Gippsland Lakes Community Health

# Gippsland Lakes Community Health - Strategic Services Plan

Final Report

June 2017

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# List of Abbreviations

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|---|---|
| ABS | Australian Bureau of Statistics |
| ACAT | Aged Care Assessment Team |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| ACE | Acute Care of the Elderly |
| ACFI | Aged Care Funding Instrument |
| ACSC | Ambulatory Care Sensitive Condition |
| ALOS | Average Length of Stay |
| AMWAC | Australian Medical Workforce Advisory Committee |
| AN-SNAP | Australian National – Subacute & Non-Acute Patient |
| AOD | Alcohol and Other Drugs |
| ASR | Age Standardised Rate |
| BRHS | Bairnsdale Regional Health Service |
| CAMHS | Child & Adolescent Mental Health Service |
| CCC | Comprehensive Cancer Centre |
| CDM | Chronic Disease Management |
| CGHS | Central Gippsland Health Service |
| CLD | Criteria-Led Discharge |
| CPAP | Continuous Positive Airways Pressure |
| DHHS | Department of Health and Human Services |
| DMFT | Decayed, Missing or Filled Teeth |
| DRG | Diagnosis Related Group |
| ECG | Electrocardiograph |
| ED | Emergency Department |
| EGMHI | East Gippsland Mental Health Initiative |
| ENT | Ear, Nose & Throat |
| FTE | Full Time Equivalent |
| GEGAC | Gippsland and East Gippsland Aboriginal Cooperative |
| GEM | Geriatric Evaluation and Management |
| GIT | Gastrointestinal Tract |
| GLCH | Gippsland Lakes Community Health |
| GP | General Practitioner |
| GRICS | Gippsland Regional Integrated Cancer Service |
| HACC | Home and Community Care |
| HARP | Hospital Admission Risk Program |
| HDU | High Dependency Unit |
| HIP | Health Improvement Program |
| HITH | Hospital in the Home |
| HSP | Home Service Package |
| ICC | Integrated Community Care |
| ICT | Information and Communications Technology |

| | |
|---|---|
| IMG | International Medical Graduate |
| LGA | Local Government Area |
| LRH | Latrobe Regional Hospital |
| MBS | Medicare Benefits Schedule |
| MCRG | Major Clinical Related Group |
| MPS | Multi-Purpose Service |
| NDIS | National Disability Insurance Scheme |
| NGO | Non-Government Organisation |
| NHRA | National Health Reform Agreement |
| NP | Nurse Practitioner |
| OAHKS | Osteoarthritis Assessment of Hip and Knee Service |
| ODH | Omeo District Health |
| ORH | Orbost Regional Health |
| PAC | Post-Acute Care |
| PARC | Prevention & Recovery Care |
| PCT | Primary Care Type |
| PHIDU | Public Health Information Development Unit |
| PHN | Primary Healthcare Network |
| PICC | Peripherally Inserted Central Catheter |
| RACS | Residential Aged Care Service |
| RAPU | Rapid Assessment Planning Unit |
| RIR | Residential-in-Reach |
| RLOS | Relative Length of Stay |
| SACS | Subacute Ambulatory Care Service |
| SCN | Special Care Nursery |
| SEIFA | Socio-Economic Index for Areas |
| SMO | Senior Medical Officer |
| SNAP | Smoking, Nutrition, Alcohol consumption and Physical inactivity |
| UCC | Urgent Care Centre |
| VIF | Victoria in Future |
| VIFSA | Victoria in Future Small Areas |
| VMO | Visiting Medical Officer |
| VPHS | Victorian Population Health Survey |
| WIES | Weighted Inlier Equivalent Separation |

# Executive summary

The Gippsland Lakes Community Health Strategic Services Plan, presented in this report, provides a 'road map' for the future development of healthcare services to meet the changing needs of the communities of the Gippsland Lakes, and in East Gippsland more broadly, over the next five to ten years.

This Plan, has been developed to focus on the Gippsland Lakes Community Health (GLCH) perspective and identifies key drivers that will influence *what* services are provided and *how* services may be delivered at GLCH, the over-arching themes to guide future health service development, specifies the major areas for service enhancement and changes to service models required to address future needs. In turn, this has influenced key considerations in relation to workforce, infrastructure, information and communications technology (ICT) and partnerships necessary to deliver the required services.

## Key drivers

There are many important drivers that shape the future development of services for GLCH. The most important are:

- Significant changes to the operating environment, including ***policy*** changes by the state. The two main changes over recent times include:
  - *Targeting Zero* (Duckett Review),[1] which highlighted amongst other things, systemic shortcomings that have resulted in avoidable adverse patient outcomes. This includes deficiencies in the Department of Health and Human Services' (the Department's) oversight of *quality and safety* in hospitals; and
  - *Design, Service & Infrastructure Plan for Rural & Regional Victoria*, which is a discussion paper that sets a new framework for planning including a stronger expectation on *service integration and collaboration* between health service providers.[2]
- The development of statewide ***clinical capability frameworks****;*
- The ***clinical capability of the workforce****;*
- Expected increases in future ***demand*** resulting from modest population growth, and more particularly through population ageing, increasing the rate of hospitalisation and community-based service demand due to an escalating burden of disease. The forecasts indicate:
  - Substantial growth in ambulatory, primary health and community services demand, averaging 2.0% per annum. There are variations in the expected average annual growth with 0.5% for community dental services and 2.7% for HACC services. There is expected to be 2.1% growth in Tier 2 acute ambulatory services; and

1. Duckett, S et.al. Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care, Victorian Government, October 2016
2. Deloitte, DHHS, Design, Service and Infrastructure Plan for Victoria's Rural & Regional Health System, September 2016

- Acute and sub-acute inpatient demand is expected to grow by around 2.6% per annum to 2036/37. This translates to 42,700 separations in 2036/37 from the current base of 24,000.

## Strategic positioning

Like all other health services, GLCH cannot expect to meet future demand challenges simply by doing more of the same. Over the next decade there will need to be strategic positioning of health services in East Gippsland to better enable them to meet future demand. This will mean:

- ***Sub-regional service planning*** and clarity around ***role delineation***. Accordingly, this plan is predicated on developing a sub-regional approach to future health care service delivery. In practice this means agreement between the four public health service providers as to the range and level of clinical capability of services that are provided at each health service. It is expected that in broad terms:
  - Bairnsdale Regional Health Service (BRHS) would consolidate its role as a sub-regional health service and 'fill gaps' in the expected sub-regional role in acute, subacute and specialist ambulatory services;
  - GLCH would become the designated principal provider of primary health and community-based services in East Gippsland. The delineation of specific ambulatory services would be agreed between BRHS and GLCH;
  - Orbost Regional Health (ORH) will continue to operate as a Multi-Purpose Service (MPS) to meet the local needs of communities in far East Gippsland; and
  - Omeo District Health (ODH) will continue to operate as a Small Rural Health Service (SRHS) to meet needs in the Omeo district.
- Establishing formal and informal ***structures and agreements*** that strengthen service integration.

## Over-arching themes

The following overarching themes proposed in the East Gippsland Strategic Services Plan (SSP), themes 1 and 5, are of most relevance to this GLCH strategic services plan. These are:

1. ***A wholly integrated service system***. Progressively develop a wholly integrated service system that would include the following priority developments:
   a. Strengthen the already solid relationship for primary health and community-based services between GLCH and BRHS. This requires partnership arrangements that *delineate roles and responsibilities for defined services*;
   b. Develop capacity to meet the expected substantial growth in demand across the range of ambulatory programs, including specialist community-based services; and
   c. Actively build (clinical and organisational) structures that better enable services to be connected remotely, and develop outreach service models.

These three priority measures are likely to address a major challenge for the catchment that has relatively low access to primary GP and specialist services, high rates of ambulatory care sensitive conditions (ACSCs), and high Emergency Department (ED) primary care type (PCT) attendances.

*GLCH, and the other service providers in East Gippsland, have the opportunity to build on the current solid foundation of cooperation, and build an exemplar model for service integration and collaboration in rural Victoria. Whilst this requires effective structures and agreements, it also requires the further development of organisational culture at each health service that fosters flexibility, adaptability and mutual support in the delivery of health care to meet changing environmental pressures.*

2. Develop and implement ***innovative service models,*** supported by ICT, that can deliver patient-centred care, and better meet community expectations. This would include, for example:
   a. Delivering more specialised health services into community settings, including patients' homes; and
   b. Outreach specialist ambulatory services.

## Service development models

There is an extensive range of service development initiatives and areas of service consolidation described in section 4 of this plan. Many of these also require changes to the service delivery models. They include:

- As a major initiative, that there is an inter-agency agreement to support ***service delineation for primary and community-based services***, with GLCH becoming the default provider of primary health and community-based services for:
  - The Lakes Entrance District and Bairnsdale District; and
  - More specialised (subregion-wide) services that would then also include the Omeo and Orbost Districts.

  Whilst the basis for service delineation is in the province of each service provider (and to some extent the 'purchasing agencies'), there are some specialist community-based acute and subacute services that need to be synergistically aligned to inpatient acute (e.g. Hospital in the Home) and subacute health services (Health Improvement Program services) that should remain with BRHS. Notwithstanding the above, and consistent with the SRHS and MPS roles, ORH and ODH would continue to deliver locally based services to their communities.
- Enhanced ***capability and capacity of community-based health services*** to the sub-region (section 4.1). In particular this would include:
  - Developing, or supporting the development of GP services in Bairnsdale to redress poor local access to primary medical services;
  - Improving access to diversion and substitution services such as Complex Care to address high ACSC acute hospital admissions and PCT attendances at the ED (section 4.8);

- There is scope for GLCH to further develop specialist chronic disease management services. The focus will increasingly require expansion of additional disease management programs (beyond the current focus on diabetes); and
- Improving *pharmacotherapy* services in East Gippsland, which is currently under-serviced.

