

The development of an Ambulatory Care Framework (ACF) derives its impetus from a number of recent major DHS policy documents that call for health system reform, in general, and the development of ambulatory services in the community, in particular. These platforms include:

- Directions for your health system: Metropolitan Health Strategy
- Community Health Services: creating a healthier Victoria
- Primary Care Partnerships – Strategic Directions 2004-2007
- Improving the Care of Older Persons
- Integrated Cancer Services Framework
- Mental Health Services – Demand Management Strategy
- Hospital Admission Risk Program

All of these policies herald the need to refocus future growth on building capacity for ambulatory care in the community as a means of improving equity and access to health care, providing more patient centred care, improving efficiency, and managing future system demand. This project seeks to pull together these policy directions to provide a coherent framework and set of enablers for the development of an ambulatory care service system that integrates hospital and community based care across Victoria.

The ACF builds on a long-standing trend in Victoria towards ambulatory care. The development of community based Mental Health Services, the Small Rural Hospitals Strategy, Primary Care Partnerships, the Hospital Demand Management Strategy, the Sub Acute Ambulatory Care reforms, the Integrated Cancer Services Framework, and the proposal to strengthen Community Health Services are examples of initiatives that are facilitating a shift from inpatient care to ambulatory care. Ambulatory care has been seen as a means of improving access to care and improving the efficiency and sustainability of the whole system by providing care closer to people's home and in less institutional ways.

Other jurisdictions have embraced the shift towards ambulatory care: NSW, SA and WA have all undertaken major reviews of their health systems in recent years and all conclude that investment in ambulatory care provides the greatest scope for improving the quality, efficiency and sustainability of the system.^{1 2 3}

2.0 Project Background

2.1 Demand drivers

Despite considerable investment, demand for health services is continuing to grow; placing pressure on the system to respond in ways that will meet changing patient needs. There are a large number of drivers underlying the increasing demand for services, including⁴:

- Increasing average life expectancy and decreasing mortality rates
- Ageing of the population

¹ *Better Health, Good Health Care*, New South Wales Department of Health 2003

² *Better Choices, Better Health*. SA Generational Review, 2003.

³ *A Healthy Future for Western Australians*. Report of the Health Reform Committee. Western Australian Department of Health March 2004

⁴ *Assessment of Wellbeing – Health*, Department of Premier and Cabinet, Victoria 2004

- Shift in burden of disease towards chronic disease and complex conditions (70% of total burden of disease in Australia can be attributed to six disease groups; mental health is third leading cause of ill health in Victoria).
- Medical and technological advances and new drug treatments that will continue to lead to shifts in the types and settings of care delivery (same day separations in Victorian hospitals has grown from 44% in 1995-96 to 54% in 2000-01, largely attributable to growth in same elective surgery).
- Growth in use of technology in health (eg health information websites, health call centres and health telemedicine).
- Consumer preferences for more patient centred care delivered in more convenient, less intrusive ways (eg after hour GP services, mobile outreach nursing and medical services, multidisciplinary teams) .
- Growth in community-based care options, as a substitute for inpatient care.
- Growing cost pressures in health (Australia has the fourth highest expenditure on health of 24 OECD countries).
- Demand for both improved efficiency and improved clinical practice.
- Development of new modes of care that address hospital/community interface issues (eg, care coordination, brokerage funds, hospital prevention programs, disease management programs)
- Demands for reform of the multiplicity of funding and reporting systems to facilitate service coordination and reduce fragmentation between service providers.
- Growing evidence that investment in early intervention, health promotion and primary prevention improves health outcomes and the efficiency of the system.

Many of these drivers are long-term trends that are evident in other developed countries and are likely to continue to drive reform of the health system over the next 10 years.

Overseas studies have argued that the growth in chronic disease poses a particular challenge to traditional health systems that are focussed around acute illness. Chronic diseases are life long progressively debilitating conditions, the treatment of which focuses not on 'curing' but on managing the symptoms and delaying functional deterioration. These studies argue that effective chronic care management requires a reorientation of the system away from resolving acute exacerbations of illness towards the management of health across the continuum of care.

