Ambulatory Care Framework 2012

Prepared by: Health Services Planning Unit
ACT Government Health Directorate
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Executive Summary

The ACT is currently faced with many challenges including an ever growing demand for clinical services. Among these challenges is the need to redesign and grow ambulatory services in a direct response to relieving pressures on the public hospital system.

Ambulatory Care services includes all outpatient, community based services, ambulatory diagnostic services and primary health care services. Ambulatory Care services in the wider community are also referred to as non-admitted services or services that do not require an overnight stay in hospital. The Ambulatory Care Framework is principles based, articulates and facilitates the implementation of ambulatory care strategies which will be sustainable in a rapidly changing health care environment.

The Health Directorate has embarked on a service and facility expansion program “investing in Canberra’s health - the Health Infrastructure Program” (HIP) designed to deliver new hospital and community health facilities, to enable the delivery of new models of care to meet the ACT and surrounding region’s health care needs into the future. As such, it is imperative that this Framework provides a structure for the delivery of Ambulatory Care services across the various service delivery arms of public health care delivery.

To achieve service success and sustain viable operations of ambulatory services, there needs to be a disciplined approach to planning and consistent applications of principles across multiple service delivery areas. Measurable goals also need to be established to monitor progress over time and to address any systemic issues that may arise.

This Framework places the patient first when deciding where services are best delivered. It also describes the ‘how’ to organise and ‘where’ to deliver Ambulatory Care services. Key objectives are stated to guide service delivery and to achieve improved health outcomes for patients and their families over time. The goal is improving relationships through the provision of well coordinated care, whilst supporting patients as much as possible in a community based setting.

This Framework promotes integrated service and communication pathways to enhance patient/consumer/client convenience and accessibility. Consideration of all options available to patients and their families should be at the forefront of ambulatory care planning. This ensures that resources are effectively and efficiently allocated based on priority needs and evidence based practice.

The Background Information to this Framework is collated in a separate document.

A summary page of the Framework is provided as an appendix to enable readers and stakeholders to have an overview of the Framework in a one page printable version. The summary page will also be used by service providers as a quick reference guide for implementing this Framework.
1. Introduction

“Ambulatory Care encompasses services ranging from primary care through to tertiary services. Ambulatory Care has as a principal aim the notion of providing care/treatment in a patient friendly environment, either in a client’s home, or at another location as close to home as possible and does not normally involve an overnight stay in an inpatient facility”.¹

This Framework is about placing the needs of the patient first and for service providers to focus on the patient’s experience and those significant to them while ensuring that Ambulatory Care services options are considered where appropriate. Sustainability of improved access despite population increase and service demand changes across the health sector is also important.

The principles underpinning the Framework are that ambulatory services should be patient and family centred; have a multidisciplinary focus; adopt a collaborative, accessible, safe, high quality and population health approach.

1.1 Purpose of the Framework

The ACT Government Health Directorate Ambulatory Care Framework (ACF) provides direction for the delivery of Ambulatory Care services by:
- identifying the function/role/location of Ambulatory Care services;
- informing facility design, service planning, workforce, technology investments;
- clarifying and progressing governance/coordination arrangements; and
- providing guidance for evaluation in implementing this Framework.

1.2 Scope

The Framework is a key element of a broader planning framework for the delivery of health services. As a Health Directorate document, this Framework covers services provided, funded and influenced by the Health Directorate. Ambulatory Care services especially affect Aboriginal and Torres Strait Islander people’s health when considered in the context of ambulatory care sensitive hospital admissions and the leading causes of death in the community.² This Framework also takes into account the context provided by other service providers and aims to maximize linkages with these services.

The Health Directorate plans, manages and delivers public sector health services to both ACT residents and residents in the surrounding regions of NSW. A steering committee made up of representatives of ambulatory services and other stakeholders including the then ACT Division of General Practice, Community Services’ Directorate, Calvary Hospital and Health Care Consumers’ Association has overseen the development of the draft Framework.

1.3 Vision for Ambulatory Care Services

Residents of the ACT will have better access to coordinated, integrated, and accessible Ambulatory Care services that support highest priority health needs of the community.

Organisation of services will:
- Encourage and support patient and family centred models of care for ambulant clients;
- Arrange appointments where possible to minimise patient inconvenience;
- Better connect hospitals, primary and community based care to meet growing and changing demand for ambulatory services;
- Work towards integrated and collaborative governance models/agreements to maximise the use of available resources;
- Improve and enhance targeted access to services and information that minimises service gaps and user confusion;
- Improve patient and family safety and quality outcomes through collaborative and multidisciplinary care;
- Use communication strategies such as e-health to link providers across all care settings including ambulatory health service delivery sites and improve quality of care for patients and their families;
- Focus on maintaining the wellbeing and independence of individuals in their local community;
- Recognise the importance of, and facilitate positive social connections and support as appropriate;
- Be underpinned by a sustainable and efficient workforce plan.
### 1.4 Guiding Principles

#### Table 1: Principles of Ambulatory Care services

<table>
<thead>
<tr>
<th>Principle</th>
<th>Core Descriptive Element</th>
</tr>
</thead>
</table>
| **Patient and Family Centred** | - Recognition of patient’s expertise  
- Focussed on patient and family needs  
- Care is delivered in the right place, at the right time  
- Care is delivered in an environment conducive to patient comfort  
- Care is coordinated  
- Needs of families and carers have been discussed  
- Respect and promote patient and carer choice |
| **Multidisciplinary and Collaborative** | - Adopt a systems approach to planning services facilitating linkages, integration and coordination  
- The workforce will be configured to deliver integrated care  
- There will be partnerships between levels of government and between public and private health services  
- Organisation of services will support funding and accountability arrangements  
- Service development will support teaching and research |
| **Accessible**                | - Service delivery will be timely, equitable, appropriate and address inequity  
- The community will know what ambulatory services are available, the eligibility criteria and how to access services |
| **Safe and of High Quality**  | - Services will be evidence based  
- Services will be provided locally where there is an appropriate level of demand to ensure service viability, or will be referred elsewhere as necessary  
- Services will be sustainable and cost effective  
- Local access should only be overridden by the needs to preserve quality through critical mass  
- Services will be framed by supportive and consistent communication and infrastructure systems including information technology, standard communication tools and protocols, facilities, equipment and information capability |
| **Population Health Approach** | - There will be recognition of the social determinants of health in the organisation and delivery of services  
- The range of services will include promotion of illness prevention, early intervention and self management  
- There is a need to improve the health outcomes of people who are disadvantage and/or are vulnerable including Aboriginal and Torres Strait Islander people  
- Data will be collected to identify needs in the community |
2. Future Directions

The Health Directorate already has a network of ambulatory services. This Framework profiles and focuses on key elements of Ambulatory Care services. All initiatives and strategies will be directed at fostering the overall sustainability of the health system through the effective management, allocation and strategic investment of resources for the benefit of the patient and their family in community based setting where appropriate.

All service providers will focus on improving care outcomes and experience of the individual patient, informed and supported by specialist clinical knowledge, research, education, information communication technology (ICT) and evidence.

Figure 1: Elements of the Health Directorate Ambulatory Care Framework 2012
## Figure 2 Ambulatory Care Model

<table>
<thead>
<tr>
<th>Level 5</th>
<th>Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Care</td>
<td>Medical specialist coordination or input</td>
</tr>
<tr>
<td></td>
<td>High acuity care required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 4</th>
<th>Specialist Diagnostics &amp; Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>People requiring speciality intervention for a defined period of time but do not require an overnight stay in hospital</td>
<td>Medical Specialist coordination or input</td>
</tr>
<tr>
<td></td>
<td>Case Management</td>
</tr>
<tr>
<td></td>
<td>Diagnostics and/or interventional procedure</td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary team coordination &amp; involvement (including specialist MO, GP, RN and/or AH)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Intensive community case management</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with chronic diseases and complex needs who use health services on recurring basis</td>
<td>GP &amp; Practice Nurse Case Management</td>
</tr>
<tr>
<td></td>
<td>Community Support</td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary team coordination &amp; involvement (including Specialist MO, Specialist RN/RM &amp; Allied Health)</td>
</tr>
<tr>
<td></td>
<td>Access to clinics</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation program (if appropriate)</td>
</tr>
<tr>
<td></td>
<td>Palliative Care (if appropriate)</td>
</tr>
<tr>
<td></td>
<td>Enrolled patient population and information sharing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Usual Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>People requiring health professional intervention with or without chronic diseases and/or complex need</td>
<td>GP/Health Professional Care</td>
</tr>
<tr>
<td></td>
<td>Single issue visit</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation program, access to community services</td>
</tr>
<tr>
<td></td>
<td>Self Management Program</td>
</tr>
<tr>
<td></td>
<td>Enrolled patient population and information sharing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Primary Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Population</td>
<td>For Example, obesity reduction, cholesterol reduction, smoking cessation, etc</td>
</tr>
<tr>
<td></td>
<td>GP Care</td>
</tr>
</tbody>
</table>
3. Strategies for the future

Work has already commenced on establishing the building blocks (refer to supporting documents) for delivering integrated and patient centred Ambulatory Care services in the hospital and community settings. The long term intent is for high quality, coordinated, accessible services meeting highest priority health needs of the ACT community. Patients continue to present with increasing complexity of conditions; most of these conditions can be well managed in a community setting (Figure 3) through multidisciplinary care input and service provision. A number of objectives (Table 2 below) are in place as a reference point for each Clinical Service to work through as they plan the ambulatory component of their care delivery.

Table 2: Objectives underpinning key focus areas

<table>
<thead>
<tr>
<th>Key Focus Areas</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Enhanced Service Coordination and Partnership</td>
<td>To encourage multiple clinical service providers to work together to provide more seamless and coordinated care for patients and their families.</td>
</tr>
<tr>
<td>2 Enhanced Service Range</td>
<td>For the Health Directorate to provide a higher level (clinical) and a broader range (prevention) of health services in the community setting.</td>
</tr>
<tr>
<td>3 Expanded Access</td>
<td>To improve the accessibility of ACT Ambulatory Care services in particular for disadvantaged and vulnerable patients who are not currently effectively utilizing ambulatory based health services.</td>
</tr>
<tr>
<td>4 Redeveloped the Health Directorate Ambulatory Services Infrastructure</td>
<td>To ensure ambulatory care facilities and community health centres are appropriately sized, designed and located to support the articulated model of service delivery and adopt effective communication and information technology.</td>
</tr>
<tr>
<td>5 Strengthened Governance</td>
<td>To support a proactive, regional population based, equity and wellness focus, whilst maintaining highest standards of clinical governance and a balance with Territory wide service delivery priorities.</td>
</tr>
<tr>
<td>6 Workforce Innovation</td>
<td>A flexible workforce able to respond to changing/evolving roles in the provision of Ambulatory Care services.</td>
</tr>
</tbody>
</table>
Figure 3: Where ambulatory care services are provided

(AHS - Aboriginal Health Service, ECHC – Enhanced Community Health Centre, CHC – Community Health Centre, NGOs – Non-government organisations)
With a focus on responding to the needs of patients and their families, the ambulatory service functional structure (refer to Figure 4 below) presents the relationships between patients and service organisation in the provision of Ambulatory Care. This Framework is underpinned by the following structure to steer a whole of service approach through the different Clinical Divisions across the continuum of care for individuals. It supports the repositioning of related services and support/resources infrastructure.

**Figure 4: Organisation of Ambulatory Care Services - Governance and Operational Profile 2012 onwards**
4. **Key Focus Areas**

This Framework has six Key Focus Areas comprising a number of high level initiatives identified in response to the challenges presented during the various planning and policy development processes and in consultation with Health Directorate staff, patients and other stakeholders.

<table>
<thead>
<tr>
<th>Key Focus Area 1</th>
<th>Enhanced Service Coordination and Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population catchment based planning.</td>
</tr>
<tr>
<td></td>
<td>Primary Care Service delivery team approach.</td>
</tr>
<tr>
<td></td>
<td>Health service case management/navigation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Focus Area 2</th>
<th>Enhanced Service Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service relocation and decentralisation.</td>
</tr>
<tr>
<td></td>
<td>Minor treatment centres.</td>
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<tr>
<td></td>
<td>Strengthening prevention and wellness.</td>
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<tr>
<td></td>
<td>The Health Directorate community based health facility delineation.</td>
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</table>

<table>
<thead>
<tr>
<th>Key Focus Area 3</th>
<th>Expanded Access</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increasing capacity for projected growth.</td>
</tr>
<tr>
<td></td>
<td>Outreach/targeting services.</td>
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<tr>
<td></td>
<td>Prioritising the marginalised/disadvantaged groups (incl - Close the Gap)</td>
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<tr>
<td></td>
<td>Incorporating patient experience narratives through Model of Care development.</td>
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<thead>
<tr>
<th>Key Focus Area 4</th>
<th>Redeveloped the Health Directorate Ambulatory Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Redevelopment of all ACT Community Health Centres and ambulatory spaces at public hospitals.</td>
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<td></td>
<td>Improved technology support to enable improved planning, implementing and monitoring of services.</td>
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<td></td>
<td>Improved communication systems such as the Electronic Health Record.</td>
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<td></td>
<td>Improved geographic access.</td>
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<table>
<thead>
<tr>
<th>Key Focus Area 5</th>
<th>Strengthened Governance</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Facility level management.</td>
</tr>
<tr>
<td></td>
<td>Clinical governance.</td>
</tr>
<tr>
<td></td>
<td>Partnership approach with participating organisations.</td>
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<tr>
<td></td>
<td>Flexibility/Innovation.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Focus Area 6</th>
<th>Workforce Innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Targeted recruitment/skills development.</td>
</tr>
<tr>
<td></td>
<td>Primary Health Care teams.</td>
</tr>
<tr>
<td></td>
<td>Workforce redesign.</td>
</tr>
</tbody>
</table>

Table 3: Key Focus Areas
5. Embedding the Framework

5.1 Implementation

The implementation of the Ambulatory Care Framework will be monitored by a cross discipline Ambulatory Care Advisory Committee. The membership of this committee will include representatives from across clinical areas and professional groups, policy and planning, various government and non-government sector stakeholder groups and health consumers.