- Support a community sponsored residential service for ***alcohol and drug rehabilitation*** in the sub-region (section 4.10);
- Undertake specific ***workforce development*** strategies that support the role of each health service, and each of the service development initiatives in the plan. These include:
  - To give effect to improved collaboration and service integration, jointly develop a workforce strategy for community-based services that provides:
    - Full-time positions with joint appointments for specialised health workers (rather than part-time appointments at each entity) to attract staff to the area;
    - Cross-credentialing of staff to enable these staff to work across the sub-region;
    - A workforce framework (Section 4.1.4) that enables joint prioritisation of community health workforce appointments; and

    The above workforce strategies need to form part of a coherent and coordinated plan for East Gippsland. More broadly, given the relative under-provision of the nursing and allied health workforce, a strategic, catchment-wide approach is warranted. A three-stage process is envisaged and outlined in section 4.1.4. It aims to realign services to improve service system integration (and models of care at patient/client level).
  - The *first stage* is to have an informed baseline of the current situation by all four health services;
  - The *second stage* is to identify how resources can be better targeted (using benchmark productivity performance), to areas where new resources are required, and areas for priority development; and
  - The *third stage* is to develop a joint position in relation to *the transfer of services and resources to alternative auspice agencies* that would lead to *improved staff utilisation and service integration*.
- Ensure that there is a sound basis for ***community engagement*** in order to increase awareness of, and affinity for, each of the health services in the sub-region;
- In terms of ***information and communication technology***, it is proposed to develop:
  - ***Connectivity within organisations, and between public health services***. The intention is to invest in integrated information systems that improve the patient experience, and improve productivity and business systems including:
    - Connectivity, and effective utilisation protocols with BRHS Emergency Department and GLCH, ORH and ODH;
    - Connectivity and real time services by aboriginal health services with GLCH and BRHS;
    - Progress implementation of electronic health records (EHRs) to facilitate information sharing across the care team with integrated decision support and chronic care management tools;

  - Enhanced data warehouse capabilities;
  - Patient referral and electronic management of appointment systems to improve the provision of timely, routine appointments;
  - Electronic real-time bed management systems; and
  - Support for patient education about their health and promotion of self-management of chronic disease.
- ***Remote location patient connectivity.*** Real time remote monitoring of patients in their homes and at other health services. This has the potential to be the *next major model of care revolution delivering health care*;
- ***External connectivity*** for clinical information to better integrate care. This includes:
  - ***Data sharing*** that enables information to transcend organisational boundaries to support improved clinical decision-making, organisation of care and outcome measures that focus on the individual rather than an episode of care;
  - Enabling the timely ***referral and 'booking'*** for patient appointments between health service providers on discharge or transfer of patients from acute health services, including GPs;
  - Simple discharge summaries for GPs;
  - Telehealth to remotely connect providers and patients in their co-management of clinical conditions and support access to specialist consultations; and
  - Supporting the Gippsland PHN's implementation of the *HealthPathways* initiative with the aim of coordinating GPs', specialists' and other health professionals' assessment, and management.
- ***Internal management support systems*** that capture activity data, resources and patient outcomes, in order to improve real time decision-making, and have the 'evidence-base' to demonstrate effectiveness;
- Developing (with the necessary partners) the ICT that can enhance the level of ***clinical training*** such as high quality 'tele-presence' technology and an extensive network to enable virtual teaching and training to be undertaken from almost any setting;
- Effective management and use of social and new media as part of a generational change in the approach to ***communication*** with the community; and
- Increased ***transparency and accountability*** in relation to health services delivered by GLCH, and their performance in meeting the needs of the community and the quality of services provided. This includes a new performance reporting framework based on a 'balanced scorecard' approach.

# 1 Purpose and approach

## 1.1 Purpose

The purpose of this report is to provide a strategic services plan for Gippsland Lakes Community Health (GLCH). The plan for GLCH has been developed as part of a broader sub-regional strategic services plan.

This strategic services plan is specific to GLCH. However, there are many elements of this plan that are common to other health services in the East Gippsland sub-region, including Bairnsdale Regional Health Service (BRHS), Omeo District Health (ODH), and Orbost Regional Health (ORH). Indeed, one of the main objectives of the broader sub-regional strategic services plan is to better integrate services within East Gippsland, including between GLCH with the broader Gippsland region.

This plan has been developed, in part, from important baseline information included in the *Environment & Service Profile Analysis Report (August 2016),* including:

- The policy context at state and federal level;
- The demography of the catchment population;
- The socio-economic profile of the population;
- The health status of the population;
- The current service profile of GLCH to enable an understanding of the range and level of services provided, including the level of self-sufficiency and rates at which the population use health services; and
- Projected increases in demand.

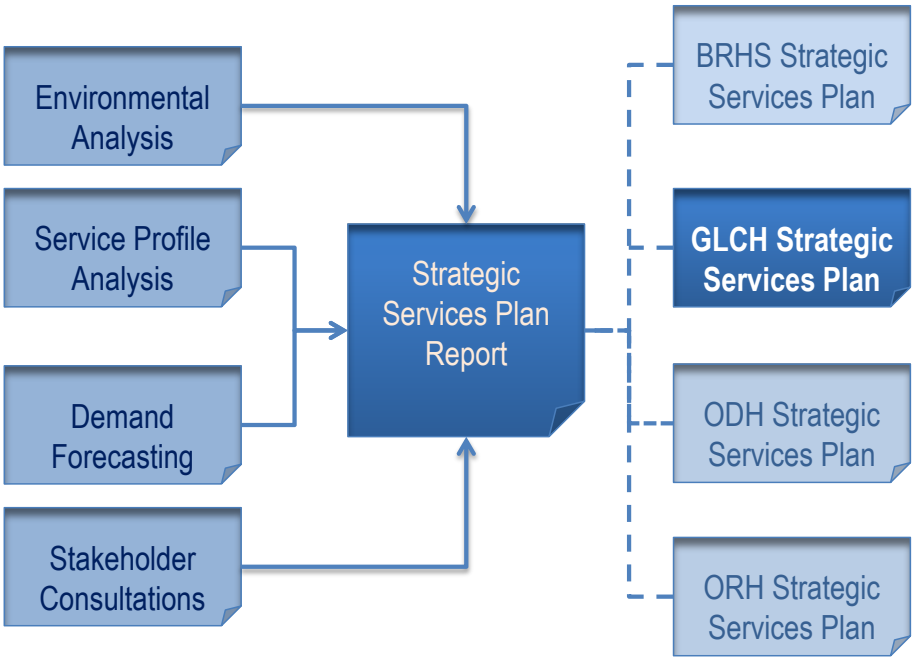
The plan has also been informed by a broad-based consultation program.

The detailed environmental analysis, *Environment & Service Profile Analysis Report (August 2016),* provides the detailed analysis. These factors influence ***the nature and level*** of services provided, as well as ***how*** they are provided. This, in turn, influences workforce, infrastructure, partnerships and other factors that determine a 'service capability frontier' that will be necessary to deliver the required clinical services across the East Gippsland sub-region.

The plan encompasses the development of the full range of health services including acute, subacute, emergency care, maternity, mental health, and primary health and community-based services. The plan is intended to consider service developments over the next five to 10 years, and provides the basis for more strategic service development over the next 20 years.

The GLCH strategic services plan is one of a series of separate and inter-related reports, as illustrated in Figure 1-1.

**Figure 1-1: Strategic Services Plan Report structure**



# 2 Key drivers

Based on the environmental analysis, demand modelling, analysis of the current service profile and stakeholder consultations, there are a number of important drivers for the future delivery of services at GLCH.

The main drivers of the plan are:

1. **Planning principles**;
2. **Policy drivers**;
3. **Self-sufficiency**. With the expected growth in demand due to both population increase and ageing, developing and maintaining the level of self-sufficiency that is appropriate for East Gippsland, particularly for acute and subacute services, will be critical to the development of services and service models at GLCH;
4. **Service integration**. The development of collaborative arrangements between health services to result in improved ***integration of services***, between health care providers within East Gippsland, and between various health care providers in greater Gippsland; and
5. **Sustainability**.

## 2.1 Planning principles

The following service planning principles ensure consistency with the various policy frameworks and the project brief for this strategic services plan.

- Meet *expected levels of demand* for a growing population, particularly in the primary catchment, where services can be delivered *relatively efficiently* and are *clinically safe*.
- The future service profile of GLCH considers the role and complementary clinical capability of other health services in East Gippsland, and the broader Gippsland region – particularly Latrobe Regional Hospital and Central Gippsland Health Service – in ensuring strong levels of *collaboration and partnering.*
- The service profile is *sustainable*.
- Further develop *innovative service systems and models of care* at GLCH and in the region that are able to:
  - Progressively respond and adapt to changes in need as circumstances change over the next 10 years; and
  - Support community and home-based services, particularly services that:
    - Substitute for inpatient admissions or ED presentations; and
    - Deliver effective primary and secondary level health services that are close to where people live.
- Further develop information and communication technologies that support timely and appropriate provision of care.
- Ensure a sustainable workforce tailored to the service profile.

- Ensure services are developed to be consistent with the state-wide clinical frameworks where these have been developed.
- Ensure that teaching and training forms a core capability at GLCH.

## 2.2 Policy drivers

There have been significant reforms in healthcare policy since the National Health Reform debate in 2007. These are captured in the stated objectives of the 2011 National Health Reform Agreement (NHRA) as:

- Reforming the basics of the health and hospital system, including funding and governance, to improve the sustainability of the system;
- Changing the way health services are delivered, including better access and more coordinated care designed around the needs of consumers. This includes a greater focus on prevention, early intervention and the provision of care outside of hospitals; and
- Increased investment to improved infrastructure and workforce resources.

Nevertheless, since the election of the Federal Coalition governments in 2013 and 2016 some of the fundamentals of the reform package have changed, which has heightened uncertainty around the fundamental issues the national reforms were intended to address. Specifically, the withdrawal of Commonwealth funding commitments has resulted in funding reductions that has a direct impact on the level of funding that would have otherwise been available to Victoria. Nevertheless, the recent Health Portfolio Statement in the 2016-17 Budget noted *"The Government will continue to work with States and Territories towards a more sustainable hospitals funding model beyond 2020."*

Victorian Government policy themes echo the national health debate but are honed to a greater level of detail to address local needs. These themes are captured in *Health 2040* and the *Travis Report* amongst others, and focus on:

- Developing a more robust, responsive and adaptable rural and regional system;
- Tailoring of services to local needs and priorities;
- Ensuring services are clinically appropriate and safe, including the support for common clinical guidelines and frameworks for rural health services;
- Building a *responsive and adaptable* rural and regional health service system that can be tailored to meet the needs and circumstances of local communities and is supported by service models that are *clinically appropriate and cost-effective*;
- Supporting greater *collaboration and partnerships*;
- Developing a workforce that can apply *flexible and sustainable* service models; and
- Develop information communication technology that supports *innovative practices and flexible* provision of care.

Given that the health services sector intersects with the full range of human and social service sectors, there are other policy influences that will have an impact on health service providers. This includes the implementation of the *National Disability Insurance Scheme*, the *Road Map to Reform* strategy for child and family services, and the *Royal Commission on Family Violence,* all of which introduce areas of major reform and are likely to have significant implications for both client/patient access to services and for health service providers.

With the recent release of the *Duckett Review,*[3] there will be a strengthened focus on demonstrated clinical capability, service delineation and collaborative clinical arrangements, amongst many other things. This focus on the development of collaborative arrangements between health services and improved ***integration of services*** is reinforced by the recently released *Discussion Paper on Victoria's Rural & Regional Health System*[4] and is consistent with the progressive development of state-wide clinical frameworks.

## 2.3 Self-sufficiency and service demand

The population growth rate in East Gippsland since the 2011 Census to 2016 has been in the order of 4.2%, that is, less than 1% per year. *Victoria in Future 2016* projections indicate population growth for the East Gippsland Shire to be 1% per annum through to 2031, an overall increase of 22% from 42,826 at the 2011 census to 52,151 by 2031.