2.2 Project Scope

Ambulatory care is a term used widely to describe care that takes place as a day attendance at a health care facility or at the consumer's home. It covers a wide spectrum of services and includes primary, secondary and some tertiary level services. These services are provided in an array of locations (hospitals, community rehabilitation centres, integrated care centres, community health centres, individual homes, general practice, local government and education settings).

The term 'Ambulatory Care' encompasses two types of care:

- acute, walk in, walk out (WIWO) episodic care
- longer term multidisciplinary care for people with chronic and/or complex conditions

There are concerns that ‘Ambulatory Care’ is hospital and/or acute-centric and does not readily incorporate primary and community health approaches. However, it is the preferred term at this stage because it is a vehicle for promoting efficiency and substitution within the acute health sector. It is also a vehicle for strengthening the integration of care across hospital and community sectors. The term therefore defines the collective ‘turf’ within which hospitals and community based services need to reconfigure their roles and develop shared models of care for the effective management of chronic and complex care conditions.

Figure 1 below shows the breadth and complexity of the current ambulatory care service system.

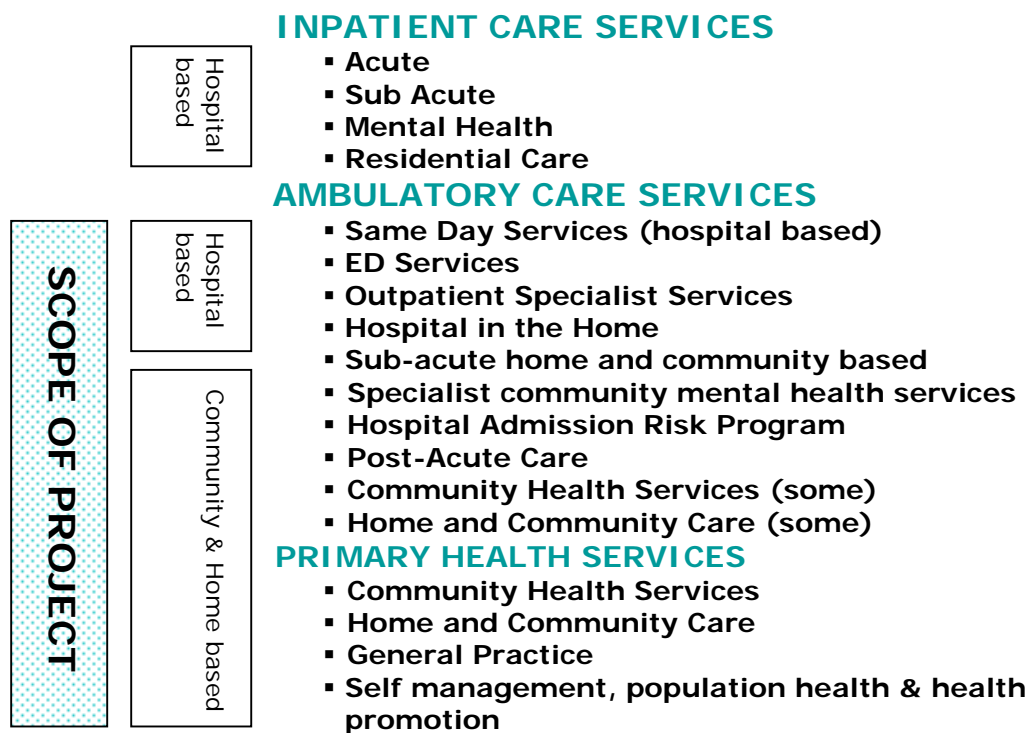


Figure 1. Current Ambulatory Care Service System.

These services are not necessarily provided in the most coherent way to optimise care and health outcomes. These services are funded from various sources, including the Commonwealth, State and local governments, client fees or a combination of these. Within government funding are multiple program lines or funding streams, each with its own funding formula, eligibility criteria and reporting requirements.⁵ The impacts of this ‘system’ on patient care include delays in accessing appropriate services, under and over servicing, inequitable distribution, duplication and inefficiencies in service delivery, fragmentation of care and poorer health outcomes for patients.