Strategies and initiatives in this Framework will be embedded into operational Business Plans of each Clinical Division responsible for delivery of ambulatory care services.

The implementation timetable for this Framework is to be confirmed. However, it is acknowledged that work has already commenced in several Divisions across the Health Directorate.

5.2 Monitoring and Evaluation

The Health Directorate will undertake a yearly evaluation of the progress of implementing the Ambulatory Care Framework. The Ambulatory Care Advisory Committee will define priority goals for each year of implementing strategies from the Framework. As the Framework is a guidance document rather than a plan, a draft list of success indicators is presented in Table 4 to guide the monitoring of this Framework’s implementation. It is proposed that the advisory committee develop an Action Plan to identify and prioritise strategies to achieve key success indicators and to monitor any associated key performance measures through the Scorecard Reporting. All planning processes need to demonstrate that a concerted effort is being made to ‘Close the Gap’. Each Clinical Division of the Health Directorate and services funded by the Health Directorate will utilise the Framework to guide the organisation and future proofing of their respective ambulatory care services.

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<table>
<thead>
<tr>
<th>Ambulatory and Community Based Services Focus Areas</th>
<th>Enhanced Service Coordination and Partnership</th>
<th>Enhanced Service Range</th>
<th>Expanded Access</th>
<th>Redeveloped Health Directorate Ambulatory Services Infrastructure</th>
<th>Strengthened Governance</th>
<th>Workforce Innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KEY SUCCESS FACTORS</strong> - Patients with complex care needs can access comprehensive, integrated and coordinated services</td>
<td></td>
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</tr>
<tr>
<td>Improved patient communication, consultation and decision making</td>
<td>Promote ‘wellness’ messages</td>
<td>Prioritised disadvantaged and marginalised individuals</td>
<td>Communicated new ambulatory structure to stakeholders</td>
<td>Demonstrated vertical and horizontal integration of services</td>
<td>Achieved efficiencies in workforce planning</td>
<td></td>
</tr>
<tr>
<td>Increased collaboration with GPs and other primary care providers</td>
<td>Actively engage patients to reduce risk factors</td>
<td>Maximised use of ICT</td>
<td>Communicated and promoted the benefits of Electronic Health Record and centralised intake system</td>
<td>Demonstrated collaboration between service delivery areas</td>
<td>Excell in primary care teams implementation</td>
<td></td>
</tr>
<tr>
<td>Identified disadvantaged and marginalised individuals</td>
<td>Communicated, educated and built capacity to promote healthy lifestyles</td>
<td>Improved understanding of demand for services</td>
<td>Improved geographic access to services</td>
<td>Demonstrated collaboration across government and non-government sectors</td>
<td>Participated in national workforce initiatives</td>
<td></td>
</tr>
<tr>
<td>Implemented Chronic Disease Management and Primary Health Care Strategy</td>
<td>Relocated services to community based environments</td>
<td>Documented clear pathways for engaging acute and complex clients</td>
<td>Ensured standardisation of referral booking and scheduling processes that take account of consumer needs</td>
<td>Translated research into practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitated a seamless service</td>
<td>Defined targeted services</td>
<td>Improved understanding of patient journeys</td>
<td>Established links to community development officer</td>
<td>Implemented innovative strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhanced multidisciplinary approach to care</td>
<td>Reviewed and adopted hospital avoidance strategies</td>
<td>Assessed cost benefit of service relocation and investment in physical infrastructure</td>
<td>Demonstrated effective organisation of services</td>
<td>Targeted recruitment and skills development</td>
<td></td>
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</tr>
<tr>
<td>Maximised efficiencies for staff and patients which can be achieved through collaboration with primary care providers</td>
<td>Reviewed service funding agreements</td>
<td></td>
<td>Formalised agreements to facilitate access to outreach sites</td>
<td>Articulated and well defined accountability pathways</td>
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<tr>
<td>Defined roles and responsibilities</td>
<td>Encouraged cross discipline interactions</td>
<td>Optimised opportunities in redeveloped facilities for more efficient patient flows</td>
<td></td>
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</tbody>
</table>
HEALTH DIRECTORATE AMBULATORY CARE FRAMEWORK: RESIDENTS OF THE ACT WILL HAVE BETTER ACCESS TO COORDINATED, INTEGRATED AND ACCESSIBLE AMBULATORY HEALTH SERVICES THAT SUPPORT HIGHEST PRIORITY HEALTH NEEDS OF THE COMMUNITY

Ambulatory Care Framework

VISON

Your health - our priority

Ambulatory Care Model

Level 5
An overnight stay in a hospital is required

Inpatients
Medical specialist coordination.
High acuity care requir

Level 4
People requiring specialty intervention for a defined period of time but do not require an overnight stay in a hospital

Specialist Diagnostics & Treatment
• Medical Specialist coordination or input.
• Case Management.
• Diagnostics and/or interventional procedure.
• Multidisciplinary team coordination and intervention (including specialist MO, GP, RN and/or AH)
• Intensive community case management
• GP & Practice Nurse Case Management.
• Community Support.
• Multidisciplinary team coordination & involvement (including Specialist MO, Specialist RN/RM & Allied Health)
• Access to clinics.
• Rehabilitation program (if appropriate).
• Palliative Care (if appropriate).
• Enrolled patient population and information sharing.

Level 3
People with chronic diseases and complex needs who use health services on recurring basis

Emergency Care
• GP/Health Professional Care
• Single issue visit
• Rehabilitation program, access to community services
• Self Management Program
• Enrolled patient population and information sharing

Level 2
People requiring health professional intervention with or without chronic diseases and/or complex need

Primary Care
• GP/Health Professional Care
• Supporting a proactive, regional population based focus and a balance with Territory wide service delivery priorities
• Flexible workforce

Level 1
Whole Population

Primary Prevention
• For example, obesity reduction, cholesterol reduction, smoking cessation, etc.
• GP Care

Key Focus Areas

1. Enhance service coordination and partnership
2. Expanded access
3. Enhanced service range
4. Redeveloped Health ambulatory care infrastructure
5. Strengthened governance
6. Workforce innovation

Objectives

• Working together better to provide more seamless and co ordinated care for patients and their families
• Providing a higher level and a broader range (prevention) of health services in the co mmunity setting
• Improving accessibility for disadvantaged aged patients
• Well designed and equipped ambulatory care facilities and Community Health Centres
• Support in a proactive, regional population based focus and a balance with Territory wide service delivery priorities

Ambulatory Care and Operational Profile

1. AMBULATORY SERVICES will be governed and coordinated through Divisions of the Health Directorate

2. PATIENTS enter services of the Health Directorate through a DIVISION

3. PATIENTS access one or several services along the CONTINUUM OF SERVICES through the DIVISION

4. Through the DIVISION, PATIENTS receive the service at one or several SERVICE LOCATIONS

Key: Resource and assignment of responsibilities

Vision

Safety, Quality, Efficiency, Effectiveness

Sustainable Strategies

Rural and Indigenous Areas

Enhanced communication and collaboration between Divisions is required to maximize the use of available resources and achieve operational efficiencies together with patient and family centred care

Focus on care coordination and target most vulnerable

Implementation

Multidisciplinary team approach
• Health Service Case Management and Navigation
• Decentralisation
• Minor treatment centres
• Strengthening prevention and wellness
• Capacity for projected growth
• Prioritising marginalised/disadvantaged groups
• New buildings
• Enhance communication and technology
• Electronic Health Record
• Partnership and co investment
• Flexibility/innovation
• Primary Care Teams
• Workforce design
6. Ambulatory Care Framework 2012
Supporting Documents

September 2012
Prepared by: Health Services Planning Unit
ACT Government Health Directorate
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Abbreviations

ABS  Australian Bureau of Statistics
ACT  Australian Capital Territory
ACF  Ambulatory Care Framework
AHWOC  Australia’s Health Workforce Officials Committee
AIHW  Australian Institute of Health and Welfare
AIP  Access Improvement Program
AMC  Alexander McConochie Centre
CADP  Capital Asset Development Plan
CALD  Culturally and Linguistically Diverse
CALMS  Canberra Afterhours Locum Medical Service
CAPAC  Community Acute and Post-Acute
CBHS  Community Based Health Services
CHC  Community Health Centres
CHI  Community Health Intake
CMD  Chief Minister’s Department
COAG  Council of Australian Governments
ECHC  Enhanced Community Health Centre
ED  Emergency Department
FWE  Full-time Workforce Equivalent
GCHC  Generalist Community Health Centre
GSAHS  Greater Southern Area Health Service
GP  General Practitioner
HACC  Home and Community Care
HIP  Health Infrastructure Program
HITH  Hospital in the Home
ICT  Information Communication and Technology
ILC  Independent Living Centre
IMPACT  Integrated Multi-Agencies for Parents and Children Together
LHN  Local Hospital Network
MHAU  Mental Health Assessment Unit
MoC  Model of Care
NGO  Non Government Organisation
NHCA  National Health Care Agreement
NPA  National Partnership Agreement
NSW  New South Wales
OOS  Occasion of Service
PHC  Primary Health Care
PHRC  Population Health Research Centre
RACC  Rehabilitation, Aged and Community Care
RADAR  Rapid Assessment of the Deteriorating Aged at Risk
WiC  Walk-in Centre
1. Background Information

1.1 Development of the Framework

A Framework is required to develop a common understanding and to state the directions for Ambulatory Care services. This document brings into line the 2006 Ambulatory Care Framework\(^1\), models of care review\(^2,3\), organisational changes at the Territory and Commonwealth Government level and the Health Directorate’s building redevelopment programs.

Ambulatory Care is about the care of patients who are seen in an outpatient and community setting or a client’s home. Ambulatory services cover a wide range of health related services and their relationships with a range of other government and non-government health care providers. This Framework includes services provided in public hospitals outpatient clinics, community health centres (CHC) and outreach centres. Ambulatory services support individuals before and/or after an admission for surgery or medical problem in an acute or subacute/non-acute hospital setting, but most patients do not need to be admitted at a hospital at all.

Like hospital outpatient services, Community Based Health Services (CBHS) are a subset of ambulatory services. The programs range from prevention, early intervention; assessment and referral; acute, post-acute treatment and continuing care services; screening and health education; services for specific population groups; group as well as individual service and delivered by medical, nursing, dental and allied health staff. As such, CBHS should not operate in isolation but be recognised as a critical element of ambulatory service delivery which contributes to the overall functioning of an integrated health system.

Primary care refers to the work of health care professionals who act as a first point of consultation for all patients. Such a professional would usually be a general practitioner. However, at the patient’s discretion and depending on location and service availability, it may be another health care professional such as a pharmacist, nurse or allied health professional.\(^4\) Primary Health Care (PHC) is also an integral part of the health care continuum. Strengthening the linkages within and between the range of ambulatory services to enhance an individual’s experience and encounter with the health system is a key direction of this Framework.

The Framework creates a more inclusive map for the organisation and delivery of Ambulatory Care services into the future. The Framework is presented in a period of organisational reform and health services facility planning to mobilise all Clinical (service delivery) Divisions across the Health Directorate in creating and implementing an integrated, coordinated and evidence based approach for achieving the vision for ambulatory services.

1.2 Approach

The Health Directorate recognises that to achieve the vision, services will need to operate within a coordinated framework, balancing specialty care provision with enhanced cooperation between service providers and the provision of seamless and preventive services. Consequently, this

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\(^1\)The Health Directorate, Draft Ambulatory Care Framework, Australian Capital Territory, 2006 and Ambulatory Care Transitional Plan.


\(^3\)The Health Directorate, Ambulatory Care Centre – Part One Model of Care, Innovation, Redesign and Access Improvement Program, Australian Capital Territory, 2010

\(^4\)The Health Directorate, Draft Primary Health Care Strategy, Policy and Government Relations, Australian Capital Territory, 2011
Framework outlines the new structure for the organisation of ambulatory services including CBHS that will enable a realistic patient centred service.

Due to the significant developmental and organisational changes occurring in the management, funding and delivery of CBHS at the Commonwealth and Territory Government, the detail of which is evolving, the focus of this work is on an overarching framework. The Framework draws out the key objectives and success indicators which will underpin ambulatory services into the future.

Work continues in ambulatory models of care development to ensure optimal patient centred service delivery is achieved as articulated in ‘Towards a patient and Family Centred Model in the ACT’.

The intention of this Framework is to pull the ambulatory care elements of existing plans/models/policies together to assess synergies, barriers, and crosscutting issues such as overarching directions, coordination arrangements, infrastructure, access/equity, technology, workforce and other elements of ambulatory service delivery. To achieve ambulatory system efficiencies, these issues are likely to be beyond the remit of any single program to address; hence the need for this Framework.