A central issue for the overall sub-regional SSP, and the flow on implications for each service plan is the appropriate level of public hospital self-sufficiency for acute and subacute services. As a general expectation, there should be around 70%, and up to 75% self-sufficiency for the sub-region.[5] The current self-sufficiency for East Gippsland of 76% is on the higher side of what might be typical.

***The significant increase in projected activity, and in self-sufficiency to 80%, has a major impact on the future planning of services. The higher expected self-sufficiency represents a prospective challenge to make the transition required from current to planned service levels.***

***For GLCH, a higher level of sub-regional self-sufficiency means increased provision of ambulatory and community-based services. Importantly, it also means enhanced clinical capability of community-based services.***

3. Duckett, S et.al. *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care*, October 2016, Victorian Government
4. Deloitte, DHHS, *Design, Service and Infrastructure Plan for Victoria's Rural & Regional Health System*, September 2016
5. The level of self-sufficiency for sub-regional services is expected to vary across the state, influenced by population size and distance from regional and metropolitan hospitals.

## 2.4 Primary health service access and integration

Primary health and community-based services are core for each of the four health services in East Gippsland. The role of ambulatory services will become even more important in the future. In the event that primary and community-based services are deficient, the flow on effects to inpatient and ED services will be significant. A key driver for this plan is to strengthen primary and community-based services, to support their pivotal role as reliable and accessible parts of an integrated service system and to articulate a specific role for GLCH.

## 2.5 Sustainability

The sustainability of services is a key driver. The plan develops a range of services that makes the services more robust with respect to:

- The ***range and level*** of services expected; and
- Ensuring ***patient safety***.

# 3 Role of GLCH

The data analysis and the stakeholder consultations have provided a strong indication of the role for GLCH, as described below. This includes important changes to the potential relationships with the three public health services, BRHS, ORH and ODH.

## 3.1 Gippsland Lakes Community Health Service

GLCH is an independently incorporated entity (registered company). Due to its multi-faceted role, GLCH is also registered as a community health service under the *Health Services Act 1988*, and a registered Community Services Organisation under the *Child and Families Act 2011*.

In short, GLCH has a different regulatory environment than the three other public health services. Nevertheless, as an integral part of health care provision in East Gippsland, the objectives of each health service are similar. In this context, the over-arching sub-regional SSP proposes that:

***GLCH should become, over time, the designated principal provider of primary health and community-based services in East Gippsland.***

GLCH has had a long history of delivering a wide range of primary health and community-based services to Lakes Entrance. The historical role has seen services expand into other townships in East Gippsland, including for Bairnsdale for core services.

The proposed role would be an extension of its current role. As part of its expected core service offering, GLCH would:

- Provide general and specialised community-based services to the Lakes and Bairnsdale Districts;
- Provide specialised community-based services to Omeo in the north, to Orbost and into far East Gippsland; and
- Look to provide specialised community-based services that are currently being delivered from out-of-catchment.

For the Lakes District and Bairnsdale Town District, the respective roles of GLCH and BRHS are complementary in most respects. There are relatively few areas of overlap. However, the overlapping areas include key ambulatory and community-based services.

# 4 Service development models

This section describes important areas where services will be enhanced over the next five to 10 years, and potentially provides the basis for more strategic service development over the next 20 years of primary health and community-based services.

## 4.1 Primary health and community-based services

### 4.1.1 OVERVIEW OF SERVICES IN THE CATCHMENT

All four health providers deliver ambulatory, primary health and community-based services to East Gippsland. In addition, GPs in each of the main population centres are pivotal to delivering health care to the catchment population. Table 4-1 provides an overview of the type and nature of services delivered by GLCH by program type. This analysis excludes private allied health, nursing and dental practices.

Highlights of the ambulatory, primary health and community services data include:

- GLCH operates the most diverse range of primary and community health services including specialist services across the catchment including:
  - Community palliative care services;
  - Drug treatment services;
  - Disability services;
  - Supported accommodation and SAAP services;
  - Child FIRST and Integrated Family Services; and
  - Family Violence outreach, counselling and case management.
- BRHS provides a range of specialist ambulatory care services including:
  - Tier 2 acute 'outpatient' services; and
  - Health independence program (HIP) services comprising Post-Acute Care (PAC), Subacute Ambulatory Care (SACS), complex care (formerly referred to as HARP) and residential-in-reach (RIR) services.
- GP services are provided from three sites: GLCH, ORH and ODH; and
- Community dental services are provided from three sites: BRHS, ORH and ODH. There are no plans to expand the dental program. However, there is a need for community dental services in more remote locations. It is proposed to develop a mobile dental service to outreach to smaller communities in East Gippsland.

**Table 4-1: Ambulatory, primary health and community-based services provided by GLCH, 2015/16**

| PROGRAM | UNIT | GLCH |
|---|---|---|
| GP primary care | Contacts | 36,816 |
| Other primary & community | Contacts | 8,031 |
| HACC allied health | Hours | 10,947 |
| HACC nursing | Hours | 2,204 |
| Other HACC and home-based care | Hours | 75,344 |
| Community Palliative Care nursing | Contacts | 2,590 |
| Community nursing | Hours | 9,517 |
| Early Health services | Clients | 611 |
| Drug Treatment services | Episodes | 787 |
| Supported accommodation & housing support | Episodes | 243 |
| Integrated family services | Hours | 12,497 |
| Family violence | Clients | 487 |
| Indigenous family violence | Clients | 167 |
| Other (Reconnect, Youth Justice, Disability & other DHHS programs) | Clients | 501 |

The breadth of catchment coverage by GLCH is evident from the summary in Table 4-2. Whilst Gippsland Lakes has the predominant share of GLCH's service focus, it can be seen that just over one-fifth (22%) of clients are located in the three other sub-regional districts: Bairnsdale, Omeo and Orbost.

**Table 4-2: Client place of residence by VIFSA by funding type, GLCH, 2015/16**

| Funding Type | Bairnsdale | Gippsland Lakes | Omeo | Orbost | Other Gippsland | Other | Total |
|---|---|---|---|---|---|---|---|
| Community Health | 1,173 | 21,621 | 1,839 | 1,433 | 224 | 877 | **27,167** |
| Other - Government | 768 | 1,070 | 86 | 82 | | 3 | **2,009** |
| HACC | 21 | 2,967 | 335 | 652 | | 3 | **3,978** |
| Private/Compensable | 181 | 2,114 | 279 | 123 | 1 | 9 | **2,707** |
| Medicare | 158 | 695 | 61 | 27 | 2 | 9 | **952** |
| Other | 1,988 | 7,735 | 648 | 841 | 6 | 714 | **11,932** |
| **Total** | **4,289** | **36,202** | **3,248** | **3,158** | **233** | **1,615** | **48,745** |

| Funding Type | Bairnsdale | Gippsland Lakes | Omeo | Orbost | Other Gippsland | Other | Total |
|---|---|---|---|---|---|---|---|
| Community Health | 4% | 80% | 7% | 5% | 0.8% | 3.2% | 100% |
| Other - Government | 38% | 53% | 4% | 4% | 0.0% | 0.1% | 100% |
| HACC | 1% | 75% | 8% | 16% | 0.0% | 0.1% | 100% |
| Private/Compensable | 7% | 78% | 10% | 5% | 0.0% | 0.3% | 100% |
| Medicare | 17% | 73% | 6% | 3% | 0.2% | 0.9% | 100% |
| Other | 17% | 65% | 5% | 7% | 0.1% | 6.0% | 100% |
| **Total** | **9%** | **74%** | **7%** | **6%** | **0.5%** | **3.3%** | **100%** |

Whilst the above description provides an overview of the currently available services across the catchment, it is relevant to consider service provision relative to planning norms or expectations. This comparative analysis is hampered by the lack of formal standards or benchmarks for core ambulatory and primary health services, including for GP attendances. Notwithstanding the paucity of planning norms, the following section assesses publicly available planning and performance benchmarks for ambulatory and primary health services in order to consider the *relative* access to these services in the sub-region and relevant metrics.

### 4.1.2 ACCESS TO GENERAL PRACTICE AND SPECIALISTS

Information from the National Health Performance Authority (NHPA) compares relative utilisation of GP and specialist services across Primary Health Networks (PHNs). It can be seen that the Gippsland PHN catchment utilisation of GPs and specialists is in the low to mid-range compared to other Victorian PHN catchments. Specifically, as shown in Table 4-3, of the six PHN catchments, Gippsland is ranked:

- *Third* for the number of GP attendances per person;
- *Fourth* for the number of specialist attendances per person;
- *Sixth* (the lowest) for the number of after-hours GP attendances per person; and
- *Fifth* for the average Medicare benefits expenditure on GP attendances per person.

**Table 4-3: Utilisation of GP and specialist services, age-standardised rates by Primary Health Networks, 2014-15**

| PHN area name | Average number of GP attendances per person | Average number of specialist attendances per person | Average number of after-hours GP attendances per person | Average Medicare benefits expenditure on GP attendances per person |
|---|---|---|---|---|
| North Western Melbourne | 6.5 | 0.94 | 0.75 | 314.04 |
| Eastern Melbourne | 5.7 | 1 | 0.57 | 273.76 |
| South Eastern Melbourne | 5.9 | 0.99 | 0.59 | 283.79 |
| **Gippsland** | **5.8** | **0.9** | **0.17** | **269.08** |
| Murray | 5.7 | 0.81 | 0.25 | 276.17 |
| Western Victoria | 5.5 | 0.88 | 0.32 | 262.11 |

Table 4-4 summarises utilisation of GP and specialist services for the statistical areas (SA3s) within the Gippsland PHN. It is apparent that the East Gippsland has the lowest level of utilisation of all Gippsland statistical areas (SA3s) for most measures. Specifically, it can be seen that East Gippsland is ranked:

- *Lowest* for the number of GP attendances per person;
- *Lowest* for the number of specialist attendances per person;
- *Second lowest* for the number of after-hours GP attendances per person; and
- *Lowest* for the average Medicare benefits expenditure on GP attendances per person.

**Table 4-4: Utilisation of GP and specialist services, age-standardised rates by SA3s, 2014-15**

| SA3 name | Average number of GP attendances per person | Average number of specialist attendances per person | Average number of after-hours GP attendances per person | Average Medicare benefits expenditure on GP attendances per person |
|---|---|---|---|---|
| Baw Baw | 6.6 | 0.93 | 0.3 | 316.42 |
| **Gippsland - East** | **4.5** | **0.73** | **0.12** | **203.57** |
| Gippsland - South West | 5.7 | 0.8 | 0.16 | 267.86 |
| Latrobe Valley | 6.5 | 1.06 | 0.19 | 293.76 |
| Wellington | 5.2 | 0.94 | 0.09 | 250.16 |

These data on GP service and specialist utilisation indicate ***a relatively lower level of access to primary and secondary health services for the East Gippsland sub-region***.