These impacts are particularly evident for people with chronic and complex conditions who require multiple services from a range of providers:

“The delivery of services to people with complex care needs is the responsibility of many different health care professionals and organisations across different healthcare sectors, with each being a distinct entity with it’s

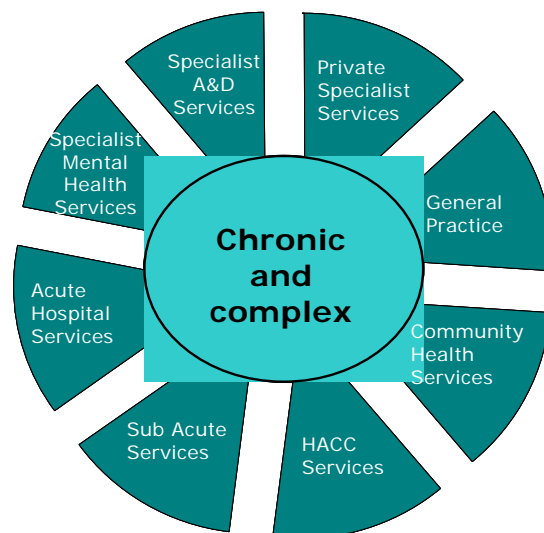
⁵ *Directions for your health system. Ambulatory care services.* Department of Human Services, Victoria 2003,

*own funding mechanism, budget and patient selection criteria. These various components of the system are not always coordinated around patient need and often work in parallel, with separate and distinct responsibilities that both overlap and leave important needs unmet.*⁶

People with complex needs require flexible service delivery with a comprehensive range of services delivered across organisational and programmatic boundaries, and clear assessment procedures, access routes and pathways through services.⁷ They require a system that takes a more proactive approach to supporting them in the community and at home to manage their conditions as best they can all their lives. A whole of system approach is required to integrate care across organisational boundaries and to shift the focus of care from episodic interactions, as acute exacerbations of illness occur, to the management of health across the continuum of care.

The figure below is a simple depiction of what this project is trying to achieve in relation to this target group. It shows that people with chronic and complex conditions require care from a range of providers, the delivery of which needs to be coordinated and planned across these agencies on an ongoing basis.

Figure 2: An integrated ambulatory care service system



The ACF will have a strong focus on chronic and complex care and on improving the integration and continuity of care across the care continuum from early intervention and prevention, diagnosis, treatment, continuing care to palliation.

The ACF is not about introducing a new program that amalgamates services; it is not about adding a new funding stream or a new layer to the system. It is about refocusing and investing in the best mix of hospital and community based ambulatory care services to better meet the needs of current and emerging profile

⁶ *Hospital admission risk program (HARP) Integrated care for clients with complex needs working party report.* Department of Human Services 2003, p1-2.

⁷ *Hospital admission risk program (HARP) Integrated care for clients with complex needs working party report.* Department of Human Services 2003

of consumers. It is fundamentally concerned with integrating the component parts of the system and reforming existing systems, structures and processes to support flexible service delivery and a consumer focussed continuity of care.

3.0 Project Objectives

3.1 Vision Statement

The vision for this project is to improve health outcomes for all Victorians by improving the accessibility, quality, responsiveness, flexibility, continuity of care, capacity and efficiency of the ambulatory care service system through:

- Developing evidence based models of care that focus on the needs of the patient/consumer, integrates services across boundaries, and recognises the importance of prevention and primary health care to improving health outcomes and managing demand for more acute services.
- Strengthening partnering and coordination arrangements across service sectors.
- Aligning funding and reporting arrangements to support integration and flexible service delivery.
- Developing a strategic approach to new capital and recurrent investment in community based ambulatory care.