### 1.3 Demographic Profile

People of the ACT are generally the healthiest in Australia, with an average life expectancy of over 80 years. Even so, there are inequities in access and outcomes between socio economic groups and there are pockets of disadvantage in the ACT. The ACT Government Health Directorate service providers, policy makers and health planners face challenges in delivering high-quality care due to changing patterns of health service delivery, existing capacity constraints and configuration issues of health buildings, increase demand and complexity of health service delivery. Preparing and equipping the health system to address the projected demographic shifts in the population whilst continuing to improve the efficiency of health service delivery through the building development program, the implementation of e-health and technologies, health service system remodelling and workforce reform calls for a documented Framework for Ambulatory Care. A conceptual approach with statistical and other information relevant for the organisation and delivery of Ambulatory Care is summarised at Appendix C.

Greater balance, understanding and standardisation in resource allocation, organisation of services and health promotion is required between hospital/inpatient care and ambulatory based sectors of the health system. To this end, this Framework will embrace and expand on the evidence and principles of the 2006 Draft Ambulatory Care Framework and Model to ensure that a more cohesive service is able to be delivered into the future for ACT residents.

Aboriginal and Torres Strait Islander people will be affected by this Framework as they interact with different areas of the health system and access services from a range of ambulatory care providers. All planning processes need to demonstrate that a concerted effort is being made to ‘close the gap’. For further demographic information on Aboriginal and Torres Strait Islander people, please refer to Appendix A.

### 1.4 Commonwealth Government Goals

This Framework has been developed during a period of significant Commonwealth and Territory policy reform and development. Primary Health Care (PHC) is considered as the foundation of the health care system and a gateway to other services.
“Primary health care is generally regarded as a patient’s first point of contact with the health care system...in its most highly developed form primary care is the first point of entry into the health services system and the locus of responsibility for organising care for patients and populations over time.” 5,6,7

At a national level, the Australian Government has outlined its thinking for reform of PHC in its National Primary Health Care Strategy. The National Primary Health Care Strategy provides a platform to guide current and future policy and practice in the Australian primary health care sector and offers four priority directions for change in Primary Health Care:

- Improving access and reducing inequity;
- Better management of chronic conditions;
- Increasing the focus on prevention; and
- Improving quality, safety, performance and accountability.

For the purpose of this Framework, PHC is a subset of ambulatory services. To achieve the national PHC objectives,8 the focus in PHC will be regional integration, networks and partnerships, information and technology, skilled and flexible workforce, physical infrastructure to support different models of care and financing system performance.

At the February 2011 COAG meeting, all jurisdictions signed a Heads of Agreement providing for further reform of the national health care system (the 2011 COAG Agreement). The Health Directorate is collaborating with the Commonwealth Government to implement the reforms outlined in these COAG agreements.

‘Local Hospital Networks’ (LHNs) are central to the reformed arrangements, and aim to increase the local accountability and drive improvements in public hospital performance. In March 2011, the ACT Legislative Assembly passed amendments to the Health Act 1993 that provide for the establishment of the ACT LHN and a skill based ACT LHN Council. The ACT LHN will be comprised of the Canberra Hospital, Calvary Public Hospital, Clare Holland House (CHH) and the Queen Elizabeth II Family Centre (QEII). Under the reforms agreed to by COAG, the ACT Government will continue to manage the system-wide public hospital service planning and performance, including the purchasing of public hospital services and capital planning, and will be responsible for the management of the performance of the ACT LHN. A key objective of establishing a LHN in the ACT is to improve the networking and coordination of health services across the ACT.

Another aspect of the COAG reforms will see Primary Health Care Organisations, to be known as ‘Medicare Locals’, established across the nation by the Commonwealth. They will work closely with LHNs and have been described as independent legal entities with strong links to local communities, health professionals and service providers, enabling them to respond more effectively to local need. Medicare Local in the ACT has committed to support health professionals to provide more co-ordinated care, improve access to services, and drive integration across the primary health care, hospital and aged care sectors.

A challenge envisaged for the Health Directorate will be to ensure that Ambulatory Care Services and Primary Health Care organisations/services do not operate in independent silos even though

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they will be governed by different entities. With the introduction of ACT’s Medicare Local in July 2011, the Health Directorate believes that the principles, objectives and structures underpinning this Ambulatory Care Framework, if embedded across service delivery areas, will assist in overcoming existing and potential barriers to integrated care.

1.5 ACT Government Goals

‘... to ensure all Canberrans have timely access to primary and acute health care and that priority is given to early intervention and prevention’.  

The ACT Government is committed to investing in health services to meet the growth in demand for acute, subacute and community based services, ensuring access to the best possible services in the least invasive environment. Programs and services have different funding arrangements. The Home and Community Care (HACC) Program for example was a joint initiative funded by the Commonwealth Government with each State and Territory to provide a variety of community based services that promotes and maintains independence in the community and aims to prevent early admission to a residential facility. These services generally include personal care, respite, home based services, social inclusion and transport, information and referral, and case coordination services. Under the national health reform, the Commonwealth has taken full funding responsibility for the provision of basic community care services under the HACC program for patients over the age of 65 years (Aboriginal and Torres Strait Islander peoples over 50 years) from 1 July 2011 and will have full operational responsibility from 1 July 2012.

Developing and maintaining quality infrastructure is another element of achieving better access and a safe network of services to implement different models of care. The ACT Government’s infrastructure priorities in health are:

- ‘provision of locally based care that meets the needs of the ageing population;
- enhanced productivity achieved through better use of technology and innovative solutions, including different ways of communication and providing care; and
- sustainable health services supported by robust funding mechanisms that are adequate to service our population’.

1.6 The Health Directorate Directions

This Framework provides the direction for a significant shift in how the Health Directorate conceptualises and provides its ambulatory services into the future. AHS are being redeveloped and reorganised to enable a greater focus on prevention, early intervention, respond to the social determinants of health, facilitating continuing care, collaborating with different providers and assisting patients to play an active part in their care plan (self manage).

This Framework draws on and has linkages with broader Commonwealth and Territory Government goals, the Health Directorate’s vision, policies and plans, strategies and initiatives as presented in Table 1. All activities planned under the Framework are underpinned by:

| The Health Directorate’s Vision: Your health our priority |

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9 ACT Government (2008), The Canberra Plan – Towards our second century
<table>
<thead>
<tr>
<th>Commonwealth Government</th>
<th>Health Directorate</th>
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<tbody>
<tr>
<td>• A healthier future for all Australians 2009</td>
<td>• Your Health - Our priority: Capital Asset Development Plan</td>
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<tr>
<td>• Closing the Gap - Prime Minister’s Report 2010</td>
<td>• Corporate Plan 2010 - 2012 (under review)</td>
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<tr>
<td>• Building a 21st Century Primary Health Care System - Australia’s First National Primary Health Care Strategy 2010</td>
<td>• Workforce Plan 2005-2010 (under review)</td>
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<td>• A national health and hospitals network for Australia’s future 2010</td>
<td>• Digital Health Enterprise Technology Strategy 2010</td>
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<tr>
<td>• Primary Maternity Services in Australia - A framework for implementation 2008</td>
<td>• Clinical Services Plan 2012 – 2017 (consultation draft)</td>
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<td>• National Maternity Services Plan 2010</td>
<td>• Adult Corrections Health Services Plan 2008-2012</td>
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<tr>
<td>• National Chronic Disease Strategy (2006)</td>
<td>• Children’s and Young People’s Justice Health Services Plan</td>
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<tr>
<td>• Australia: the healthiest country by 2020: National Preventative Health Strategy</td>
<td>• Health Status of Young People 2011</td>
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<tr>
<td>• Primary Health Care Reform in Australia 2009</td>
<td>• Towards a Healthier ACT : a Strategic Framework for the Population Health Division 2010 - 2015</td>
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<td>• National Mental Health Policy 2008</td>
<td>• ACT Primary Health Care Strategy 2011 - 2014</td>
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<tr>
<td>• National Mental Health Plan 2009-2014</td>
<td>• ACT Chronic Disease Strategy 2008 – 2011 (under review)</td>
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<tr>
<td>• Delivering Better Cancer Care 2010</td>
<td>• Draft Ambulatory Care Framework 2006 (being updated)</td>
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<tr>
<td>• Health and wellbeing of young Australians 2010</td>
<td>• Mental Health Services Plan 2009 - 2014</td>
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<tr>
<td>• National Men and Women’s Health Policy</td>
<td>• Improving women’s access to health care services and information: A Strategic Framework 2010 - 2015</td>
</tr>
<tr>
<td>• ACT Government</td>
<td>• Draft Rehabilitation and Aged Care Plan</td>
</tr>
<tr>
<td>• The Canberra Plan - Towards our second century 2008</td>
<td>• Draft Cancer Services Plan</td>
</tr>
<tr>
<td>• ACT Population projections for suburbs and districts 2009 to 2021</td>
<td>• Condition specific health services plans: Diabetes, Renal</td>
</tr>
<tr>
<td>• ACT Government Infrastructure Plan 2010</td>
<td>• Palliative Care Strategy 2012 – 2017 (consultation draft)</td>
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<tr>
<td>• Young People’s Plan 2009 - 2014</td>
<td>• Reconciliation Action Plan 2012-2015 (consultation draft)</td>
</tr>
<tr>
<td>• ACT Women’s Plan 2010 - 2015</td>
<td>• Alcohol, Tobacco and other Drug Strategy 2010 -2014</td>
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<tr>
<td>• General Practice and Sustainable Primary Health Care - The way forward 2009</td>
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2. Ambulatory Care Framework and Model 2006

In 2005/06, an Ambulatory Care Framework and Model (Figure 1 and 2) was developed. The model focussed on the patient needs, improving access to treatment, minimising hospital admissions, increasing capacity and promoting the primary and acute service interface. Although the 2006 draft Framework is superseded by the 2012 Framework, the strategies remain relevant for the future organisation and delivery of ambulatory care services and are broadened out to encompass the delivery of territory wide public health services delivered to patient and families who access ambulatory care across Health.

A recommendation from the 2005/06 ambulatory service planning process was the relocation of suitable services currently based at a hospital into community health centres. The notion of the 2006 draft Ambulatory Care Framework was, where appropriate, to provide only specialty level services on hospital grounds and thus provide non tertiary/non-acute services in the community setting.

Considerations influencing the identification of hospital services for relocation included:
- level of community demand,
- effective and efficient use of staff time,
- availability of resources, and
- patient safety.
Though this initiative was implemented where feasible, numerous barriers relating to the size and configuration of existing CHC facilities, change management issues and organisational arrangements impeded the full application of the model and the wide ranging outcomes being sought. The 2006 draft Framework and Model has provided the building blocks for the reform in the planning, organisation and delivery of ambulatory care services across the Territory into the future.

Figure 2: Draft Ambulatory Care Model (2006)
3. Health Infrastructure Program (HIP)

The Health Directorate’s capital program (CADP) is now known as the Health Infrastructure Program. The Capital Asset Development Plan in 2009 initiated various processes to inform the redevelopment and building and planning of Community Health Centres. Options to safely and appropriately maximise the number of services that can be moved from the hospital to the community were investigated. The intention is to ensure that only those services that need to be on hospital grounds are on hospital grounds, hence freeing up valuable clinical space for specialty services, and making services more readily accessible to the community. These include renal dialysis, chronic disease management, occupational therapy, cardiac rehabilitation, antenatal care, and a range of speciality outpatient services.

To further support and facilitate integration of services across the Health Directorate, Models of Care for each service area are being developed. These new models of care are needed to ensure that:

- Clinical service delivery is evidence based
- An enhanced environment is provided for patients, staff and visitors
- Patient outcomes are improved
- Costs are managed and contained
- Access and response times are optimised.

The model of care for CBHS has reiterated and confirmed directions for the delivery of services in that each Community Health Centre (CHC) will be shaped to reflect the needs of the local community. Care will be streamlined and provided locally where possible. Connecting and integrating all aspects of a person’s care and treatment with the support of their family and/or community will be a major focus. Community based health services will expand their role in managing chronic and complex patients in the community, assisting people to self manage their chronic conditions, thereby reducing the likelihood of admission to hospital and/or the need for pre and post admission clinical services.

As of December 2011, models of care are at different stages of development in the following areas:

- The Integrated Cancer Care Centre
- Community Health Centres Models of Care
- Women’s and Children’s Hospital
- The Mental Health Assessment Unit
- Acute Mental Health Adult Inpatient Unit
- Canberra Hospital Surgical Assessment Planning Unit
- Canberra Hospital Surgical Short Stay Ward
- Canberra Hospital Intensive Care Unit and the Calvary Critical Care Unit
- Walk-in-Centre
- Canberra Hospital Emergency Department
- Canberra Hospital Ambulatory Services
- Adolescent and Young Adult Mental Health Inpatient Unit
- Aboriginal and Torres Strait Islander Residential Rehabilitation Service
- Positron Emission Topography –Computed Tomography (model of service delivery)
As part of reorganising ambulatory services located on the Canberra Hospital campus, a detailed examination of services was undertaken at the hospital through the development of the Ambulatory Care Centre Model of Care (Part One). It was recognised that new methods of providing health care and facilitating communication between services and providers must be explored to achieve a truly patient and family centred model of service delivery. The relocation of services provided from a hospital campus, ensuring that only those ambulatory care services that must be supported by tertiary hospital facilities will be included in hospital based Ambulatory Care Centres.