The relatively lower access to primary and secondary health services has the potential to have flow-on effects on demand for up-stream health services such as hospital services and ED

services. There are two specific measures that are frequently used as population-level indicators of access to primary and secondary health services: per capita rates of hospital admission for ambulatory care sensitive conditions (ACSCs); and utilisation of ED services for primary care type (PCT) admissions.

It can be seen from Table 4-5 that the East Gippsland population has ***very high*** rates of hospital admission for ACSCs and higher ED presentation rates, both in terms of total ED attendances and PCT attendances. Specifically, East Gippsland has:

- ***12% higher*** per capita ACSC hospital admission rates compared to the Gippsland region and ***8% higher*** admission rates compared to rural Victoria;
- ***9% higher*** per capita ED attendance rates compared to the Gippsland region and ***28% higher*** admission rates compared to rural Victoria; and
- ***10% higher*** per capita PCT ED attendance rates compared to the Gippsland region and ***35% higher*** admission rates compared to rural Victoria.

**Table 4-5: Rates of ACSC admissions, ED admissions and PCT ED admissions per 1,000 population, East Gippsland versus other LGAs and rural, metropolitan areas, 2012-13**

| Area | Ambulatory care sensitive conditions, admission rate per 1,000 pop'n | Rank, Ambulatory care sensitive conditions, admission rate per 1,000 pop'n | Emergency Department presentations per 1,000 pop'n | Rank, Emergency Department presentations per 1,000 pop'n | Primary care type presentations at EDs, per 1,000 pop'n | Rank, Primary care type presentations at EDs, per 1,000 pop'n |
|---|---|---|---|---|---|---|
| **LGA** | | | | | | |
| Bass Coast (S) | 43.6 | 25 | 426.9 | 8 | 195.5 | 14 |
| Baw Baw (S) | 31.2 | 66 | 396.9 | 13 | 195.5 | 14 |
| ***East Gippsland (S)*** | ***47.2*** | ***20*** | ***415.8*** | ***9*** | ***206.9*** | ***10*** |
| Latrobe (C) | 44.9 | 23 | 398.4 | 12 | 195.6 | 13 |
| South Gippsland (S) | 40.7 | 36 | 125.1 | 69 | 49 | 68 |
| Wellington (S) | 42.8 | 29 | 428.8 | 7 | 231.3 | 7 |
| **Region** | | | | | | |
| Gippsland | 42 | 3 | 380.2 | 1 | 187.6 | 1 |
| **Metro/rural** | | | | | | |
| Metro | 34.2 | 2 | 240.9 | 2 | 94.7 | 2 |
| Rural | 41.6 | 1 | 311 | 1 | 144.7 | 1 |
| Victoria | 36.1 | NA | 258.8 | NA | 107.5 | NA |

### *Implications*

The area-based analysis of service utilisation data for GP and specialist services indicates that East Gippsland has lower than expected utilisation rates. From a health system perspective, there is some evidence that a corollary of the relative under-provision of community-based GP and specialist services is that the East Gippsland population has higher than expected rates of preventable hospital admissions and also, higher rates of use of ED services for conditions that could be potentially managed within a community setting.

The quantitative analysis summarised above is consistent with stakeholder feedback from the consultations. There was widespread acknowledgement that access to primary medical services in many towns of East Gippsland is difficult. For example, we understand that GPs in Bairnsdale have 'closed their books', and that there is a cost to 'registering to get on the

books'. It is not uncommon for Bairnsdale residents to attend GPs in Lakes Entrance and Sale. The challenge of gaining access to GPs in East Gippsland, and Bairnsdale in particular, is not a recent phenomenon.

This is a strategic issue not only for accessing primary medical care for the general community, but the associated implications for BRHS as the sub-regional health service, in terms of increasing attendances to the ED, and the capability of the GP VMOs to cover inpatient and on-call responsibility.

Both GLCH and BRHS are actively seeking options to auspice GP services, including establishing GP practices in close proximity to BRHS. ***In this context, it is incumbent on both BRHS and GLCH to collaborate and develop an agreed joint position on any new service, its location and service model. The scope for outreach to ODH as part of the establishment of a GP practice is also relevant given the challenges of remoteness in assuring local GP participation in the ODH clinic roster.***

### 4.1.3 DEMAND MODELLING

Future demand for ambulatory, primary health and community-based services has been projected for each program and each health service. Demand modelling has been based on current age-specific utilisation rates applied to future changes in the catchment population. For GLCH, the modelling accounts for the wider sub-regional coverage across each of the statistical districts (VIFSAs) in the East Gippsland catchment. For remaining health services, the catchment projections are modelled through reference to the change in the age profile of their respective local catchment: Bairnsdale for BRHS; Orbost for ORH; and Omeo for ODH.

Table 4-6 summarises the results of the projected demand[6] across the period 2015/16 to 2031-32. Projected rates of demand, expressed as per annum growth rates, vary from -1.6% per annum for early health services and -0.1% for supported accommodation and housing support, largely driven by the projected reduction in population in the Orbost District and 0.52% for community dental services. Conversely, the programs with the largest per annum growth rates are those predominantly used by older age groups, namely: HACC, 2.7% growth; acute Tier 2 services, 2.1%; and HIP/chronic disease management services, 1.9%.

[6] *Changes to the model for the provision of HACC services have not been accounted for in Table 4-6. There may be growth implications for GLCH as the service model changes. From July 1 2016 Victorian HACC services for persons over 65 years (50 years and over for the ATSI population) transitioned to the Commonwealth Home Support Program. Funding for younger persons remains the responsibility of the Victorian Government. In conjunction with this change as of 1st August 2016 the allocation of services, including assessment, for older persons will now occur through My Aged Care provider portal. GLCH has made the necessary transition to support this change and anticipate that their HACC contacts will increase.*

**Table 4-6: Projected demand, ambulatory, primary health & community-based services, 2015/16 to 2031-32**

| Program | Unit | 2015/16 | | | | | 2031-32 | | | | | Change | Change % p.a. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | GLCH | BRHS | ORH | ODH | Total | GLCH | BRHS | ORH | ODH | Total | Total | Total |
| Acute (Tier 2 or other ambulatory) | Contacts | **0** | 8,316 | | 49 | **8,365** | **0** | 11,488 | 0 | 81 | **11,569** | 3,204 | 2.05% |
| HIP/Chronic disease management | Contacts | **0** | 17,587 | 1,333 | | **18,920** | **0** | 23,410 | 1,981 | - | **25,391** | 6,471 | 1.86% |
| GP primary care | Contacts | **36,816** | | 25,273 | 3,804 | **65,893** | **46,165** | 0 | 26,633 | 5,026 | **77,824** | 11,931 | 1.05% |
| Community dental | DWAU1 | **0** | 2,222 | 2,995 | 200 | **5,417** | **0** | 2,845 | 2,777 | 215 | **5,837** | 420 | 0.47% |
| Other primary & community | Contacts | **8,031** | 1,512 | 7,972 | 319 | **17,834** | **10,457** | 2,089 | 10,428 | 528 | **23,501** | 5,667 | 1.74% |
| HACC allied health | Hours | **10,947** | 5,932 | 974 | 510 | **18,363** | **16,436** | 8,729 | 1,579 | 1,062 | **27,807** | 9,444 | 2.63% |
| HACC nursing | Hours | **2,204** | 7,364 | 1,871 | 385 | **11,824** | **3,309** | 10,837 | 3,034 | 802 | **17,981** | 6,157 | 2.65% |
| Other HACC and home care | Hours | **75,344** | 38,745 | 17,905 | 4,228 | **136,222** | **113,119** | 57,016 | 29,030 | 8,808 | **207,973** | 71,751 | 2.68% |
| Palliative care nursing | Contacts | **2,590** | 2,342 | | | **4,932** | **3,681** | 3,219 | 0 | - | **6,901** | 1,969 | 2.12% |
| Community nursing | Hours | **9,517** | 1,467 | 232 | | **11,216** | **12,391** | 1,975 | 345 | - | **14,711** | 3,495 | 1.71% |
| Early Health services | Clients | **611** | | 3,877 | | **4,488** | **659** | - | 2,802 | - | **3,461** | -1,027 | -1.61% |
| Drug Treatment services | Episodes | **787** | | | | **787** | **1,008** | - | 0 | - | **1,008** | 221 | 1.56% |
| Supprted accom & housing supp't | Episodes | **243** | | 1,314 | | **1,557** | **311** | - | 1,218 | - | **1,530** | -27 | -0.11% |
| Integrated family services | Hours | **12,497** | | 1,775 | | **14,272** | **14,971** | - | 1,411 | - | **16,383** | 2,111 | 0.87% |
| Family violence | Clients | **487** | | | | **487** | **583** | - | 0 | - | **583** | 96 | 1.14% |
| Indigenous family violence | Clients | **167** | | | | **167** | **200** | - | 0 | - | **200** | 33 | 1.14% |
| Recnct, Yth Justice, Dsblty & oth | Clients | **501** | | | | **501** | **641** | - | 0 | - | **641** | 141 | 1.56% |
| School health & counselling | Contacts | **0** | | 380 | | **380** | **0** | - | 235 | - | **235** | -145 | -2.96% |

***Implications***

*Overall demand projections for ambulatory services are conservatively estimated to increase by about 2% per annum. Even at these conservative rates:*

- *There is expected to be substantial growth in demand across the range of ambulatory programs, and most notably for GLCH programs;*
- *This will exacerbate the challenge for the catchment which has relatively low access to primary GP and specialist services and high rates of ACSC and ED PCT attendances;*
- *There are opportunities to improve the service model for HIP; and*
- *Growth is not uniform across the catchment.*

### 4.1.4 ACCESS TO COMMUNITY DENTAL SERVICES

Public community dental services are delivered from three sites in East Gippsland; Bairnsdale, Omeo and Orbost.

The provision of dental services in East Gippsland – across all ages – is 0.2 occasions per 1,000 population[7], which is only marginally lower than the state average of 0.3 occasions per 1,000 population.

More significantly, Dental Health Services Victoria data indicates that oral health outcomes for children in the sub-region are worse than for Victoria, most notably:

- Children in East Gippsland Shire consistently present at a higher rate, when compared to the Victorian rates, with at least *one decayed, missing or filled primary or permanent tooth (DMFT).* The 2014-16 data indicates that presentations for East Gippsland are:

| Age Group | East Gippsland | Victoria |
|---|---|---|
| 0-5 | 38% | 31% |
| 6-8 | 67% | 57% |
| 9-12 | 71% | 64% |
| 13-17 | 70% | 70% |

- There are also higher rates of potentially preventable hospitalisations due to dental conditions for children aged 0-4 years with a rate of 6.78 per 1,000 population for East Gippsland in 2013-14 compared to the Victorian rate of 3.85 per 1,000.

The average DMFT for adults attending public dental health services in 2014-2016 are also marginally worse than for Victoria.