3.2 Principles

The principles that should guide the development of the framework should include:

- A whole of health approach that recognises the interdependency between levels of service within the system and the brings together the hospital, aged care, community, primary and mental health service sectors to reconfigure capacity to meet changing patient needs and provide improved options for care.
- A commitment to build on existing and successful elements of the current ambulatory system and to optimise use of existing infrastructure.
- A commitment to reform existing State funded programs, structures and systems that inhibit flexibility to optimise coordination of care.
- A commitment to developing client centred models of care that are committed to improving care from the perspective of the individual and those caring for them.
- A commitment to providing care in community settings, wherever possible.
- A population health approach that addresses the social determinants of health and promotes preventive and early intervention to prevent the onset and delay the progression of chronic and complex conditions.
- A focus on improving health equity through prioritising capital and recurrent investment in ambulatory care services in disadvantaged areas in Victoria.
- Recognition that the private sector plays an important role in meeting the health needs of the community and should be encouraged to expand this role, particularly through co-location.

3.3 Outcome objectives

There are three priority outcome objectives for the project that will collectively build a framework for ambulatory care services across Victoria. These are:

- An area based approach to planning.

This work will identify a consistent area based approach to planning ambulatory services, using Primary Care Partnerships catchments as a starting point. For each planning area, the number, type, size, roles and locations of ambulatory care services will be defined, including the location and composition of additional health precincts and super clinics. The work will lead to the development of planning benchmarks and a capital investment strategy to guide the expansion of community based ambulatory care across Victoria. The strategy may involve, in some cases, relocation and/or collocation of services to maximise the potential for service integration and coordination.

- A whole of system approach to delivering integrated models of care.

This work will focus on developing models of care that optimise same day models of care in hospitals and continuity of care across hospital and community agencies. The continuum of care incorporates prevention, early intervention, diagnosis, treatment, continuing care to palliation. The models will be evidence based and include principles, guidelines and protocols for integrating service planning and service delivery across organisational and program boundaries. A key principle underlying these models is that services should be located in the community wherever possible, and integrated around patient needs.

These models will draw on overseas comparative evidence, as well as national and local chronic disease initiatives. These latter include but are not limited to the Hospital Admission Risk Program, Improving Care for Older Persons Policy, Palliative Care Policy, Primary Care Partnerships Strategic Directions, Community Health Services Strategic Directions, and the Integrated Cancer Services Framework

- A set of agreed policies, strategies and incentives to support implementation of an integrated ambulatory care service system.

This work will define the respective roles and responsibilities of service providers and the funding, reporting and partnering arrangements that should be developed to underpin integrated care and flexible service delivery. These roles and relationships may differ for metropolitan and rural and regional Victoria. This work will lead to a set of recommendations on how key enablers of reform (workforce, IT, program structures, funding incentives) can be brought to bear to support the implementation of the new models.

4.0 Enablers of change

Implementation of the framework will require action on a number of enablers of change. These enablers are critical to successfully balancing Victoria's health system and are equally driving some of the trends in health service delivery to which this framework responds. There are six key enablers:

- Broad support for whole of system reform that builds on existing infrastructure and services.
- Information and communication systems.
- Workforce planning and development of new workforce models.
- Capital developments.
- More effective funding of services.
- Commitment to develop and implement a joint change agenda.

4.1 Broad support for whole of system reform that builds on existing infrastructure and services.

As mentioned above, across many areas of the Department there is broad agreement on the direction we need to head. The policy directions detailed in the *Directions for your health system: Metropolitan Health Strategy*, the *Community Health Services – Creating a Healthier Victoria* and *Primary Care Partnerships: strategic directions 2004-2005*, *Improving the Care of Older Persons*, and the *Integrated Cancer Services Framework*, taken together, provide a strong basis for building a system of ambulatory care. The first three of these collectively provide a broad set of enablers to implement this direction.

Under the Metropolitan Health Strategy, a key direction is that ambulatory services will be community based, where possible, and will only be provided at hospital sites where necessary for reasons of safety, quality of care and efficiency. New community-based settings will include the establishment of health precincts and super clinics to build community 'hubs' of services. These 'hubs' will provide an expanded range of ambulatory care services, some of which will be private services and which will enable, by leveraging off collocation, improved sustainability, service coordination and workforce retention.