This Framework directs clinical divisions to continually identify those hospital based services that can be more appropriately delivered in a community setting.

Your Health – Our Priority outlines the infrastructure and asset capacity required to build a sustainable and modern health system to ensure the safety, availability and ongoing viability of quality health care in the ACT. The building a health future today program is designed to ensure the ACT Government can continue to achieve outcomes in the following key action areas:

- Timely access to better care
- Improved care for the elderly
- Comprehensive services for mental health
- Chronic disease management
- Supporting children and vulnerable families
- Addressing gaps in Aboriginal & Torres Strait Islander health outcomes.

These action areas have a direct link to ambulatory type services.
4. Ambulatory Services Profile

Ambulatory Care Services in the public hospital sector are generally planned services provided as pre or post hospital care as well as ongoing client care through program areas in different locations across the ACT. There are variations in the way ambulatory services are organised, coordinated and provided at the Canberra Hospital, Calvary Hospital and Community Health Centres. The support that patients receive in different settings for the same clinical presentation can depend on available resources rather than clinical need or standardised processes.

While some ambulatory services have for a long time been provided in the outpatient/community setting, new models of care has meant a shift from providing services in a tertiary hospital setting to a community health setting in a number of locations to meet demand and improve the patient’s experience. Among the benefits of increasing community based AHS are that hospital admissions can be averted, earlier discharge from hospitals can take place and accessibility increased for people who are disadvantaged/marginalised.

The Community Health Intake (CHI) telephone based contact centre (located in Civic Health Centre) provides a single access point to a wide range of community based health services and information.

Community Health Centres (CHCs) provide a wide range of community health services to individuals, families and disadvantaged/marginalised groups. There are no formal Information Communication Technology (ICT) links between CHI and hospital based ambulatory care services.

Ambulatory (outpatient) Services at the Hospital also referred to as ‘level 4’ in the Ambulatory Care Model are for: ‘People requiring specialty intervention for a defined period of time but do not require an overnight stay in hospital’. The patient may require ongoing treatment for chronic illnesses, follow-up treatment stemming from an inpatient service, or as a result of short-term trauma and/or illness. The services are provided by medical specialists, nurses and allied health professionals.

Each community based service delivery program coordinates a range of services and initiatives based on the clinical specialty. Despite the comprehensive nature of services, there exists a mismatch between implementing overarching directions in prevention, early intervention, collaboration and reducing inequity due in the main to priority regularly being given to addressing demand from the acute hospital setting. The shift of hospital based ambulatory care services to more appropriate settings, new governance structures and refined models of service delivery is expected to alleviate the mismatch and service gaps.

4.1 Innovative Achievements in Ambulatory Services

With the demand for health service delivery ever increasing, the introduction of a number of initiatives and programs over the last few years in Ambulatory Care Services has had a positive impact on health outcomes of ACT residents. These initiatives and programs will be systematically supported and disseminated as examples of other building blocks for broader reforms. A sample of these achievements is outlined below:

- The collaboration between the Health Directorate and General Practice resulted in the ACT having the highest immunisation cover in Australia in 2010-11.

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• Dental services is targeting the oral health of vulnerable ACT residents in collaboration with the Salvation Army, Communities at Work and a pro bono dentist. At June 2011, 58 patients were receiving treatment or had completed their course of care under this program.
• The IMPACT (Integrated Multi-agencies for Parents and Children Together) Program is a partnership between The Health Directorate, the Office for Children, Youth and Family Support, General Practice and Community Pharmacy to provide intensive and coordinated care for vulnerable families. At June 2011, 51 families were engaged in the program.
• Allied Health enhanced partnerships with local and interstate training institutions, maintaining and extending an active teaching and training program to support the future allied health workforce. The first ever dental student placements in the ACT occurred in 2009-10.
• Following the successful Pilot of Self Management of Chronic Conditions in 2004 to improve the management of chronic conditions and focus on optimal wellbeing, 2009-10 saw a renewed focus on supporting patients to self manage their condition in the community. In 2010-11, 108 participants completed the Living a healthy Life with Long term conditions program. The program is in partnership with Arthritis ACT and SHOUT Inc.
• The women’s health service exceeded its target of 30 per cent of women accessing services being from Cultural and Linguistic Diverse (CALD) backgrounds in 2010-11.
• Increases in demand for community nursing and allied health services were able to be met whilst ensuring that timely access is consistent with clinical need.
• Breastscreen ACT opened a satellite screening site in Woden helping the program to exceed its target for screening.
• The Rapid Assessment of the Deteriorating and At Risk (RADAR) aged service assisted in avoiding admission to hospital for 75 percent of all patients seen.
• Embedding the Care Coordination Model within all Mental Health ACT Community Teams.
• Developing service protocols between Mental Health ACT and Housing ACT to determine support and tenancy management models for the Housing and Accommodation Support initiative.
• The establishment of the Cancer Outpatient Treatment Clinic has facilitated early follow-up of patients in an outpatient setting. This has resulted in earlier discharge planning and has improved continuity of care.
• Mental Health Services adopted a ‘no wrong door’ philosophy to improve the responsiveness of its service to all people who make contact.
5. Why have an Ambulatory Care Framework

5.1 The environmental context

Planning for services is based on a projected demand for services, the priorities of the local community and the context of the health system in which services are delivered. This section details how a number of broad drivers are working to change the environment of Ambulatory Care Services.

Table 2: Drivers for change

<table>
<thead>
<tr>
<th>Issues</th>
<th>Core Descriptive Element</th>
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| Service Fragmentation           | * Service fragmentation occurs in the organisational structure and service delivery culture of ambulatory services  
                                 | * Health services provided are not consistent nor standardised across locations  
                                 | * Services gaps exist between government and non-government health service providers and among government health services providers  
                                 | * Service fragmentation results in increasing number of emergency presentation and hospital admissions                                                                                                                                 |
| Growing Demand                  | * Demand for health services – acute, chronic and preventive is growing.  
                                 | * Population ageing is resulting in growing demand for additional support associated with age, frailty and changing social context  
                                 | * Consumer participation and health provider expectations on what can be achieved will impact on the way health services are designed, organised, delivered and evaluated  
                                 | * There is increasing pressure in primary and community health services workforce and the size, composition and location of the workforce is a key determinant of the capacity                                                                                                                                 |
| Inequity in Access and Outcomes  | * Inequities in access and outcomes in terms of socio economic groups and geographic location to both hospital and community based care persist  
                                 | * There are no standardised rationale underpinning services provided to the main target groups for all public Ambulatory Care services  
                                 | * There is a need to better address the determinants of ill health and inequality in access to health care services  
                                 | * There is a need to secure service provision for disadvantaged patients who need access to health care and require to be seen by the right people with the right skills, in the right place and at the right time.                                                                                                                                 |
| Changing Disease Profile        | * Although people are living longer and are healthier on the whole, not all years gained in life expectancy do people remain in good health  
                                 | * Chronic disease is posing a significant burden on the health budget and there is considerable demand for broader range, innovative and more efficient services                                                                                                                                 |
| Workforce/service Innovation    | * A more flexible and well-trained workforce able to respond to changing roles in the provision of Ambulatory Care services  
                                 | * Collaboration between tertiary education sectors, Vocational Education Training Services and The Health Directorate to respond to changing workforce demands and provide a ready to work workforce for diverse specialty areas of primary care  
                                 | * Staff resourcing appropriate to meet level of demand for ambulatory services                                                                                                                                                                 |
| Emerging Models of Ambulatory Health Service Delivery | * International, national and local initiatives proven model of care focussing on prevention of illness, early intervention and primary health care to better manage health problems through Ambulatory Care services.                                                                                      |
5.2 The literature evidence

“Healthcare reform initiatives and advancements in patient care and treatment will ensure not only that ambulatory services will continue to grow, but also that they will move closer to the centre of care delivery within hospital systems, rather than being offered as an adjunct to inpatient services”. 15

Future ambulatory services needs to be modified and adapted to respond to the changes in the demographic profile and burden of disease facing the community. Based on the latest National Health Survey, an estimated 80% of Australians had a long term condition.16 Enhanced integration and coordination of ambulatory services will enable people living with chronic conditions to take a more active role in the day to day management of their condition and its impact on their life. A truly integrated ambulatory service will also facilitate and improve the utilisation of available resources.

Table 3: Evidence that supports proposed changes

<table>
<thead>
<tr>
<th>Principle</th>
<th>Evidence</th>
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<tbody>
<tr>
<td><strong>Patient Centred</strong></td>
<td>● Patient centred approaches have a range of clinical benefits including improving health outcomes, adherence to medication regime and reducing anxiety.17</td>
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<td></td>
<td>● Recognising the cumulative effect of small co-payments for a range of services which can be a major challenge on client resources, particularly those with chronic/long term health conditions.18</td>
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<tr>
<td><strong>Multidisciplinary and Collaborative</strong></td>
<td>● The positive health outcome achieved from care coordinators, for individual patients with chronic illness, who assist with accessing appropriate services and self management support (often with multidisciplinary support).19</td>
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<td></td>
<td>● Australia has significant shortages in the primary health care workforce, as well as difficulties with recruitment and retention in areas of workforce need. In 2010-11 there were 65.6 GP FWE per 100,000 people in the ACT compared to 91.5 FWE for Urban Australia.20</td>
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<td>● The benefits of the strategy of encouraging GPs to work with allied health to form primary care teams by either physical co-location in Community Health Centres (Victoria, New South Wales, South Australia) or virtual linkages (shared care).21,22,23</td>
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<td>● Diabetes patients who adhered to a multidisciplinary care plan had improved metabolic control and cardiovascular risk factors. 24,25,26</td>
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<td></td>
<td>● Benefits of nurse led services for general and minority populations. 27,28,29</td>
</tr>
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</table>

26NZwar et al, ’Do multidisciplinary care plans result in better care for patients with type 2 diabetes?’, Australian Family Physician, Jan 2007, Vol 36, No1/2, pp 85-89.
<table>
<thead>
<tr>
<th>Principle</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible</td>
<td>• Funding approaches drive provision — this can lead to models that are not appropriate for patient needs and circumstances.</td>
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<td></td>
<td>• Australia National Evaluation of Second Round Coordinated Care Trials, Mainstream trial findings = Patient Outcomes; Evidence of improved access to services, improved self-reported health and well being, and improved empowerment. Community: Given knowledge and access to range of community care options, personal and community responsibility for health increases. Efficiency: Increased overall health awareness, diagnosis, and self management which may lead to a reduction in hospitalization (inpatient), and if the trials operated longer, total intervention costs would probably have fallen below control costs, and may have absorbed the costs of care coordination.30</td>
</tr>
<tr>
<td>Safe and High Quality</td>
<td>• The negative effects of service fragmentation and conversely the positive effects of strategies to reduce service fragmentation.31, 32</td>
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<td></td>
<td>• The importance of matching enhanced clinical governance of community health facilities as hospital services are devolved.33</td>
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<td></td>
<td>• At least some of the expected growth in hospital based care services has the potential to be managed in settings and modes other than hospitals.34,35,36</td>
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<td></td>
<td>• Pathways into and out of services need to be clearly defined, communicated and managed.</td>
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<tr>
<td>Population Health Approach</td>
<td>• Demand for health services — acute, chronic and preventive is growing. Demand projections suggest a significant and growing demand for all levels of care.37,38,39,40</td>
</tr>
<tr>
<td></td>
<td>• Social research for the ACT suggests that compared to higher income groups, the lower income quintiles in the ACT have worse health status; higher levels of disability/long term health conditions; more difficulty accessing services; less able to get support in times of crisis; and lower levels of general trust and trust in the health system — doctors and hospitals.41</td>
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<td>• There is a need to develop a systematic approach to involving community organisations/groups/ members in the identification and addressing of local health problems. 42,43,44</td>
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<td></td>
<td>• There are benefits when local health services are responsible for coordination and delivery of services to enrolled population.45</td>
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26 Queensland Health, Community Health Services Reform Project; Literature Review July 2007, page 1, 31.  
33 S Maslen, Marginalised and isolated women in the Australian Capital Territory, Women Centre for Health Matters Inc, February 2008.  
6. Redesigning the Health Care System

For the Health Directorate this new future is requiring a re-orientation in how it plans, targets, and provides Ambulatory Care. It will also require new governance arrangements, and a substantial investment in the infrastructure, communication and information technology and workforce for Ambulatory Care.

The Health Directorate through its Divisions and Branches will take a leadership role in the development of a structured approach (Figure 4 ACF) to regional population catchment based health planning. Central to this new way of working will be an enhanced role for ACT Community Health Centres.

Planning in Community Health Centres across Canberra will be premised on a social model of health, facilitated by inter-sectoral collaboration and adopting solutions focussed approach. Through the employment of Community Development Officers, the Health Directorate will encourage health related, non-government and social organisations in that catchment to work together to meet identified health needs. Referrals for Ambulatory Care Services will be processed through a centralised intake system.

Into the future, each Clinical Division will be supported by specific ambulatory services initiatives in the areas of health promotion, communication and information management and workforce planning, re-design and change management by the Corporate Branches of the Health Directorate to implement the strategies articulated in the Framework.