The above data is reinforced by the:

[7] Dental services include specialist services such as orthodontics and oral surgery. Source: National Human Services Directory (NHSD) 2015

- Poorer dental health reported in Gippsland, which was ranked second highest in Victoria with 8.5% of the population, behind the Grampians region with 8.7%, and compared with other regions and the Victorian rate of 5.6%[8]; and
- Relatively low oral health workforce in East Gippsland. There are 38.1 average hours per week per 1000,000 population by oral health staff, considerably lower than the Victorian rate of 51.7. Furthermore there is a clear paucity of dental hygienists and dental prosthetists in the sub-region.

**Table 4-7: FTE Rates for Oral Health Practitioners in East Gippsland - 2014**[9]

| Profession | East Gippsland | | | Victoria | | |
|---|---|---|---|---|---|---|
| | FTE[10] Number Public | FTE Number Private | FTE Rate[11] | FTE Number Public[1] | FTE Number Private | FTE Rate |
| Dental Therapists | 2.0 | 0.5 | 6.4 | 64.7 | 35.3 | 1.9 |
| Dentists | 6.5 | 9.3 | 38.1 | 370.3 | 2,372.7 | 51.7 |
| Dental Hygienists | 0.0 | 0.0 | 0.0 | 4.7 | 182.9 | 3.4 |
| Dental Prosthetists | Value < -1 | 31.8 | Value < -1 | Value < -1 | 188.8 | 5.0 |

***Implications***

The implications relate mainly to a stronger education and prevention strategy, public health water fluoridisation, and increased access/availability or oral health workforce.

### 4.1.5 STRATEGIC DIRECTION AND ROLE DELINEATION

Outlined in this section are the main strategies for primary health and community-based services for the next five years.

It will be imperative that the main system stewards and planners actively develop service capacity and capability in the sub-region. The current informal structures between the four service providers, together with the Gippsland PHN and the department, that review and develop community-based services are reasonable, and probably more effective than most areas of rural Victoria. It is on this solid base that the following strategies are put forward.

It is proposed that a three-staged process be developed to realign services to improve service system integration (and models of care at a patient/client level).

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8 Victorian Population Health Survey, Department of Health and Human Services, 2011

9 AIHW National Health Workforce Dataset - http://analytics.aihw.gov.au/Viewer/VisualAnalyticsViewer_guest.jsp?reportPath=%2FAIHW%2FReleasedPublic%2FExpenditure%2FReports&reportName=Health%20Workforce&appSwitcherDisabled=true

10 FTE Number is based on the number of hours worked divided by the standard working week. This is assumed to be 38 hours a week for all processions with the exception of medical practitioners, where it is assumed to be 40 hours.

11 FTE rates are based on the weekly hours worked per 100,000 population. Populations are ABS estimated resident population for the relevant year.

The *first stage* is to have an informed baseline of the current situation by all four health services. This involves:

- The joint development of a 'workforce framework' of FTE and skill/capability in the sub-region (including visiting services from outside the sub-region); then,
- Compare the workforce profile against the activity profile between and within each entity. The comparison is intended to identify service overlap/duplication, any service gaps, identify relative productivity, the degree of alignment with service priorities etc.

Once there is a common understanding of baseline services and resources, the *second stage* is to identify how resources can be better targeted, areas where new resources are required, and areas for priority development.

The *third stage* is to develop a joint position in relation to *the transfer of services and resources to alternative auspice agencies* that would lead to *improved service integration*, whether through enhanced access, comprehensiveness of services, service synergies, economy/efficiency, avoiding duplication, etc. In other words, there would be a reallocation and realignment of primary health and community-based functions.

Improving the delineation of roles and functions is being proposed not only because of its intrinsic worth. It is being proposed because the two main health services delivering primary health and community-based services have a sound working relationship and adopt a systems approach to service development. This represents an opportunity to be structurally innovative, which is largely unprecedented in rural Victoria.

It is also a confronting and challenging prospect for all parties, including service funders and planners. If this were not challenging enough, consideration could be given to establishing a default on which future services would be delineated between service providers.

***It is proposed that there is an inter-agency agreement for GLCH to become the default provider of primary health and community-based services for:***

- ***The Lakes Entrance District and Bairnsdale District; and***
- ***More specialised (subregion-wide) services that would then also include the Omeo and Orbost Districts***

***Whilst the basis for role delineation is in the province of each service provider (and to some extent the 'purchasing agencies'), there are some community-based acute and subacute services that need to be synergistically aligned to inpatient acute and subacute health system. In the event that this proposition is supported, HITH and HIP programs would remain with BRHS.***

***Notwithstanding the above, and consistent with the SRHS and MPS roles, ORH and ODH would continue to deliver locally based services to their immediate communities. ORH also provides some services in other small communities including Mallacoota, Bemm River, and Cann River.***

### 4.1.6 COLLABORATION

Notwithstanding the outcome of the potential realignment of functions as outlined above, there are specific measures that can be considered as part of, or independent of, the above

delineation process. This section also considers areas of perceived or actual duplication of services:

- *GP services in Bairnsdale.* As previously noted in Section 4.1.2, both GLCH and BRHS are actively seeking options to auspice GP services, including establishing GP practices in close proximity to BRHS. It is incumbent on both GLCH and BRHS to collaborate and develop an agreed joint position on any new service, its location and service model.
- *Sub-regional GP services*. The provision of GP services at Omeo and Orbost are a core part of the primary care services in the northern and eastern parts of East Gippsland. However, they are fragile services. On a collaborative basis, develop specific strategies that enable a more robust service, particularly for weekend medical coverage, considering the further development of nurse practitioners and/or outreach medical services from Bairnsdale;
- *Infrastructure.* There are opportunities for GLCH and BRHS to collaborate with respect to infrastructure in Bairnsdale. Both health services are separately planning new infrastructure for primary health and integrated community care centres.
- *Alcohol and drug services*. All four health services need to collaborate – potentially with third parties – to establish a residential rehabilitation service for alcohol and other drugs, and fill this service gap.
- *Dynamic and proactive service models*. To the credit of both GLCH and BRHS, there are examples of several health and community services within the sub-region that look to effectively triage and adopt multi-disciplinary approaches that genuinely break down the clinical discipline barriers; provide a more holistic service; and fill gaps. However, this is not always the case. There are still services that function on traditional models, operate largely within business hours and/or principally on clinical discipline lines. Some of these services include community allied health services.
- *ICT*. There are opportunities to innovatively exploit ICT to maximise the flexibility of service delivery and patient 'reach' and to ensure reliable and accurate patient information is accessible from remote sites and in patients' homes.
- *HACC funding*. The transfer of Home Care Support services funding to the Commonwealth (with tendering through the PHN) is likely to create short-term instability and longer-term changes to the model of care for community-based services to predominantly aged patients. Whilst it is unclear at this time as to the precise nature of the impact, the level of collaboration within the region to develop a coherent response to NDIS and Commonwealth Home Support Programs requires unprecedented strategic positioning by all East Gippsland health services.

### 4.1.7 SERVICE GAPS

An important issue for consideration in the overall sub-regional SSP for East Gippsland is to ensure that access to primary health services is commensurate with other communities in Victoria. For East Gippsland, this means:

- Increasing capacity at rates higher than the growth in population; and
- Reasonable distribution or outreach.

Based on the data and the consultations, the main service gaps include:

- *Chronic disease management.* The high rates of ACSC admissions provide evidence of a relative under-provision of effective chronic disease management services in the catchment;
- *Workforce capability*. It is likely that the clinical capability of nursing and allied health staff will need to increase across the board to manage higher acuity/complexity of clients/patients;
- *Early intervention*. Specific early intervention programs identified include:
  - Early testing and remedial services for children relating to audiology, speech therapy, occupational therapy, and psycho-social services;
  - There would appear to be very little in the way of early intervention relating to renal disease caused by diabetes. This is a service gap. A chronic disease management (CDM) model for diabetes is in place at both GLCH and BRHS, and being developed by ORH, that could potentially be extended with respect to its service offering, and its reach to clients with higher risks associated with kidney disease;
- *Acute specialist medical services.* All four health services have service deficits in accessing medical specialists, even by telehealth. Access often means significant travel to Traralgon or Melbourne. This is corroborated by the analysis of MBS data indicating a substantially lower level of utilisation of specialist services by the East Gippsland relative to age-standardised rates for other Gippsland statistical areas and other PHNs;
- *Residential rehabilitation for alcohol and other drugs.* This is seen to be a gap in the service offering that relates to inpatient services at BRHS and community-based rehabilitation provided by GLCH. There is no residential rehabilitation in the sub-region;
- *Pharmacotherapy* is under serviced in East Gippsland; and
- *Community mental health.* The capacity and responsiveness of community mental health is not meeting service expectations of stakeholders. An alternative model is proposed for Lakes Entrance and Bairnsdale that develops the role of community-based psychiatrists to a far greater extent. This service model would entail greater use of MBS-based services (bulk-billed) to support timely early intervention and management of patients with low to moderate mental illness who do not require treatment within an acute mental health setting or by a community mental health team. Any such initiative would also need to be planned in consultation with priority commissioning objectives relevant to mental health.

#### 4.1.8 WORKFORCE

As previously noted, to give effect to the improved collaboration and service integration, there would appear to be significant opportunities to develop a joint workforce strategy for community-based services that provides:

- Full-time positions with joint appointments for specialised health workers (rather than part-time appointments at each entity), to attract staff to the area;
- Cross-credentialing of staff to enable these staff to work across the sub-region;
- A workforce framework (Section 4.1.4) that enables joint prioritisation of community health workforce appointments; and
- Having common office and administration staff for GLCH and BRHS operating in Bairnsdale.

### 4.1.9 INFORMATION AND COMMUNICATION TECHNOLOGY

For community-based services, Information and Communications Technology (ICT) offers the potential to promote integrated ambulatory and primary health care. ICT strategies have the potential to significantly enhance models of care and are particularly relevant in the context of CDM for patients with multiple co-morbidities and who could benefit from team-based care planning.

Key components of an ICT strategy relevant to integrated ambulatory and primary health care include:

- Electronic management of appointment systems to improve the provision of timely routine appointments;
- Electronic health records (EHRs) to facilitate information sharing across the care team with integrated decision support and chronic care management tools;
- Laboratory and pharmacy information systems integrated with EHRs to support chronic disease management;
- Structured care plans that can be tailored to individual patients and which enable care plan tracking for follow up and review;
- Support for patient education about their health and promotion of self-management of chronic disease; and
- Telehealth to remotely connect providers and patients in their co-management of chronic disease and to support access to specialist consultations.

The Gippsland PHN is implementing the *HealthPathways* initiative with the aim of coordinating GPs', specialists' and other health professionals' assessment, management and specialist referral decisions within a local context. It is intended to provide evidence-based, best practice guidelines and local referral templates for clinicians through a practical on-line manual used at the point of care, primarily by GPs. It also seeks to improve health literacy through patient education resources.