Victoria's state wide network of 100 Community Health Services (CHS) and the new directions for CHS provide a ready-made platform for providing a comprehensive range of integrated ambulatory care services in the community: from primary health and health promotion services for populations in need; to more sophisticated disease management for people with chronic and complex conditions. Expanding the scope and role of CHS in this way will ensure that investment in early intervention and prevention approaches will continue at the same time as investments in integrated disease management in the community.

The Primary Care Partnerships (PCP) Strategy has had positive results in terms of improved efficiencies; early identification of client needs, improved coordination of a broad range of services and effective integrated health promotion programs targeting priority conditions and at risk populations. PCPs can and do play a major role coordinating services across local populations, they are well connected to their communities and have a track record of achieving concrete changes at agency level. With further investment, PCPs could become a key enabling mechanism for engaging service providers, consumers, carers and communities in the design and delivery of a system for ambulatory care that is structured around the needs of patients.

These policies are, or will shortly be, ministerially approved policies. Capital and recurrent investment in ambulatory care services is already a key theme in the Government's budget for 2004-2005 (eg super clinics, GPs in Community Health Services, public dental health). The existence of a strong policy environment and political commitment to reform is a key enabler for the development of an ambulatory care framework.

4.2 Information and communication systems

Health is probably the most information intense and dependent of all government sectors, yet there is currently less spent on information and communication technology in health than in any other sector.⁸ The development of an integrated ambulatory care system will be dependent on information and communication

⁸ *Whole of Health Information and Communication Technology Strategic Plan 2002-2007*.
Department of Human Services 2003

connectivity and ultimately, on common medical records. This will enable patients and health care professionals to move seamlessly between programs and geographic settings supported by the integration of patient and clinical information.

The *Whole of Health Information and Communication Technology Strategic Plan 2003-2007* details the required upgrade to the information and communication technology across the health system. It will be important to ensure that this Strategic Plan incorporates the requirements of a developing ambulatory care service sector.

4.3 Workforce planning and development of new workforce models

The shift towards delivering ambulatory care services in community-based settings with hospitals becoming increasingly specialised sites using sophisticated technology, has significant implications for the workforce. New workforce models are needed to support the development of efficient integrated models of care. As outlined in the MHS:

*"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."*⁹

Given the current workforce shortages in many areas of health service delivery – surgical, medical, nursing, allied health – it will be important for this project to work closely with stakeholders through Departmental-wide initiatives to develop new workforce models. It will be important to fund the development of pilots to test these new models.

4.4 Capital developments

Strategic planning and investment in capital is required to enable expansion of ambulatory care services, particularly in disadvantaged areas and reconfiguration of the system to support new models of care and renew existing infrastructure. A capital investment strategy to support the provision of sustainable ambulatory care services in the community across metropolitan Melbourne will be developed and a commitment to build three super clinics in the first round has already been made. Capital development priorities in rural and regional areas will be different and will likewise need to be determined and prioritised for funding.

4.5 More effective funding models

Funding models are integral to meeting policy directions and supporting change. As mentioned above, the current multiplicity of funding responsibilities and models across governments and programs has led to fragmentation, duplication and inefficiency in service delivery and is a major barrier to achieving continuity of care across the care continuum. Implementation of the framework will require funding and programmatic changes to be made to improve service flexibility and service coordination. Funding flexibility is particularly important for services provided to the chronically ill where episodes of care in hospitals will occur within continuing or ongoing care in the community or at home. This project will need to work closely with other areas of the department to ensure that program funds are targeted to

⁹ *Directions for your health system. Metropolitan Health Strategy.* Department of Human Services, Victoria 2003

meet the range of ambulatory care services deemed appropriate in specific catchment areas.

4.6 Commitment to develop and implement a joint change agenda

Implementation of the framework will require a commitment of a range of key stakeholders to work together. These stakeholders include patients, carers, clinicians, metropolitan and rural and regional health services, community health providers, other providers, many areas of the Department and the wider community. Stakeholder involvement will ensure that the proposed changes are influenced and owned by patients, practitioners and health service management and are able to be tailored to meet local needs.