This Framework:
- provides direction for the what, how and where of Ambulatory Care Services;
- ensures the sustainability of its services into the future from the directions provided;
- outlines a strategically focussed package of initiatives designed to significantly enhance the level of cooperation and interaction within and between services across the Territory; and
- plans for a higher quality, more patient centred and seamless service to patients and their families.

The Health Directorate will continue to improve the individual’s health care experience across the continuum of services across different settings and by diverse health professionals. Some initiatives and activities areas have been developed in response to the issues and drivers for change to achieve the objectives being sought from this Framework. These are outlined under each focus area in the following chapters.

6.1 Enhanced service coordination and partnership

The call for enhancement of service coordination and partnership is supported by a number of Commonwealth Government and Health Directorate policy Frameworks including Primary Health Care Strategy, Population Health Strategy and ACT Chronic Disease Strategy. The Health Directorate would encourage/facilitate a primary care service delivery team approach to provide holistic multidisciplinary care to patients requiring a diverse range of support (expanded in Appendix C).

In relation to GP services, the Health Directorate will work in partnership with GPs to maximise access to disadvantaged individuals through shared care type arrangements. Linkages to primary
health care services provided through General Practice, non-government organisations and other professionals outside the Health Directorate will be strengthened. Given that the funding of GPs to provide generalist primary care services is a Commonwealth Government responsibility, the Health Directorate will only be involved where significant local gaps are identified such as the Canberra Afterhours Locum Medical Service (CALMS).

Each CHC will focus on the health of its population catchment allowing for local variation in services provided and supported by a community development officer to bridge communication gaps between different levels of primary, community and acute services. A number of services will continue to be delivered in outreach centres such as Schools and Child & Family Centres or the patient’s home.

It is envisaged that the role of Hospital In The Home (HITH) will expand into the future. Intravenous infusion therapy of antibiotics, total parenteral nutrition, chemotherapy, analgesia, home ventilators, oxygen therapy, home-based imaging, and telemedicine monitoring of chronic disease can be deployed by a HITH service to treat acute illness in lieu of an acute hospital admission. Home monitoring has been demonstrated to improve the mental and physical needs of the elderly and chronically ill, and assist them to remain out of hospitals and other institutions.

The Health Directorate home based telemonitoring service was established in 2010. The service provides selected patients who have chronic disease conditions with home telemonitoring equipment which enables them to record clinical measurements at regular intervals. These clinical measurements are then monitored by Health Directorate’s clinicians and appropriate interventions are undertaken by, or in consultation with, the patient’s specialist. The service is set to grow to meet the increasing demands of people living with chronic and complex conditions.

The Health Directorate will collaborate with the ACT Medicare Local in implementing Close the Gap project.

The Health Directorate will further explore innovative models of care and partnerships/leverage approaches with primary care providers to achieve enhanced service outcomes for patients. There is an emerging body of evidence\(^{46, 47}\) that a restorative approach to home based care has significant advantages over the traditional approach aimed at maintenance and support only. The combination of timely interventions, education, healthy ageing approaches and assistive technologies is especially relevant in planning the care and discharge of frail older adults and assisting them to resume independence and activity.

Health service case management/navigation is hindered by service complexity and fragmentation, the multidisciplinary requirements for effective prevention and management of chronic disease, and the opportunities for improved efficiency of, and access to, health services through the greater involvement of broader health service delivery organisations. Providing a seamless service system is a priority across many service programs. Hence, in order to encourage multiple Clinical Divisions to work together better so as to provide more seamless and coordinated care for patients, several strategies/future directions are being designed and implemented. The Health Directorate has a solid foundation from which to build and will expand the options for better defined, collaborative and integrated care in the future.

\(^{46}\) B Ryburn, Y Wells, P Foreman, Enabling independence: Restorative approach to home care provision for frail older adults, 2009, Health Social Care Community.

6.2 Enhanced service range

Against the principles of the 2006 and 2012 Ambulatory Care Framework, the Health Directorate plans to relocate appropriate ambulatory services from hospitals to community health facilities. Establishing linkages across the whole of ACT Government, with the Australian Government, with non-government organisations, patients and carers and facilitating reciprocal access with social support services will better maintain an optimum state of wellbeing for Canberra residents.

The Health Directorate has implemented a Walk-in Centre (WIC) health care model facilitated by appropriately skilled nurses at the TCH campus. The service provides a fast free one-off treatment for minor injuries and illnesses. The locations and possible expansion of Walk-in Centres will depend on the review of the service pilot.

The adoption of ‘wellness’ as a way of working across all the Health Directorate community health sites involves a focus on keeping people well and addressing lifestyle issues before they become symptomatic through multidisciplinary primary health care facilities that address lifestyle determinants of health.

Through the Health Improvement Program, there are a number of initiatives aimed at early prevention and reducing risk factors. These include establishing healthy habits in children, the Breastfeeding Strategic Framework, Kids at Play Active Play and Eating Well project, SmartStart for Kids, Active phase for Go for 2&5, the Aboriginal and Torres Strait Islander Tobacco Control Strategy, Healthy at work program and Stamp Out Chlamydia awareness campaign.

The Health Directorate Promotion Grants program aims to improve the health of people in the ACT by encouraging health promotion partnerships and supporting targeted programs that promote and facilitate healthy lifestyles, policies and environments; and build the capacity of individuals, groups and communities to make healthy choices. There are four separate funding rounds:

- The community round promotes health and wellbeing
- The Stay on your Feet Falls Prevention round
- The Healthy Schools Healthy Children round
- The Health Promotion Sponsorship

Through the National Partnership Agreement (NPA) on preventive health, the Commonwealth Government is providing funds to the ACT Government to deliver interventions for children and young people that promote healthy lifestyles. The portfolio of projects and campaigns will be announced in the coming months through the Health Directorate Children’s Initiative. Whilst most proposed initiatives target the whole population, there are also specific programs that target at risk groups. The strategies to be used include communication, education, capacity building and policy development.

A new subacute facility will be built on the north side of Canberra as part of the Health Infrastructure Program. With the completion of the new Northside Subacute Hospital, the Territory will have a network of three public hospitals with clearly delineated roles. The Health Directorate has commenced the services planning process which aims to identify the full range of services and support services to be located in the new Northside Subacute Hospital, and how these services will operate in a seamless and integrated manner with the two acute hospitals and the community health centres.

It is envisaged the Community Health Centres will become highly visible and valued community institutions that:
• proactively reach out to identify community health needs and to work with the community and a broad range of social and health service provider organisations to meet those needs;
• are resources to the community to increase the health literacy and capacity of the community to enter and successfully navigate the health system;
• provide valued and valuable services that both prevent illness, and minimise the need of the community to travel further (particularly to hospital) for pre/post acute services; and
• have a particular focus on the most disadvantaged to reduce exclusion and social disparities.

Community Health Centre Delineation

Effective organisation of clinical services is achieved where each CHC has a clearly delineated role. Role delineation sets the infrastructure parameters required to deliver a range of services. The new delineation of ACT Community Health Centres has been developed to support the new approach proposed in this Framework. This is summarised below:

• “Generalist Community Health Centres” will be Gungahlin, Tuggeranong, and Civic. Dickson would continue to be smaller/more focussed health centre for the Inner North Canberra, with the Narrabundah based Winnunga Nimmityjah Aboriginal Health Services providing access for Inner South residents to outreach services.
• “Enhanced Community Health Centres” will be the location of the more specialised services that require high cost/scarce resources (staff and equipment) and/or only have demand to justify provision in one or two sites. These will be at Belconnen and Phillip.

Village Creek provides a specific range of age and rehabilitation related services. The individual service delineation and revised role is a work in progress for some specialised services. The future location of some services is yet to be determined through planning and assessing capacity for clinical networking, to ensure that there is an appropriate level of demand for ongoing clinical competence. Sustainable service levels that best meet the needs of the community can only be achieved through improved alignment and networking of clinical streams across clinical service delivery sites.

Beyond each community health centre, there will also be a requirement for a broad range of outreach sites for the delivery of specific services and activities. These sites would vary between services and could include community/neighbourhood centres, schools, shopping centres, local pharmacies, family/child centres and GP clinics.

The defining feature of these outreach sites is that there needs to be flexibility to meet the needs of different services and to respond over time as population needs change. It is not intended that the Health Directorate would be building nor owning its own facilities at this level, rather working and partnering with other government and non-government organisations to integrate better with the community.

6.3 Expanded Access

Health services provided in the ambulatory care setting will expand to respond to the projected increase in acute and complex patients and assist with the self management of chronic conditions.

The Health Directorate will proactively reach out to disadvantaged/marginalised groups and individuals in each health centre population catchment. Within the Health Directorate, services giving priority for the provision of services to the marginalised/disadvantaged will ensure that services do reach those that have historically had poor access. For example, since January 2011,
the ACT Women’s Health Service has changed its priority focus to target women who experience significant barriers to accessing services elsewhere.

An Aboriginal Health Impact Statement was developed in this planning process (Refer to Appendix A).

### 6.4 Redeveloped Health Directorate Ambulatory Infrastructure

Further work is required on establishing criteria and processes for engaging patients. The processes need to be clearly articulated for patients, staff as well as other service providers. This approach is to ensure consistently applied and responsive models of service provision.\(^{48}\)

All ACT Government Health Directorate ambulatory care facilities will be redeveloped to provide for increased patient load, allow more efficient patient flows and to encourage where appropriate cross discipline provider interaction. The programmed plan of replacement / refurbishment of the current ACT community health facilities under HIP will facilitate the Ambulatory Care Framework adoption process. High quality, accessibility and the integration of services are key aims of the Framework. Information communication technology systems must be designed to support these aims. The HIP Information and Communication Technologies (ICT) comprise a patient record system, clinical decision support systems, support services and Digital Infrastructure.

The establishment of an electronic health record will:

- Help facilitate improvements in the quality of care delivery through the delivery of accurate and trusted patient health information made available to the right person at the right place at the right time to enable informed care and treatment decisions in an efficient and timely manner;
- Enable health care providers within the Health Directorate to link to other health care providers in the ACT and beyond, to care for patients as a virtual health care team;
- Enable patients to have electronic access to their health information so that they can participate in their care planning and treatment regimes; and
- Reduce the need for patients to repeat their health related information each time they present to a different point of care or visit a different health professional.

The Health Directorate Services Directory project will develop a single trusted source of provider and health care services information for the ACT and surrounding regions. This information will be made available to all Health Directorate patients, the Health Directorate providers and staff and non-Health Directorate providers via the internet.

Operational policies and practices will be underpinned by assisting the general population to understand, navigate and use the health system in the right environment (health literacy). A principle of this Framework is that the community will know what services are available locally and how to effectively access them.

### 6.5 Strengthened Governance

To achieve longer term sustainability and to establish a truly integrated service system, partnerships and collaborative practices are required between services regardless of their funding base, governance or location. Patients and families of Ambulatory Care services may require access to many or only one of the services available as part of the care continuum.

\(^{48}\) The Health Directorate, Towards a patient and family centred care model in the ACT, Australian Capital Territory, 2010.
Facility level management of the Health Directorate Community Health Centres will be strengthened to enable whole of centre management, cross disciplinary interaction and learning. Clinical governance of each program area will remain with the Division and be vertically and horizontally linked from each Clinical Division through the relevant professional group.

A collaborative approach will be adopted between the Health Directorate and participating government or non-government organisations whereby organisations voluntarily (governed by a Memorandum Of Understanding as appropriate) come together to conduct agreed activities and ways of working, but maintain separate governance and funding streams whilst achieving best value for investments.

The whole HIP process foundation is that all planning emphasise flexibility and innovation to accommodate future models of care, technology and change. Health is a dynamic environment which needs to continually respond to changing challenges and emerging evidence. Greater flexibility in the way that services in the health system are planned, implemented and evaluated allows for changes in the population and disease profile, addresses the economic, social and cultural realities of individuals and groups in the community, ensuring that appropriate services are delivered to patients, their families and carers.

### 6.6 Workforce innovation

Sustaining the range of health care provision at current levels, further expanding some services and introducing new services will require substantial workforce redesign and modernisation. National and international shortages in many health professions are driving a review of how health services conduct business. In addition, a shift towards service models that emphasise prevention, primary, community and home based services requires education strategies and new training modules to integrate new skills as they emerge. Service providers need to work together to redefine professional roles and build a workplace that supports patient and family centred care and enhances collaborative practice.

Ambulatory Care services development needs to include mapping of the workforce in the current hospital based ambulatory and community based services setting to determine existing workforce roles, identify workforce demographics, identify any workforce issues that impact on recruitment or retention and identify opportunities to use the workforce more effectively.

Services need to be resilient, proactive, sustainable, flexible and cost effective. Roles and responsibilities in the workforce need to meet increased complexity of patient needs and evidenced based service models (for example Primary Care Teams need to include GPs, nurses and midwives, allied health professionals and non-government supports). Consumer needs and new technologies will inform the development of new or expanded roles and changes in models of care.

Lifting the recruitment rate, retaining experienced staff and ensuring that succession planning is in place will facilitate diversity in the workforce and preserve knowledge and skill within the service. Strategies also need to be developed to reorganise work to minimise duplication across sites and to make best use of available staff. Where appropriate and practicable, develop client/carer self care and self monitoring initiatives. Creating new professional/practitioner or assistant roles and extending existing roles and scope of practice will provide greater workforce flexibility.