The Australian Government is also supporting the rollout of EHRs through *My Health Record*, previously known as the Personally Controlled Electronic Health Record (PCEHR). *My Health Record* is intended to provide GPs and specialists with access to patient information including: Shared Health Summary authored by the treating doctor; Hospital Discharge Summaries; Diagnostic imaging reports; and Prescriptions and dispensing information.

Whilst some of the key components of an ICT strategy, as described above, are likely to be met through the MyHealth Record and the HealthPathways initiative, the challenge is to ensure the scope of ICT linked services extends beyond GPs and hospitals to include all relevant ambulatory and community-based services. This is clearly a medium to long term strategic priority.

We understand that GLCH has commenced point of care data entry (in the community) and electronic devices that provide supporting services to staff (worker compendia). These technologies should be consolidated and extended to all health services in inpatient and community settings.

There are also considerable opportunities to enable telehealth access to acute ambulatory services at Bairnsdale from Melbourne or LRH, and to the more remote communities in East Gippsland from Bairnsdale.

### 4.1.10 CAPITAL INFRASTRUCTURE

Strategic development of infrastructure to support the collocation of ambulatory and primary care services has the potential to substantially address the service planning constraints identified for the catchment. A number of capital development initiatives are under consideration including:

- The purchase of land by GLCH in Bairnsdale to support future expansion of its community-based services; and
- The development by BRHS of an Integrated Community Care (ICC) Health Hub in Bairnsdale.

In addition, LRH has relocated their community mental health services to new facilities in Bairnsdale.

These three independent developments are incompatible with the strategic direction for community services. The challenge is to ensure that any asset investment strategy promotes rather than hinders service integration. Fundamentally, the asset investment proposal should be consistent with the service planning priorities of the catchment services. Accordingly, infrastructure development priorities should aim to:

- Promote an expansion of GP primary care and specialist service availability;
- Promote collocation of allied health and specialist ambulatory care services with primary care services; and
- Facilitate collocation of a range of health and human services relevant to meeting the needs of clients with complex care requirements and who have multiple service needs.

Strategic alignment with state and federal government primary health reforms is key to the vision of having an enhanced role for GLCH in ambulatory and primary health services and associated infrastructure development. This includes:

- Responsiveness to the commissioning role of Gippsland PHN including commissioning of mental health and drug treatment services; and
- Alignment with the Australian Government's trial of 'Health Care Homes'. The aim of Health Care Homes – which are to be delivered by GP practices or Aboriginal Medical Services – is to co-ordinate all of the medical, allied health and out-of-hospital services required as part of a patient's tailored care plan.

***It is proposed that there is joint planning and development of an ICC hub in Bairnsdale that can accommodate both GLCH and BRHS services in Bairnsdale. This may require an expansion of the proposed hub site.***

## 4.2 Emergency treatment

GLCH has stabilisation capacity with BRHS being the designated ED providing a 24/7 emergency service for the sub-region. The current service model for stabilisation services at GLCH is expected to continue but is reliant on an effective/responsive ambulance service.

GLCH relies on Ambulance Victoria (AV) to transfer patients requiring acute hospital care and likewise AV uses GLCH to manage patients who may require general practice care. This clearly only works well when GLCH is open. The availability of after-hours GP services means that the default position for patients is 000 and transfer to Bairnsdale.

## 4.3 Subacute services

### 4.3.1 PALLIATIVE CARE

GLCH also has a Nurse Practitioner Candidate (NPC) who works with the direct care staff and families to coordinate the management of palliative clients across East Gippsland providing leadership and support to the district nurses. This includes tasks such as liaising with specialists and GPs, organising meetings, sending reminders and acting as the conduit for information between the service and inpatient units in addition to assessing and admitting palliative care clients, writing care plans, obtaining appropriate medications and establishing relationships with GPs and specialists. The NPC visits the more complex clients. Specialists believe that the NPC role has been instrumental in improving the standard of palliative care for patients in East Gippsland.

GLCH has found this model very effective, however, it is reliant on a service model that may not be sustainable. GLCH is presently identifying the potential service models to maintain the service. *The Model for Community Palliative Care in Gippsland* report[12] indicates that the role is "the biggest innovation in palliative care" and notes the significant impact in improving the standing of palliative care in their communities and with GPs. This role is imperative to access good palliative care services in the community and it should be continued.

## 4.4 Mental health

The provision of clinical mental health services for the Gippsland region is vested with LRH.

Three main program areas deliver clinical mental health services. Services include:

- *Child and Adolescent Mental Health Services* (CAMHS), which target clients between 0 and 18 years of age. This service is complemented by *headspace*, which provides primary mental health care for persons aged 12-25 years, including case management, who have, or may develop, a severe mental illness, or eating disorder;
- *Adult Mental Health Services* to those between 16 and 64 years of age; and
- *Aged Persons Mental Health Services* to those aged 65 years or older.

[12] *The Model for Community Palliative Care* Report, Gippsland Region Palliative Care Consortium (2014)

The *East Gippsland Mental Health Initiative* (EGMHI) provides community mental health support services, including the provision of a six bed Prevention and Recovery Care (PARC) service.

Current and emerging issues for mental health services include:

- *The impact of Mental Health Reform*. Recovery oriented service delivery demands that services challenge some of their historical practices and move to a system of care delivery that aims to change the course of an illness and improve life-chances, rather than being focused on stabilisation and symptom control. LRH continues to assimilate these (and other) changes.

  The direct and more immediate implications for health service providers in East Gippsland including GLCH will be the shift in clinical practice that is likely to result in more ED presentations and the delivery of primary care services where mental illness is a comorbid condition of other health conditions. At the outset GLCH has indicated that this change in the focus of service delivery is likely to have significant impacts on their service delivery model as mental health clients are increasingly referred to community-based services.

- *Service Gaps*. There are several elements to community mental health that are seen to be problematic for East Gippsland providers, including:
  - Under-developed service responses for out-of-hours presentations;
  - The growing demand for community mental health services;
  - The availability of Consultation-Liaison psychiatry to BRHS VMOs; and
  - In general, GP liaison activity has helped to better manage demand for adults and children/adolescents. Nevertheless, the community mental health services available for children and young people are perceived to be under-resourced.

- *Integration & Partnership*. The strategic intent over the next ten years is to progressively improve the level of integration of the specialist clinical mental health program with all other core health services. The intention is to collaborate and integrate LRH clinical services with generic health services delivered by each of the four health services in East Gippsland. This may include such initiatives as:
  - Single electronic record for patients;
  - Multi-disciplinary services in BRHS ED; and
  - Integrated community mental health services, including the future co-location of the Bairnsdale clinical mental health team with the Integrated Community Health Hub services, amongst others.

- *Primary prevention.* Primary mental health and prevention services enhance the capacity of primary care providers (especially GPs and community health workers) to recognise and respond to mental disorders more effectively. It is proposed that:
  - Clinical mental health staff be invited/supported to work alongside East Gippsland staff in ED and in primary health settings;
  - Support LRH to deliver a responsive capability for early intervention and prevention; and
  - Support the consolidation/extension of the community mental health services in relation to:

  - Community mental health nurses associated with GP practices (funded through the Gippsland PHN);
  - Psychology support services (through Access to Allied Psychological Services); and
  - Mental Health Community Support Services (funded through DHHS).
- *Workforce development*.
  - *Staff rotations*. Develop/support staff rotations within the community/NGO sector and with other health services delivering mental health services; and
  - *Nurse practitioner*. Support LRH with the development of a business case for a community mental health nurse practitioner model over the next five years for East Gippsland.

## 4.5 Alcohol and other drugs

There was consistent feedback that the prevalence of alcohol and illicit drug abuse was a significant issue for the primary catchment and was deteriorating. The major funded provider of AOD in the primary catchment is GLCH through a contract with Latrobe Community Health Service.

The GLCH and BRHS services are more integrated and coordinated than is typical for rural Victoria. The current model is designed to:

- Enable ease of access to AOD services through referral systems within the health and community services sectors;
- Be fully integrated with a network of providers including GLCH and BRHS, participating GPs and supported by Gippsland PHN. This seeks to provide a connected and planned continuous pathway;
- Connectivity with regional and state-wide AOD networks to remain connected; and
- Clarity of roles between clinical and non-clinical support roles for services.

Notwithstanding these successes, there are pieces of the AOD jigsaw that are missing, or could be improved including:

- A *residential withdrawal* program in East Gippsland;
- More timely access to *day programs* by GLCH (operating within the current centralised intake and assessment service). This may include a '*dayhab'* program for people supported in the community;
- *Prevention services.* Prevention would include ongoing funding for a coherent and targeted set of strategies for 'at risk' groups in the community, particularly youth (and specifically aboriginal youth);
- *Community-based pharmacotherapy*. There is only a limited pharmacotherapy service with two GPs in Bairnsdale and two in Lakes Entrance that have completed training to prescribe pharmacotherapy to more than five patients. There is also a pharmacotherapy nurse in Bairnsdale.

The GPs provide services in both Bairnsdale and Lakes Entrance, with some patients electing to travel from Bairnsdale to Lakes Entrance for treatment. Pharmacotherapy is also provided to members of GEGAC. Nevertheless, these prescribers are insufficient to meet the current demands within East Gippsland. It is understood that there are other GPs who are also interested in training as prescribers which would alleviate the current need somewhat in the future and may also form part of an Integrated Community Care Hub; and

- *Demand.* Research into a more accurate analysis of (expressed and latent) demand for different types of AOD services.

## 4.6 Aged Care Services

GLCH provides home-based aged care services through its delivery of Aged Care Packages, post-acute care (PAC) and home services to clients with disabilities. Seventy percent of the work focuses on services provided by staff in clients' homes including personal care and respite care. By far the majority of care has been funded through Home and Community Care (HACC). The Community Services central intake manages all of these referrals.

The Aged Care team at GLCH consists of four main areas:

- *Assessment* – through the common assessment tool from *My Aged Care*. In the longer term the plan is for a region-wide assessment team. It is anticipated that there will be a call for tenders in late 2018 for the coordination contract for Gippsland Assessment;
- *Direct care team and supervisors.* A team of 95 direct care staff provide the direct care to the community;
- *Home care package team.* GLCH currently has 65 Home Care Packages, Levels 1 and 2 (48), Level 3 (13) and Level 4 (4) as part of the Commonwealth Programme. At present there are waiting lists to access packages. In 2017 a further reform to the *Home Care Packages Programme* will be implemented in alignment with the Commonwealth Government's policy around increasing consumer choice. From that point funding for a home package will follow the consumer. GLCH is potentially in a good position to increase the overall number of packages that they manage; and
- *Disability team* – This team services approximately 30 to 40 clients. In 2019 this will transition to the NDIS.