Consultation with stakeholders will be crucial to this project and will occur largely through existing mechanisms such as through health service community advisory committees, consultations through PCPs, as well specific consultations with individual services in respect of their strategic plans and with clinical and consumer groups in respect of models of care.

There is broad support across the Department for whole of system reform towards a system that is more preventive, more integrated and more patient centred. The need for service reconfiguration has been recognised and supported by the Government in its investment in practice improvement and substitution and diversion services under the Hospital Demand Management Strategy and in new capital developments such as super clinics and new elective surgery centres. A communication strategy to engage health service professionals, consumers and carers will need to be developed to build broader public support and awareness of the benefits of this direction.

The collaborative advantage to be gained by building a shared direction will mean that the framework for ambulatory care services will not lead to the establishment of unconnected “mini-hospitals-without-beds” in the community but to a person centred, community oriented service system that promotes early intervention and prevention and provides responsive care in the least intensive way possible.

5.0 Potential Benefits of the Approach

The potential benefits of the approach include:

- Stronger roles for families and local GPs in the provision of self care, primary care and prevention.
- More responsive local community health service systems capable of providing a greater range of flexible, responsive and coordinated services, including a more effective response to acute primary care problems, after hours. These systems will “pull” services away from the hospital sector to more local settings and will “push” the development of more patient centred models of care.
- Better capacity for integrated high-end care within local communities particularly for elderly people, people with chronic and complex conditions or people requiring palliative care.
- Improved viability of hospitals by diverting some services to community settings.
- Better demand management across the whole system by facilitating a right care, right place approach to service delivery and removing some of the system barriers to this innovative approach.

6.0 Risks

The risks include failure to ensure significant and continuing commitment from all relevant program areas across DHS, from external stakeholders and from the Government that is required to deliver this project. A risk analysis will be completed as part of the first workshop.

7.0 Costs

Costs estimates will be prepared following the completion of Step 4 above and amended progressively as key tasks are completed.

8.0 Project Governance

The development of the ACF is a joint initiative of the Rural and Regional Health and Aged Care Services Division and Metropolitan Health and Aged Care Services Division. The Ambulatory Care project management team is located within the Primary and Community Health Branch of the Rural and Regional Health and Aged Care Services Division and is responsible for the development of the ACF.

9.0 Communication Strategy

A comprehensive communication strategy will be developed to ensure engagement and consultation with a broad range of stakeholders.

10.0 Conclusion

This project is about implementing a framework to guide the development of ambulatory care services, focussing on building the capacity for care continuity for people with chronic and complex conditions (at the higher end) and proactive, preventative care for people who are at serious risk (at the lower end).

The framework will facilitate the development of sustainable ambulatory care services, particularly in the community, over the medium to long term by:

- replacement of existing inadequate facilities
- reduced fragmentation of service delivery through a consistent strategic area based planning approach and leveraging the opportunity of co-location
- better coordination between hospitals and community services through development of arrangements
- better coordination of State-funded and other health services through co-location
- improved sustainability of services by providing facilities, systems and models of care that enable robust area based governance and service coordination and attract, train and retain an appropriate workforce
- improved efficiency and effectiveness of services through improved opportunities for substitution and diversion to community based health services, rationalised funding arrangements that support integrated models of care and streamlined service administration.
- improved communication protocols between agencies to support service coordination
- creating facilities for the delivery of specialist services to maintain the health status and functional capacity of the community (particularly older people and those with chronic health conditions and disabilities)
- improved access to GP services particularly in disadvantaged areas and in the growth corridors of Melbourne

- providing better value for money through more strategic investment and reduced recurrent costs in supporting multiple facilities (including reduced lease costs as appropriate).

To implement the framework, it will be necessary to change the way services are funded, how they relate to each other and, in some cases, where they are located. It is envisaged, however, that these changes will be incremental rather than transformational. Significant improvement can be achieved by building on existing infrastructure and innovative initiatives already in place or in progress in Victoria.