The role Ambulatory Care services plays in teaching and exposing students to patients with a range of conditions who are no longer managed in the inpatient setting should be flagged as an
area that requires further exploration in the area of workforce education and innovation as is the role of the student in helping to meet service needs whilst on clinical placement.

A number of national health workforce initiatives are occurring, including a new National agency; Health Workforce Australia which has a mandate to assist workforce supply of health professionals across Australia. A single national registration and accreditation system has also been set up for ten health professions, with another four professions to join in 2012. They include Aboriginal and Torres Strait Islander Health Practitioners, Chinese Medicine Practitioners, Medical Radiation Practitioners and Occupational Therapists. This new arrangement will help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce. The Australian Health Workforce Officials Committee (AHWOC) has developed a health workforce impact checklist.
7. References/Bibliography


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Appendix A – Aboriginal and Torres Strait Islander Health Impact Statement

Title of Strategy/Policy/Program

Draft Ambulatory Care Framework

Unit Responsible for this Impact Statement

Health Services Planning Unit, Service and Capital Planning Branch

Please describe how and why Aboriginal and Torres Strait Islander people in the ACT will or will not be affected by your strategy, policy or program.

‘Ambulatory Care encompasses services ranging from primary care through to tertiary services. Ambulatory Care has as a principle aim the notion of providing care/treatment in a patient friendly environment, either in a client’s own home, or at another location as close to home as possible and does not normally involve an overnight stay in an inpatient facility’.49

Aboriginal and Torres Strait Islander peoples will be affected by this Framework as they interact with different areas of the health system and access services from a range of ambulatory care providers. It has been reported that there are ambulatory care sensitive conditions which if targeted in the Aboriginal and Torres Strait Islander community, can improve health outcomes for individuals.

The target population:

In 2009, there were 4,599 Aboriginal and Torres Strait Islander ACT residents. The Aboriginal and Torres Strait Islander population is relatively young, with a median age of 21 years compared with 37 years for the non-Aboriginal and Torres Strait Islander population. This is largely the product of higher rates of fertility and deaths occurring at younger ages among the Aboriginal and Torres Strait Islander population (ABS 2004c). As more people live to older ages, the prevalence of chronic diseases and associated co-morbidity will increase markedly. This changing pattern of disease will create greater diversity in the care needs of Aboriginal and Torres Strait Islander peoples.

Table 1: Aboriginal and Torres Strait Islander Population Australian Capital Territory

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Aboriginal &amp; Torres Strait Islander population</th>
<th>Proportion of Australian Aboriginal and Torres Strait Islander population (%)</th>
<th>Proportion of jurisdiction population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>4,599</td>
<td>0.8</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Source: ABS 2009

Aboriginal and Torres Strait Islander peoples are culturally and linguistically diverse. Their proximity to services, and the physical and social environments in which they live, impact on their wellbeing and capacity to prevent and manage serious illness. Between 1996 and 2006, there has been a large shift of ACT’s Aboriginal and Torres Strait Islander population to

49 ACT Health (2006). Draft Ambulatory Care Framework
Queanbeyan.  Whether or not this cohort is still accessing health services in the ACT is difficult to assess and quantify. It was noted in a Chief Minister’s Department (CMD) report that at the 2006 Census that there were 5,809 Aboriginal and Torres Strait Islander people in the Australian Capital Region (not including the ACT). This is important for planning purposes as the target group often cross into the ACT for family, services and employment.

Life expectancy for Aboriginal and Torres Strait Islander Australians (2001) was 59 years for males and 65 years for females, compared with 77 years for all males and 82 years for all females, a difference of around 17 years. In 2010, the gap has been revised to 11.5 (67.2) years for Aboriginal and Torres Strait Islander men and 9.7 (72.9) years for Aboriginal and Torres Strait Islander women. The ABS cautions that comparisons between the original and revised estimates should not be interpreted as a change in Aboriginal and Torres Strait Islander life expectancy, but should be seen as the result of a revision in statistical methods used to calculate life expectancy.

Aboriginal and Torres Strait Islander people health profile:

Aboriginal and Torres Strait Islander people experience significantly more ill health than other Australians. The most frequently reported long-term health conditions reported in the ACT were eye or sight problems, asthma and ear and hearing problems.

Ambulatory care sensitive conditions:

Ambulatory Care services especially affect Aboriginal and Torres Strait Islander people’s health when considered in the context of ambulatory care sensitive hospital admissions and the leading causes of death in the community. These conditions can be considered in three categories as outlined in Table 2.

<table>
<thead>
<tr>
<th>Category</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine preventable</td>
<td>Influenza, tetanus, measles, mumps, rubella, pertussis, polio</td>
</tr>
<tr>
<td>Potentially preventable acute</td>
<td>Dehydration, gastroenteritis, kidney infection, cellulitis, pelvic inflammatory, ear, nose and throat infections</td>
</tr>
<tr>
<td>Potentially preventable chronic</td>
<td>Diabetes, asthma, angina, hypertension, chronic obstructive pulmonary disease</td>
</tr>
</tbody>
</table>

Other contextual information:

The target group of the Ambulatory Care Framework can be broken down by early childhood, youth, adult, older people and the disadvantage which lends itself to addressing the varying disparities in health status as evident across the life cycle of Aboriginal and Torres Strait Islander Australians in the population. An awareness of areas for improvements can assist health.

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50 Chief Minister’s Department (2010). ACT Aboriginal and Torres Strait Islander Population – A Demographic Analysis.
providers to target resources and monitor performance to ensure the strengthening of health gains.

The AIHW (2008) reported that the five leading causes of death for Aboriginal and Torres Strait Islander people were: diseases of the circulatory system; injury; cancers; endocrine, metabolic and nutritional disorders (including diabetes); and respiratory diseases as illustrated in Figure 2. Condition specific plans are being developed by the Health Services Planning Unit (For example: Diabetes, Renal and Cancer).

Figure 1: Leading causes of death

![Figure 1: Leading causes of death](image)


The 2008 AIHW study reported that Aboriginal and Torres Strait Islander Australians typically experience higher rates of disability and long-term health conditions and hospitalisation than do other Australians (ABS 2006c; ABS & AIHW 2005). A more recent publication from the AIHW (2011), The health and welfare of Australia’s Aboriginal and Torres Strait Islander people - an overview reveals that injury and diabetes were much larger contributors to the Aboriginal and Torres Strait Islander burden of disease than to that of the whole Australian population. There is the continued high occurrence of certain conditions such as trachoma, otitis media and rheumatic heart disease.

Initiatives in the ACT:

The Health Directorate has made a commitment under the National Partnership Agreement to address targets set by COAG for Closing the gap in health outcomes between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander Australians. Although most of the targets focus on childhood, young people and adult interventions, the lifelong target which applies to this plan is to close the gap in life expectancy within a generation. The agreement is centred on five priority areas:

- Tackling smoking,
- Providing a healthy transition to adulthood,
- Making Aboriginal and Torres Strait Islander health everyone’s business,
- Delivering effective primary health care services and
- Better coordinating the patient journey through the health system.

There are still significant gains to be achieved in the area of Child and Maternal Health in regards to live births weighing more than 2,500 grams, smoking rates of mothers, improved access to
pre and postnatal services, Aboriginal and Torres Strait Islander Smoking Status and Alcohol consumption risk level in the ACT.

Key priority areas on *Aboriginal and Torres Strait Islander Early Childhood Development*, 2009-2014 includes antenatal care, pre-pregnancy; teenage sexual and reproductive health; increase access to and use of maternal and child health services by Aboriginal and Torres Strait Islander families.

The Health Directorate committed to developing a *Reconciliation Action Plan* and this initiative has resulted in the development of an action plan for the period July 2011 to July 2012. The aim is to bring about change by creating a health environment that is culturally sensitive. All planning processes need to demonstrate that a concerted effort is being made to close the gap.

The Health Directorate has also committed to four initiatives to improve quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative data sets. One of these initiatives is to develop an Aboriginal and Torres Strait Islander identifier.

Another is to develop a specific information and awareness program to support and encourage health workers to identify Aboriginal and Torres Strait Islander clients and Aboriginal and Torres Strait Islander patients to self identify.

Other initiatives include the development of effective resources to reflect Aboriginal and Torres Strait Islander Health issues; cultural awareness training; increase the number of Aboriginal and Torres Strait Islander Staff within the Health Directorate; the Health Directorate funded community organisations identify projects and programs that contribute to closing the gap; and new health facilities are to include Aboriginal and Torres Strait Islander language names, allocated, dedicated space and welcoming entrances.

**Please describe the consultation process that has been undertaken.**

Initial consultation regarding the impact of this Framework will be undertaken with the Health Directorate Aboriginal and Torres Strait Islander Health Unit. The plan will also be presented to Winnunga Nimmityjah Aboriginal Health Service, Gugan Gulwan Youth Centre and Aboriginal Liaison Service at the public hospitals. Members of the steering committee who are contributing to the development of the Framework are required to seek information from ambulatory services stakeholders on the impact of this Framework on their patients.

A literature search was undertaken to complement information which will be accessed from consultation processes.

**Please describe the outcomes from the consultations.**

A summary of relevant points from the literature search are presented below. Although some points are not specific to the Aboriginal and Torres Strait Islander population, they are listed due to the potential level of impact that they can have on the target group.

1. There are still quality and completeness issues around data collection so there needs to be a system in place within each clinical service Division to have the assurance that Aboriginal and Torres Strait Islander people are being accurately identified and receiving appropriate services.

2. Key life stages are associated with a series of risk factors including but not limited to: poor health and disability, loss of status and purpose, inward personality type, being a carer, lack of suitable housing, lack of close family, lack of local knowledge, lack of English proficiency, gender factors and diminished economic capacity. This is of particular relevance in regards to each ambulatory care zone (whether in a hospital or health centre environment) taking an active role in identifying vulnerable populations in their local area ensuring that relevant information is disseminated to reach the target
population. A communication strategy about ‘ambulatory sensitive conditions’\textsuperscript{55} that is medical conditions that could be treated, across life stages, with appropriate primary health care, could benefit the community.

3. Aboriginal and Torres Strait Islander Australians are not a homogenous group. Each community has its own unique customs, cultural beliefs and associated ceremonies. The culture is continually changing and adapting depending on the influences on the person and the community. To note that although there is an identified Aboriginal Health Service in the ACT, service providers should not assume that all members of the community will choose or prefer to attend Winnunga Nimmityjah or Gugan Gulwan Aboriginal Health Services. Moreover, the Federal Government approach to putting into effect ‘a shared responsibility to improve Aboriginal and Torres Strait Islander health outcomes and care’ will mean that all Divisions across ACT Health will be required to demonstrate their accountability to the special needs of Aboriginal people.

4. Aboriginal and Torres Strait Islander health is more than the physical wellbeing of an individual. It encompasses cultural, social, emotional and spiritual wellbeing, including the wellbeing of the whole family and community in which each individual lives. Through the Australian Government Department of Families, Housing, Community Services and Aboriginal and Torres Strait Islander Affairs, a \textit{Growing Healthy Families} program is being implemented.

5. Reforms are needed to improve the responsiveness of mainstream health services to the specific needs of Aboriginal and Torres Strait Islander people. A set of principles have been developed from a cardiac rehabilitation study in relation to improving the engagement of Aboriginal and Torres Strait Islander Peoples in rehabilitation services. These are attached for information as Attachment 1 as they can be applied to a wide range of ambulatory care services.

6. A study undertaken found that there is a tendency within the Aboriginal and Torres Strait Islander population to experience longer periods of hospitalisation. With the move towards aiming for shorter inpatient stay, consideration ought to be given about the impact on the length of support required by Aboriginal and Torres Strait Islander families who choose to access services in a mainstream ambulatory care setting.

7. Aboriginal and Torres Strait Islander visits to an ambulatory care setting are more likely to be complicated by co-morbidities. The enhanced case management and multidisciplinary model of service delivery in ambulatory settings underpinned by principles of collaboration and partnerships should greatly benefit that cohort of patients in the population.

8. In the context of ambulatory services, a cultural element for discussion is how local boundary and catchment population approach may impact on Aboriginal and Torres Strait Islander people?

9. The ACT Chronic Disease Strategy 2008-2011 articulate a number of specific actions that are provided in an ambulatory care setting which target the health care needs of Aboriginal and Torres Strait Islander people.

10. The National Aboriginal Community Controlled Health Organisation (NACCHO) suggests that targets should be set to monitor Aboriginal and Torres Strait Islander’s access to services, residential facilities, immunisation and screening programs.

Previous consultations for other planning processes have revealed the need for person centred, holistic, accessible and flexibly delivered services. There will be differences in individual’s ability to contribute and participate in decision making but what the community requests of health

\textsuperscript{55}Ambulatory care sensitive conditions (ACSC) are those for which hospitalisation is considered potentially avoidable through preventive care and early disease management, usually delivered in a primary health care setting such as a general practitioner’s surgery or community health centre.
service providers is that they be treated with respect and understand the importance/obligations of extended family and elder/kinship systems.

Spokespersons for the community reported that members of the community would like the opportunity to be more involved in program design. This strategy would demonstrate that service providers respect the local community’s knowledge and are empowering individuals to be more involved in decision making. As the Health Directorate undergoes a program of service and facility redevelopment, there is a commitment to ensure Aboriginal and Torres Strait Islander representation on all planning committees.