The following are the priority areas and issues for aged care during the life of this service plan:

- *Training and re-training* direct care staff who deliver home care services. The recent move to the Easy Tracker Application has improved the process for the allocation of work and the completion of time sheets;
- *Response to population growth* – Growth in retirement population brings both threats and opportunities. An ageing workforce will create issues for service delivery, with reductions in supply as older workforce cohorts reach retirement age. On the positive side, an ageing population provides increased opportunity for GLCH to meet the increasing demand for home care services;
- *Competition from disruptor organisations* providing services to clients. The impact of this competition is unknown however there is a sense that the aged care services at GLCH

need to be marketed. This will also ensure that the community becomes aware of the services provided by GLCH; and

- *Development of other models of home care* – These models would include value-add services that are outside the current service model. This would have the overall impact of increasing the service volume.

## 4.7 Aboriginal health and *Closing the Gap*

There has been a strong focus on aboriginal health needs by GLCH, BRHS and ORH. There has been investment in specific initiatives and support to the Aboriginal Community Controlled Health Organisations (ACCHOs) in East Gippsland with the presence of the Djillay Ngalu Consortium. Djillay Ngalu works on behalf of the four ACCHOs in East Gippsland (LEAHA, Lakes Tyers Health and Children's Services, Gippsland and East Gippsland Aboriginal Cooperative, and Moogji Aboriginal Council) to oversee and administer funds to assist in the delivery of culturally appropriate health programs. The overall focus is on equity and closing the gap, as well as service developments that support higher utilisation of mainstream health services by aboriginal residents of the catchment.

This includes:

- GLCH support for the Lakes Entrance Aboriginal Health Association, and the Lake Tyers Health and Children's Service;
  - GLCH has a strong partnership with LEAHA. The main offices are collocated on the same site in Lakes Entrance. GLCH provides corporate services to LEAHA including Finance, HR and ICT. A representative from GLCH sits on the Board of LEAHA as a representative from LEAHA sits on the Board of GLCH. The existing partnership has resulted in clients from LEAHA having access to any service offered by GLCH. Whilst a GP may only be present on site at LEAHA once a week, the relationship with the indigenous community is such that if they require medical care on other days they are now more receptive to attending GLCH for treatment.
- ORH liaison with the Moogji Aboriginal community; and
- The award-winning 'Pathways' program at BRHS that has developed a one-stop-shop for ED presentations and 'frequent flyers', including service co-design with the Gippsland & East Gippsland Aboriginal Cooperative (GEGAC) that has established positive and sustained relationships with Aboriginal communities in East Gippsland.

For this plan, it is proposed that in addition to the further development of relations with ACCHOs, that there is a focus on:

- Consolidating referral pathways to and from the ACCHOs with ORH, GLCH and BRHS;
- Acute coronary syndrome through the current initiative using the Heart Foundation assessment tool;
- Prevention of renal failure from diabetes;
- Optometry (and treatment of eye diseases) mainly from diabetes;
- (Other) chronic diseases;
- Audiology; and

- Dental health.

# 5 Workforce models

The strategic service developments identified in the previous sections require changes to the service models (models of care) and workforce requirements. These are critical to the effective implementation of the plan. Specific consideration is given to:

- Regional integration models; and
- Primary health and community services integration.

The opportunities exist in the sub-region to undertake sub-regional workforce planning for all disciplines to ensure that where possible permanent full-time appointments can be shared across multiple sites. This is more attractive to the workforce with the focus on long-term sustainability.

***Implications***

### 5.1.1 GENERAL PRACTITIONERS

GLCH provide GP appointments are available at Lakes Entrance, Monday to Friday, 9am to 5pm and Saturdays 9am to 12pm with urgent appointments only scheduled for Sundays 9am to 12pm. Outreach GP clinics are provided by appointment at Metung, Bruthen, and Nowa Nowa. The GPs attend Lake Tyers Aboriginal Trust and Lakes Entrance Aboriginal Health Association on a regular basis. GP retirement in the next five years is likely.

The increasing needs of the local and surrounding communities for primary medical services will see recruitment of the medical workforce as a high priority area throughout the term of this service plan.

### 5.1.2 SPECIALISTS MODEL STRUCTURES

For each of the specialist clinical disciplines there are a variety of potential service models. For example it is possible to consider:

- Hub-Spoke with outreach arrangements;
- Joint appointments (or consortium agreements) with agreed rotational services; and
- Direct recruitment.

These three basic service models could be supported by:

- Clinical alliances and clinical ‘councils’;
- Formal agreements for clinical pathways, protocols and referrals; and
- Clinical Director roles for multiple health services.

There are currently twelve visiting specialists including a paediatrician and a neurologist who either attend GLCH in person or via teleconference. The development of models of care by GLCH should be based on the estimated level of clinical risk, critical mass, the specialist 'market', sustainability, and relative cost.

### 5.1.3 NURSING AND ALLIED HEALTH

Building a sustainable service model across the region is reliant on the availability of staff. Service provision is jeopardised if it is reliant on a single provider or clinician particularly in the event of temporary or permanent absences. Many of the specialist nursing services and allied health services are dependent on sole practitioners. There is a need to identify the skills that are available across the region and to develop a viable plan to utilise all of the regional resources. Recently the diabetes educator at GLCH went on leave and the educator from Orbost was able to fill the gap.

Difficulties in attracting allied health professionals to the region have meant programs have been developed which rely on the use of allied health assistants. In these programs the allied health assistants provide the direct care and work under the direction and supervision of the health professional. A good example of this is the Lorikeet program – a group program that focuses on the development of fine and gross motor skills and speech development.

# 6 Enablers

This section consolidates the discussion with respect to each of the critical enablers on:

- Workforce development;
- Partnerships and community engagement;
- Infrastructure;
- Information communication technology development;
- Teaching, training & research; and
- Community engagements

## 6.1 Workforce development

Consideration of the future workforce needs for the catchment across health services is difficult and ultimately indicative. There is a recognised paucity in granular workforce data in Australia on which to reliably project future need. The most recent (AIHW) data is provided in Table 6-1, which provides an overview of current estimated clinical professions in selected categories in the primary catchment (FTE), and the rates per 100,000 population as at 2014 (the latest year for which data is available).

The AIHW data on workforce numbers and rates indicate that the East Gippsland catchment has FTE rates *below* the Victorian and Australian average across most clinical areas. East Gippsland has higher per capita rates for some clinical workforce categories, such as dental therapists; enrolled nurses; and optometrists. It has comparable rates for occupational therapists and pharmacists.

The data on per capita rates of medical workforce requires careful interpretation. Overall, East Gippsland's per capita rate of medical practitioners, at 183.2 per 100,000, is around one half (49%) lower than the Victorian rate of 360.0 per 100,000. However, a consideration of the sub-categories of the medical practitioner workforce indicates the following:

- **Medical practitioner GPs**, East Gippsland is *9% higher* at 119.4 versus 109.5 for Victoria;
- **Medical practitioner hospital non-specialists,** East Gippsland is *49% lower* at 20.8 versus 40.7 for Victoria; and
- **Medical practitioner specialists,** East Gippsland is *88% lower* at 15.6 versus 133.2 for Victoria.

The apparent higher per capita supply of GPs in East Gippsland is inconsistent with the previous finding that the catchment has lower per capita rates of GP attendances. This is seems particularly anomalous given the poor access identified for the largest population centre, Bairnsdale. A confounding factor may be that the GP workforce Bairnsdale is also providing a substantial component of the medical workforce for hospital services.

**Table 6-1: Clinician FTE per 100,000 population, 2014**

| Profession | East Gippsland SA3 | | Gippsland PHN | Victoria | Australia |
|---|---|---|---|---|---|
| | FTE Number | FTE rate | FTE rate | FTE rate | FTE rate |
| Dental Therapists | 4.0 | 6.4 | 4.4 | 1.9 | 3.1 |
| Dentists | 19.0 | 38.1 | 38.0 | 51.7 | 54.7 |
| Medical practitioners | 78.8 | 183.2 | 249.8 | 360.0 | 370.3 |
| Medical practitioners - GPs | 51.8 | 119.4 | 120.2 | 109.5 | 110.6 |
| Medical practitioners - hospital non-specialists | 8.0 | 20.8 | 29.6 | 40.7 | 47.4 |
| Medical practitioners - specialists | 8.0 | 15.6 | 51.7 | 133.2 | 132.2 |
| Medical practitioners - specialists-in-training | 9.0 | 22.4 | 44.1 | 71.4 | 72.2 |
| Medical radiation practitioners | 17.0 | 33.4 | 38.7 | 46.8 | 45.9 |
| Midwives | 41.8 | 49.4 | 60.7 | 61.5 | 55.4 |
| Nurses (Enrolled) | 161.7 | 279.1 | 280.0 | 239.2 | 186.7 |
| Nurses (Registered) | 399.4 | 766.8 | 768.7 | 830.4 | 830.3 |
| Nurses and Midwives | 551.3 | 1,024.2 | 1,027.1 | 1,059.4 | 1,012.3 |
| Occupational Therapists | 24.0 | 45.3 | 41.0 | 47.8 | 46.6 |
| Optometrists | 10.0 | 22.2 | 15.7 | 16.8 | 16.5 |
| Osteopaths | 2.0 | - | 5.8 | 13.7 | 6.5 |
| Pharmacists | 35.0 | 77.5 | 74.8 | 82.0 | 79.0 |
| Physiotherapists | 24.8 | 51.9 | 52.2 | 83.5 | 79.8 |
| Podiatrists | 6.0 | 13.3 | 15.4 | 19.2 | 15.3 |
| Psychologists | 19.0 | 34.0 | 44.3 | 81.4 | 75.9 |

1. FTE Number is based on the number of hours worked divided by the standard working week. This is assumed to be 38 hours a week for all processions with the exception of medical practitioners, where it is assumed to be 40 hours.
2. FTE rates: Based on weekly hours worked per 100,000 population. Population based on estimated resident population as at 30June 2014

The increase in population from 43,772 in 2014 to 52,150 in 2031 will require an additional 10 GPs, from 52 to 62, to retain the *existing* per capita rate of GP FTE.

In the case of specialist medical practitioners, if the current rate of 15.6 specialists per 100,000 population were unchanged into the future, there would be only a minor change in supply by 2031, from 8.00 to 8.14 specialists.

Nursing (registered nurses) and allied health services are relatively under-provided in East Gippsland compared to Victorian rates, which is not unexpected.

### 6.1.1 NURSING AND ALLIED HEALTH SERVICES

There are three main streams of activity. The first is for the development of nursing and allied health capability across inpatient settings. The second relates to community-based settings, and the third stream of activity is to ensure that the strategies are coherent, coordinated and jointly developed.

### *Acute nursing and allied health*

- *General and specialised nursing* recruitment and retention – Consideration may be given to:
  - Supporting a mental health nurse practitioner based in Bairnsdale; and
  - Supporting succession planning for nurses with a special interest in aboriginal health.
- *Allied health* recruitment and retention would be focused on where allied health professionals can have the most significant impact in improving care integration and patient outcomes (and reducing length of stay). This should include examination of specific areas where allied health assistants would be clinically appropriate and economical.
- Collaborate with LRH, Melbourne-based hospitals, and GLCH to trial clinical staff rotations. This initiative is designed to build understanding of the different operating environments, and expose staff to new ways of delivering services. The successful implementation of this one initiative has the potential to build very strong relationships between providers.