**What features have been included in your strategy, policy or program to address these outcomes?**

The Health Directorate will continue to:

- Work towards understanding the needs and issues of the target group;
- Identify and address the outcomes of the consultation findings from the Aboriginal Health Impact Statement development and facilitate the assessment of the impact of programs, strategies and policies;
- Provide an Aboriginal and Torres Strait Islander liaison service;
- Work with Winnunga Nimmityjah and Gugan Gulwan Aboriginal Health Service to support the delivery of health care to Aboriginal and Torres Strait Islander people;
- Provide culturally appropriate services and develop partnerships with organisations to develop and implement culturally appropriate programs;
- Encourage and/or provide cultural awareness training for all Health Directorate staff and across the sector56;
- Tailor strategies and interventions to address the specific cultural and linguistic needs of the target group; and
- Respond to the National Partnership Agreement on Closing the Gap in Aboriginal and Torres Strait Islander Health Outcomes by making Aboriginal and Torres Strait Islander health everyone’s business.

- A meeting place has been earmarked for Aboriginal and Torres Strait Islander peoples in the planning of the new Canberra Hospital campus. This place is being planned to minimise the social and cultural isolation experienced by patients and family members while spending time in hospital.
- A working group is working on the Health Directorate’s first Reconciliation Plan under the ‘Reaffirming ACT Health’s commitment to improving the health status of Aboriginal and Torres Strait Islander peoples in the ACT through the focus areas of Relationships - Respect - Opportunities’. It is envisaged that the actions from the Reconciliation Plan will provide further guidance to health service delivery to the target community.

**Please provide details of links established with existing mainstream and/or Aboriginal-specific policies, programs, strategies or services**

It is envisaged that the location of the Aboriginal and Torres Strait Islander Support Unit in the Health Directorate’s restructure, will afford greater opportunities to oversee and facilitate the necessary linkages to ensure appropriate ambulatory services are delivered to the target

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56ACT Health (2009). Aboriginal and Torres Strait Islander Cultural Awareness Workshop. Yurauna Centre on behalf of CIT solutions.
community. An understanding of the key elements of the Framework and the outcomes being sought in its implementation are critical to forging stronger links across the full scope of ambulatory services.

The work being done by the Health Directorate on patient and family centred care will also contribute to delivering services which are tailored to individual needs and respect and promote patient and carer choice.

Has the policy, program or strategy been endorsed by ACT Health’s Aboriginal & Torres Strait Islander Policy Unit?
No

Please describe any additional resources that have been allocated to support the implementation of the Aboriginal health aspects of your strategy, policy or program.

No additional resources have been allocated to support the implementation of the Aboriginal and Torres Strait Islander health aspects of The Framework.

Please describe any partnerships that have been established to assist with the implementation of the Aboriginal health aspects of your strategy, policy or program.

No new partnerships have been established.

Please describe how you will evaluate the success of the Aboriginal health aspects of your strategy, policy or program.

The implementation of the Ambulatory Services Framework will be monitored by a multidisciplinary advisory committee that will comprise of representatives across the sector stakeholder groups. Initiatives in the Framework will be led by the Health Directorate, and further developed into strategies in the business plans for each lead Division. Funding will be considered in the context of the operational plan in future budget processes.

A number of nationally established performance benchmarks to monitor improvements in Aboriginal and Torres Strait Islander Health relating to ambulatory care services are presented in Appendix 3 for consideration by the Framework’s steering committee.

Unit Name: Health Services Planning Unit

Head of Unit: ________________________________
Name __________________________ Signature ____________

Manager ATSIHU: ________________________________
Name __________________________ Signature ____________

Date: __________________________
Attachment 1: Extract from Medical Journal of Australia 2006 article
Strengthening cardiac rehabilitation and secondary prevention for Aboriginal and Torres Strait Islander peoples

Key points for success

- Ensure that cultural competency is integral to the core business of an organisation and supported at all levels within the organisation (eg, employ Aboriginal and Torres Strait Islander staff across the organisation, support cultural awareness training for non-Aboriginal and Torres Strait Islander staff, ensure availability of and support for interpreters and cultural mentors).
- Involve Aboriginal health workers and family members in the care of Aboriginal and Torres Strait Islander patients and develop flexible approaches to raising awareness of the importance of cardiac rehabilitation.
- Ensure community involvement in planning, implementing and evaluating health promotion, including the development of culturally appropriate materials.
- Incorporate elements of cardiac rehabilitation and secondary prevention into existing activities or set up activities that draw on existing networks within the community.
- Develop and sustain partnerships between organisations (eg, a hospital providing outreach cardiac rehabilitation services through the local Aboriginal Community Controlled Health Service).
- Take the specific needs of Aboriginal and Torres Strait Islander patients into consideration in planning and delivering mainstream cardiac services and develop policies and procedures to address these needs (eg, identifying Aboriginal or Torres Strait Islander status, providing culturally appropriate information on hospital discharge).
- Develop a specialist education base for continuing training and support of all health professionals working in cardiac care, including Aboriginal health workers.

Attachment 2: Key Concepts

“Primary Health Care” means “...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s overall health system, of which it is the central function and main focus, and the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.” (Alma-Ata Declaration, 1978.)

The provision of this calibre of health care services requires an intimate knowledge of the community itself and its health problems with a community response for the most effective and appropriate way that identified health problems can be addressed. These programs would include promotive, preventative, curative and rehabilitative services. (Adapted from the W.H.O. Alma-Ata Declaration 1978)\(^\text{57}\)

Some suggested principles for Health Professionals interactions with members of the Aboriginal and Torres Strait Islander Community:

\(^{57}\) AH&MRC Monograph Series. Volume 1. Number I. 1999. PRIMARY, SECONDARY AND TERTIARY HEALTH CARE SERVICES TO ABORIGINAL COMMUNITIES
• Relationships between Aboriginal and Torres Strait Islander peoples and their health care providers should be based on a foundation of mutual respect.

• Health professionals should recognize that the current health care system presents many gaps and barriers for Aboriginal and Torres Strait Islander individuals and communities seeking health care – suggestion to review key protocols to assess impact on target population.

• Health professionals should work proactively with Aboriginal and Torres Strait Islander individuals and communities to address the gaps and barriers.

• Health professionals should work with Aboriginal and Torres Strait Islander individuals and communities to provide culturally appropriate health care.

• Health professionals should ensure availability of accurate data-sets on prevalence of health problems to facilitate forward planning in ambulatory care setting.

• Health services for Aboriginal and Torres Strait Islander peoples should recognize the importance of family and community roles and responsibilities when attempting to service individuals.

• Health professionals should respect traditional medicines and work with Aboriginal healers to seek ways to integrate traditional and western medicine.

• Health professionals should take advantage of workshops and other educational resources to become more sensitive to Aboriginal and Torres Strait Islander peoples.

• Health professionals should get to know Aboriginal and Torres Strait Islander communities and the people in them to prevent inappropriate responses of services by reducing multiple referrals, untimely or rushed appointments.

**Attachment 3: Sample of Performance Indicators**

Performance Indicators are a tool used to demonstrate accountability and commitment to address Aboriginal and Torres Strait Islander health. Work needs to continue on making data available to measure progress and inform policy and allocation of resources to evidence based models of service delivery. The table below present a sample of indicators which can be monitored to demonstrate progress in the area of ambulatory care services.

<table>
<thead>
<tr>
<th>Access</th>
<th>Improve services for disadvantaged populations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Access to antenatal services</td>
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<tr>
<td></td>
<td>Access to ambulatory care services</td>
</tr>
<tr>
<td>Child health</td>
<td>Immunisation rates for vaccines in the national schedule</td>
</tr>
<tr>
<td></td>
<td>Health checks for children</td>
</tr>
<tr>
<td>Service delivery</td>
<td>Selected potentially preventable hospitalisations</td>
</tr>
<tr>
<td></td>
<td>Develop innovative evidence based models of care for Aboriginal and Torres Strait Islander Australians</td>
</tr>
</tbody>
</table>
Attachment 4: Literature Search

- ACT Health (2006). A New Way: The ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan
- NSW Health (2005) Aboriginal Chronic Conditions Area Health Service Standards
- Australian Government (2009). Overcoming Aboriginal and Torres Strait Islander Disadvantage - Key Indicators 2009
- Commonwealth Department of Health and Ageing (2010). Closing the Gap – Helping Aboriginal and Torres Strait Islander Australians reduce their risk of Chronic Disease.
- Australian Institute of Health and Welfare (2011). The health and welfare of Australia’s Aboriginal and Torres Strait Islander people – an overview. Cat no IHW 42. Canberra AIHW.

Appendix B – Key Definitions

Aboriginal or Torres Strait Islander person
An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.

Aged care services
All health services that relate to the specific care of an older person or someone with an age related illness. The patients are usually 65+ years of age though younger patients may also access the services. Services may be curative or preventive and encompasses both hospital and community based health care services.

(The) Australian Institute of Health and Welfare (AIHW)
The AIHW is Australia's national agency for health and welfare statistics and information. It is an Australian Government statutory authority that works closely with all State, Territory and Australian government health, housing and community services agencies in collecting, analysing and disseminating data. More information can be found at http://www.aihw.gov.au/

Acute care
Is a short-term secondary or tertiary level medical treatment, usually in a hospital, for people who have an acute illness.

Ambulatory care
“Ambulatory Care encompasses services ranging from primary care through to tertiary services. Ambulatory Care has as a principal aim the notion of providing care/treatment in a patient friendly environment, either in their own home, or at another location as close to home as possible and does not normally involve an overnight stay in an inpatient facility”. Ambulatory care is provided to such patients of emergency departments, outpatient clinics and community based health care services.

Ambulatory Care Centre at the Canberra Hospital
The Centre will consist of a comprehensive range of adult consultation, day treatment and related diagnostic services for specific conditions or patient groups. The Centre will focus on the delivery of Level 4 ambulatory care services as defined in the Ambulatory Care Framework. These services typically require medical specialist coordination or input, case management, diagnostic and/or an interventional procedure and multidisciplinary team coordination and involvement; therefore cannot effectively be delivered in a community based setting.

Community Based Health Services
Community based health services are defined as all health services that do not involve admission for an overnight stay in a hospital – irrespective of who funds/provides those services or whether these services are curative or preventive. The types of services provided include health promotion, education and early intervention, primary health care, home nursing, nutrition services, allied health such as physiotherapy, post hospital discharge programs, rehabilitation, palliative care and coordination of care between providers such as hospitals, GPs and community health service providers

Community Development Officer
Community Development helps people to develop economically & socially viable communities, which can assist, strengthen & support individual & family growth& enhance the quality of life. Community development officers work closely with a range of community groups to find out
their views and needs, and to try to best fit services to their requirements. Health related work include targeting disease prevention programmes for those particularly at risk, because of their age or background.

**Continuity of care**

Continuity is the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs and personal context. Continuity of care is distinguished from other attributes of care by two core elements—care over time and the focus on individual patients. Three types of continuity exist in all settings: informational, management, and relational. The emphasis on each type of continuity differs depending on the type and setting of care.

**Enhanced Community Health Centre (ECHC)**

They will have a dual role as the local community health centre for their catchment population and as a facility to accommodate more specialised services that require scarce staff/equipment and or only have demand to justify provision in one or two sites. Identified interventions that do not require an overnight stay in hospital such as community renal dialysis will take place in the ECHC. The facility will incorporate general Xray and ‘fast’ ultrasound capacity.

**Evidence based practice**

EBP encourages consistent and judicious integration of best available research evidence with clinical expertise and patient values and preferences for making clinical decisions.

**Funding of Ambulatory Based Health Services**

- Under the National Health Care Agreements there are state funded clinics whose services are provided free of charge to patients and are funded through the allocated public hospital or Community Health budget.
- Under private practice agreement with individual specialists, there are MBS billed ambulatory clinics where patients with a Medicare card are bulkbilled. The funding is only available for the medical specialist component and other multidisciplinary input is not reimbursed.
- Some Health Promotion/Education programs receive specific funding from the Federal Government.
- Private specialists can pay a fee to utilise public facilities and clients are responsible to paying any gap between the specialist charge and the Medicare rebate.

**National Health Care Agreement (NHCA)**

The NHCA replaces the Australian Health Care Agreement. This agreement defines the objectives, outcomes, outputs and performance measures and clarifies the roles and responsibilities that will guide the Commonwealth, State and Territory Government in the delivery of services for the health sector.

**Nurse practitioner**

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of patients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practise and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise.
Occasion of Service (OOS)

Single encounter OOS is any examination, consultation, treatment or other direct clinical care attended by a patient not admitted to hospital. Direct care is when patient contact is made; either face to face, via telephone or email for clinical care or intervention and a file notation is made in the health record.

Group encounter (OOS) is any examination, consultation, treatment or other direct clinical care provided to a group of non admitted patients.

(An) Older person

Someone aged 65 or over or 50 yrs for a person of Aboriginal and Torres Strait Islander descent.

Patient Centred Care

The Health Directorate recognises that:

- Patients and families are partners in their healthcare
- Patients and families have knowledge and expertise essential to their care
- Each patient is unique with diverse needs
- Patient centred care characteristics

Team-based care—doctors, nurse practitioners, nurses, and others as needed, including social workers, nutritionists, exercise physiologists, and behavioural health specialists.

Advanced access—ease of making an appointment, timely appointments, short waiting time in office, e-mail visits and electronic prescription refills, timely response to e-mails and telephone calls, efficient use of doctors' and patients' time, off-hours service with prompt access to medical advice and care.

Patients as informed and engaged partners in their care—shared decision-making, assistance with self-care and behaviour change, information on condition/treatment options/treatment plan, patient education, anticipatory guidance and counselling for parents on child development issues.

Information technology and smart office systems—patient reminders/alerts and patient access to electronic medical records and treatment plan, streamlined scheduling and medication refills, monitoring of adherence to recommended care, decision support for physicians, longitudinal charts on risk factors/health outcomes/use of services, and specialist reports.

Coordination of care—coordination of specialist care, prompt feedback, systems to prevent errors that occur when multiple physicians or sites are involved in care, post-hospital follow-up and support, links to community resources.

Patient feedback on experiences with care, such as patient-centred care surveys.

Primary Care

Primary care refers to the work of health care professionals who act as a first point of consultation for all patients. Such a professional would usually be a general practitioner. However, at the patient's discretion and depending on location and service availability, it may be another health care professional such as a pharmacist or a nurse.
Primary Health Care

Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.

Rehabilitation

Rehabilitation services aim to provide people who have a loss of function or ability due to injury or disease with the highest possible level of independence (physically, psychologically, socially and economically) following that incident. This is achieved through a combined and co-ordinated use of medical, nursing and allied health professional skills.

Rehabilitation Medicine Services

Identified units of patient care providing comprehensive rehabilitation services for inpatients and non-inpatients as well as in the community, under the direction of a Rehabilitation Physician. A rehabilitation medicine service aims to provide people with loss of function or ability due to injury or disease with the highest possible level of independence (physically, psychologically, socially and economically) following that incident. This is achieved through a combined and co-ordinated use of medical, nursing and allied health professional skills. It involves individual assessment, treatment, regular review, discharge planning, community integration and follow up of people referred to that service.

Secondary care

Specialised ambulatory medical service for patients who are not confined to bed and need more complex specialised health care skills. Services can either be provided in primary care or hospital care settings.

Tertiary care

Is specialist care, usually on referral from primary or secondary medical care personnel, by specialists working in a centre that has personnel and facilities for special investigation and treatment.
Appendix C - Conceptual Approach for the delivery of Ambulatory Care Services

Ambulatory Care services delivery is based on the following model/concept of a comprehensive, multilevel service framework which aligns with the 2006 Ambulatory Care Model (Figure 2). The model is another way of illustrating the relationship between the target population, the diverse range of health states, interventions and service providers. This model was adapted from the work undertaken through the Centre for Health Service Development at the University of Wollongong.58

The essence of the model is that based on social status and health states, different groups within the population (early childhood to older people) will have varying levels of health needs (not at risk to chronic) over time, which will in turn require different response/interventions over time. Clearly some of these health needs will require treatment in an acute hospital setting, however the majority of the needs can and should be managed in a community setting. Mention is made of disadvantage in the population group to highlight the need to target at risk patients with the greatest health needs. All elements captured in the model come together to present an overview of what constitutes Ambulatory Care services. Figure 1 provides a conceptual approach to Ambulatory Care services.

Population
- Early Childhood
- Youth
- Adult
- Older
- Disadvantage

Health States
- Not at Risk
- At Risk
- Symptomatic
- Acute
- Chronic

Interventions
- Primary Prevention
- Secondary Prevention
- Hospital Avoidance
- Treatment
- Continuing Care/Rehabilitation

Ambulatory Health Service Providers
- General Practice, Government Community Health, Private Allied Health, Pharmacy, Ambulance, Acute Hospital, Non-Government Organisations, Residential Aged Care, Social/Non health providers

To obtain a better understanding of the model described above, relevant information has been summarised in the following sections to translate the concept to a living picture of the context for the delivery of ambulatory services into the future.

---

In the cycle of care, the focus has traditionally been on symptomatic and acute care, and patients are only seen when they are ill. The key issue from this model’s perspective is not only the quality, timeliness and accessibility of health responses to population needs but most importantly the consideration of all elements (holistic approach) within the concept when ambulatory services are designed, implemented and evaluated.

**Population Profile**

Ambulatory Care services are provided for the ACT population, but under the National Health Care Agreement are also open to residents of the surrounding areas of NSW - primarily the former Greater Southern Area Health Service (GSAHS) of NSW. GSAHS residents only receive ambulatory services that relate to hospital care.

The estimated resident population of the ACT at 30 June 2011 was 365,421 persons. For the year ending 30 June 2011 the ACT population rose 1.9%, well above the national growth rate of 1.4%.

Based on the assumption of a continued moderate growth rate, is projected to grow to 395,000 persons by 2017 and 414,000 by 2021.

The area covered by the Southern NSW Local Health District is projected to continue to grow by 7% from over 203,000 in 2011 to around 217,000 in 2017 (NSW Health Population Projection Series 1.20092).

The suburbs of Canberra are organised into a hierarchy of districts and town centres. The town centres form a basis for the planning and development of health services. Canberra’s residential districts were developed with the intention of being semi-self-contained satellite towns with an intended population of about 80,000 people. Table 2 provides an overview of current and projected population growth for Canberra’s districts. CHCs are strategically located in key district areas of Canberra.

Much of the Territory’s population growth is projected to occur in the new development areas of Gungahlin and Molonglo, with these areas increasing by 20,500 and 10,300 persons respectively. Lower level growth is projected to occur in Belconnen, North Canberra, South Canberra, Woden Valley and Weston Creek. Tuggeranong is projected to experience a small decline of around 0.1 per cent per annum. The overall average growth in ACT’s population per annum is projected to be at 1.4% but the growth for Gungahlin is projected at 4.9% per annum between 2009 and 2021.
Table 1: Projected population ACT districts

<table>
<thead>
<tr>
<th>Year</th>
<th>North Canberra</th>
<th>Belconnen</th>
<th>Woden Valley</th>
<th>Weston Creek - Stromlo</th>
<th>Molonglo</th>
<th>Tuggeranong</th>
<th>South Canberra</th>
<th>Gungahlin - Hall</th>
<th>Remainder of ACT</th>
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</thead>
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<td>39,500</td>
<td>32,900</td>
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<td>85,150</td>
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<td>72,900</td>
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</table>

Average p.a. Growth (2009-2021)

| % aged 0-14 | 1.4% | 0.3% | 0.0% | -0.5% | 38.5% | -0.4% | 1.4% | 4.9% | 1.0% |
| % aged 15-64 | 7.5% | 18.8% | 16.9% | 17.5% | 68.1% | 20.3% | 14.9% | 24.3% | 15.4% |
| % aged 65+ | 12.2% | 71.5% | 66.5% | 67.7% | 73.6% | 77.5% | 70.8% | 74.3% | 74.5% |

Source: CMD ACT Population Projections 2009-2059

As well as growing, the ACT and neighbouring NSW population is ageing. At present, the proportion of the ACT population aged 65 years and over is approximately 11 per cent. This is projected to increase to 14 per cent by 2021. The established districts with the youngest population in 2019 are projected to be North Canberra (driven by the prominence of tertiary education institutions in this area).

In 2006, it was estimated that 1.3% of ACT’s population was of an Aboriginal and Torres Strait Islander origin and 22.9% were born overseas. Around 14% of the population was born in a non-main English speaking country (exclude people born in Canada, Ireland, New Zealand, South Africa, United Kingdom and USA). The largest overseas born cohort (7.4%) was from North West Europe followed by South and Eastern Europe at 3.5% and South East Asia at 3.1%. The most common languages other than English spoken at home were Italian, Greek, Cantonese, Arabic, Mandarin, Vietnamese and Spanish. The fastest growing overseas birthplace groups since 2001 to 2006 have been Burundi, Liberia, Guinea, Sierra Leone, Rwanda, Sudan and the Congo. Although non overseas migration contributed the most to ACT’s population growth, international students do play an important role in the ACT population growth.59

An AIHW publication 'Specialist Homelessness Services Collection’ reports that between July to September 2011, 2,264 clients sought assistance from specialist homelessness agencies in the ACT; of these 26.8% reported sleeping rough.60 Information collected from the 2006 Census (ABS) estimates that the rate of homelessness was 4.2 per 1,000 ACT population on Census night.

There were 883 high care and 1,148 low care residential places at 30 June 2011. There were 1,118 community care packages and 49 transition care packages.

It was estimated that the Alexander Machonochie Centre, which became operational in 2009 has the capacity to accommodate an average of 300 sentenced and remand ACT prisoners.

**Population Health Status**

The ACT enjoys a high level of health. The National Health Survey estimates that the majority (61.5%) of adults in the ACT rate their health as either excellent or ‘very good’ and mortality indicators suggest that more people in the ACT are living longer lives than ever before. Life expectancy in the ACT is high in comparison to other jurisdictions and expected to increase over the next ten years. By 2015, life expectancy at birth is projected to be 83.1 years for males and 86.5 years for females. This increase will be associated with an increase in the number of people in the population living with a chronic disease.\(^{61}\)

Chronic diseases dominate the disease burden. By 2023, cancer, cardiovascular disease, diabetes, chronic respiratory and musculoskeletal conditions are expected to account for more than half (52%) of the national disease burden. The Australian Institute of Health and Welfare (AIHW) has identified seven major largely preventable risk factors that impact adversely on the incidence and prevalence of many chronic diseases. They include:

- Tobacco smoking
- Risky and high risk alcohol use
- Physical Inactivity
- Inadequate or poor nutrition
- Excess weight
- High blood pressure
- High blood lipids.

The **ACT Chronic Disease Strategy** recognises the central importance of a range of health providers in delivering optimal disease prevention, detection and management. The Health Directorate is developing a register of all patients with targeted chronic conditions to optimise patient care through the use of decision support tools, reminders and recalls and performance data. Education programs and coordinated care are initiatives being expanded to respond to the demand.

**Interventions**

- **Primary Prevention** is reducing the likelihood that a disease or disorder will develop. The objective is that ACT residents are supported to stay healthy through a stronger focus on wellness, prevention, early detection and appropriate intervention to maintain people in as optimal health as possible. A greater focus is being sought to support individuals with the behavioural changes required to reduce the risk of disease.

- **Secondary Prevention** interrupts, prevents or minimises the progression of a disease or disorder at an early stage. Improving the capacity of patients to engage in self-management enables them to monitor and manage signs and symptoms of illness, identify strategies for dealing with disease related problems, appropriately use medications, implement health maintenance actions, communicate effectively with health professionals and effectively use community resources.

- **Hospital Avoidance** is about preventing hospital admissions through early identification and treatment of illness. Acute exacerbations are minimised and prevented through appropriate support in the community. This support is required for people living at home or are homeless and also in residential care facilities.

• Treatment – Patients are treated as outpatients (non-admitted) in the community. Point of care decisions forms part of a treatment plan in the community. Treatment is supported by radiology, pathology and pharmacy services.

• Continuing Care – For people living with multiple, ongoing and complex conditions, services need to be coordinated across multiple care providers with transitions across health care sectors. Continuity of care is critical to the person’s experience. Further, as length of stay continues to decline in the inpatient setting, community based services will increasingly be required to provide care to patients with higher acuity needs in the community.

Ambulatory Health Service Providers

There are a variety of Ambulatory Care Services currently provided in the ACT through both government and non-government sectors. These services are provided from a number of locations across the Territory, including:

• Canberra and Calvary Public Hospitals Ambulatory Care Centres (after hours general practice, day surgery/procedures, pre-surgical assessment/admission, specialist/allied health outpatient clinics, ante/post natal care, renal dialysis, radiotherapy and chemotherapy services, sexual health, alcohol and drug, pain management, rehabilitation, falls prevention, Hospital in the Home.

• Community Health Centres located at Civic, Belconnen, Philip, Tuggeranong, and Dickson. Currently these centres provide a broad range of mental health, maternal and child health and community nursing/allied health based clinics (physiotherapy, podiatry, dental services, wound services, pap smear, breast screen, immunisation, well baby clinics).

• Child Health Clinics at 19 locations across Canberra that provide immunisation and preventive/promotive child health services.

• General Practice - generally spread in the suburbs across the Territory. The majority are serviced by less than five practitioners– but recently a corporate medical centre provider has established two relatively large GP clinics at Belconnen and Philip. ACT General Practices provide a variety of operating hours and co-located allied health services.

• Private allied health/diagnostic (including dental, physiotherapy, podiatry, counselling, pathology, radiology etc).

• Community Retail Pharmacy - which, in addition to providing community access to medication/medical equipment, also provide information and advice, weight loss advice/programs, and opioid replacement.

• Ambulance ACT – which in addition to providing emergency transport services, also provides significant on-site management of health care problems (with the highest non-transfer rate in Australia).

• NGO Service Providers (often at least part funded by ACT Government) spread across the territory including, but not limited to, Winnunga Nimmityjah Aboriginal Health Service (Narrabundah), Family and Sexual Health Services, Marie Stopes reproductive health (City), Directions ACT, Junction Youth Health Services, psychosocial rehab, and a broad range of health promotion/information providers (funded under The Health Directorate Grants program).

• Child and Family Centres run by the Directorate of Community Services and currently located at Tuggeranong and Gungahlin (with one planned for West Belconnen). These centres provide a range of family support activities and are the location of some health specific services such as speech pathology, maternal and child health clinics, and early childhood developmental services (Therapy ACT).

• Residential Aged Care Facilities – which in addition to provide residential care for the elderly, also provide significant elements of medical/health care to residents.