### *Community-based nursing and allied health*

There are two parts to this strategy – general primary health and HIP.

Strategies for general primary health nursing and allied health are directly linked to the over-arching strategy of service delineation for primary health and community-based services. The focus over the short and medium-term is to ensure that:

- The nursing and allied health teams at GLCH and BRHS are effectively integrated and ensure no duplication of effort/services;
- Develop a common referral and patient booking service; and
- Enable the rotation and/or secondment of staff between the two services.

The key strategy is to enable access to patients with complex care needs (including some acute conditions) to be managed in the community by nursing and allied health staff with the requisite skills.

### *Coherent and coordinated nursing and allied health strategy*

The above strategies need to form part of a coherent and coordinated plan for East Gippsland. More broadly, given the relative under-provision of the nursing and allied health workforce in the catchment, there is a need to consider a strategic, catchment-wide approach to this cornerstone of the service system. A three-stage process is envisaged and outlined in section 4.1.4. It aims to realign services to improve service system integration (and models of care at patient/client level).

- The *first stage* is to have an informed baseline of the current situation by all four health services;
- The *second stage* is to identify how resources can be better targeted, areas where new resources are required, and areas for priority development; and
- The *third stage* is to develop a joint position in relation to *the transfer of services and resources to alternative auspice agencies* that would lead to *improved service integration*.

## 6.2 Partnerships and alliances

Strong and effective partnerships are the foundation for providing integrated health care. Integration in this context refers to *seamless care,* or care that enhances the patient journey in an increasingly complex, and often fragmented system. It is only through such partnerships that improved access and continuity of care can be attained. Effective coordination of service delivery can enhance the quality of services to the consumer, as well as offer benefits to service providers, such as more efficient use of resources, enhanced skills of the workforce, and improved working relationships.

East Gippsland health services already have an array of formal and informal partnerships and there is a strong history of cooperation between health services. Nevertheless, it is essential that *partnerships need to cover a wider range of services* in the future. This SSP envisages that there will be a strong collaborative network between the four health services in East Gippsland, namely GLCH, BRHS, ODH and ORH. This would include, but should not be confined to:

- An agreement between GLCH and BRHS with respect to the default provider of primary health and community-based services;
- The nature of the clinical support by GLCH and BRHS to Orbost and Omeo services; and
- The nature of access to specialist medical and nursing services across East Gippsland.

There are other pivotal relationships that will be developed/enhanced over the next five years with:

- ***Gippsland Primary Health Network***. The Gippsland PHN will be an important partner in service provision with respect to the funding of current core services (such as HACC), recently commissioned mental health services and the collaborative service models that are possible within Gippsland, along with providing a common understanding of health needs and priorities for the region. Gippsland PHN is proposed as an important partner in:
  - The development of role delineation for primary and community-based services;
  - Substitution and diversion services to reduce the rate of PCT ED presentations and preventable ACSC admissions;
  - Clinical workforce development for the primary catchment;
  - Supporting *'Closing the Gap'* and community mental health initiatives; and
  - ICT strategies to promote service integration across the continuum.
- ***East Gippsland Shire***. Key elements of this relationship include:
  - The integration of primary and community-based health with social services in the primary catchment;
  - Support for the social determinants of health approach in the *Municipal Public Health and Wellbeing Plan* and the Shire's role in improving/sustaining the health of the whole community; and
  - Supporting viable maternal and child health services that are well integrated with health and social services.
- ***Latrobe Regional Hospital***. It is proposed to partner with LRH as the regional service provider on the following priority projects/services:

- Clear referral paths for East Gippsland patients requiring cancer treatment, and interventional cardiology, along with early repatriation back to East Gippsland health services following these procedures/treatments; and
- Clinical workforce development, including medical specialist recruitment across a number of disciplines based on a mutually supportive and collaborative approach.

- Local ***Aboriginal Community Controlled Health Care Organisations*** including GEGAC. This involves continuing the excellent ATSI programs by GLCH and BRHS in particular, and building on this base to have an impact on *'Closing the Gap'*;
- ***GPs*** in relation to:
  - The continued and active support of GPs in their role as providing core inpatient services in general medicine, obstetrics and anaesthetics;
  - Supporting improved access to primary medical services to the community of Bairnsdale; and
  - Supporting local GP training programs.
- ***Ambulance Victoria*** in relation to:
  - Cardiac reperfusion (pre-hospital thrombolytic) services;
  - Ongoing dialogue relating to timely access to ED; and
  - Protocols relating to the transfer of mentally ill patients.

***Outreach***

In relation to outreach there appear to be some specific initiatives relating to:

- Obstetric and midwifery support and advice relating to birthing services to sub-regional health services by BRHS and ORH;
- Geriatrician outreach by BRHS;
- Specialist clinic and HITH outreach by BRHS; and
- GP outreach to remote and isolated communities including:
  - GLCH outreach to Lakes Entrance communities.

## 6.3 Infrastructure

The current immediate infrastructure priorities for health services in the East Gippsland catchment include:

- Ambulatory, primary health and community-based services in Bairnsdale. Specifically, there is a requirement for collaborative planning by GLCH and BRHS to ensure that the opportunity to develop a primary medical care clinic with associated ambulatory and community-based services is jointly planned to maximise service integration opportunities from physical collocation of these services into an Integrated Community Care Health Hub in Bairnsdale.
- Community mental health services in Bairnsdale. LRH has separately sought to establish a community mental health service away from the BRHS campus. In the future, the opportunity should be pursued for collocation of the community mental health service with the general ambulatory and primary health services to be auspiced by GLCH and BRHS. The intent is to maximise service integration, particularly for clients who have complex and multiple support needs.
- Support the establishment of a community residential rehabilitation service for alcohol and other drugs.

## 6.4 Information communication technology

The focus for the next five to ten years will be advances in each of the following:

- ***Connectivity within organisations, and between public health services***. The intention is to invest in integrated ICT systems that improve the patient experience, and improve productivity and business systems including:
  - Connectivity with, and effective utilisation protocols for, BRHS ED, GLCH, ORH and ODH;
  - Connectivity and real time services by aboriginal health services with GLCH and BRHS;
  - Progressive implementation of electronic medical records;
  - Enhanced data warehouse capabilities;
  - Patient referral and booking systems; and
  - Electronic real-time bed management systems;
- ***Remote location patient connectivity.*** Real time remote monitoring of patients in their homes and at other health services. This has the potential to be the *next major model of care revolution delivering health care*;
- ***External connectivity*** for clinical information to better integrate care. This includes:
  - ***Data sharing*** that enables information to transcend organisational boundaries to support improved clinical decision-making, organisation of care and outcome measures that focus on the individual rather than an episode of care;
  - Enabling the timely ***referral and 'booking'*** for patient appointments between health services providers on discharge or transfer of patients from acute health services, including GPs; and

- Simple discharge summaries for GPs;

- ***Internal management support systems*** that capture activity data, resources and patient outcomes, in order to:
  - Improve real time decision-making; and
  - Having the necessary evidence-base to demonstrate effectiveness.
- Developing (with the necessary partners) the ICT that can enhance the level of ***clinical training*** such as high quality tele-presence technology and an extensive network to enable virtual teaching and training to be undertaken from almost any setting;
- Effective management and use of social and new media as part of a generational change in the approach to ***communication*** with the community; and
- Increased ***transparency and accountability*** in relation to East Gippsland health services and their performance in meeting the needs of the community and the quality of services provided. This includes a new performance reporting framework based on a 'balanced scorecard' approach.

## 6.5 Teaching and research

Integral to the future delivery of health services in regional Victoria and to the recruitment strategy of senior specialists is the development and embedding of teaching and research into health services. East Gippsland will be no exception.

Over the next five to ten years strategic priorities with respect to teaching and research are as follows.

### Clinical Transition Services

- Consolidate and progress career pathways across clinical and corporate professions, including:
  - Pathways for special targeted groups such as the local Aboriginal population and those living with disability; and
  - Inter-agency placements.

### Staff Training & Development Services

- Develop (with necessary partners) the infrastructure and ICT that will enhance clinical training and skills development. This will include expanding the use of tele-presence technology to enable virtual teaching and training to be undertaken from almost any setting.
- Support workforce redesign initiatives through:
  - Consolidation and growth of *inter-professional learning*; and
  - Implementation/development of scope of practice competency and capability frameworks that are contemporary, flexible, and evidence-based.
- Support sustainable education services through integration of these functions with local and regional health services; and

- Appropriate 'teaching space' in wards, clinics and community health settings.

**Practice Development Services**

- Seek and establish new research and practice development partners with emphasis on contributing to the body of evidence for healthy ageing and community care.
- Support implementation of best practice by:
  - Developing clinical leadership skills and attributes that transform the context and culture of care;
  - Developing education and training programs that both build capacity in leadership to manage change (and staff resilience); and
  - Embedding and strengthening accountability through the best practice in clinical learning environments framework.

## 6.6 Community engagement

The importance of community engagement as an enabler cannot be understated. It is key to ensuring that in the development of the strategic direction for East Gippsland's health services there is scope for community input and canvassing of diverse perspectives.

This is particularly relevant for the strategic focus on service integration and role delineation of ambulatory and community-based services.

# 7 Goals and strategies

This section summarises the main goals and related strategies for both GLCH and more broadly for the East Gippsland SSP. Those that relate directly or indirectly to GLCH are in black font, and those that are relevant to other services are in grey font.

The goals and strategies are provided for each of the four health services to support service development in the catchment. It is expected that these goals and strategies would form the basis of an operational plans at each health service.

| Goals | Strategies |
|---|---|
| **Strategic positioning** | |
| **1. Develop a Wholly Integrated Service Model** | 1.1. Strengthen the already solid relationship for primary health and community-based services between GLCH and BRHS. This requires partnership arrangements that *delineate roles and responsibilities for defined services*<br>1.2. Develop capacity to meet the expected substantial growth in demand across the range of ambulatory programs, including specialist community-based services<br>1.3. Actively build (clinical and organisational) structures that better enable services to be connected remotely, and develop outreach service models<br><br>These three priority measures are likely to address a major challenge for the catchment that has relatively low access to primary GP and specialist services, high rates of ACSCs and ED PCT attendances.<br><br>*The service providers in East Gippsland have the opportunity to build on the current solid foundation of cooperation and build an exemplar model for service integration and collaboration in rural Victoria. Whilst this requires effective structures and agreements, it also requires the further development of organisational culture at each health service that supports/fosters flexibility, adaptability and mutual support in the delivery of health care to meet changing environmental pressures.* |
| **2. Maintain BRHS' capability to operate as a sub-regional hospital** | 2.1. Maintain 80% self-sufficiency for inpatient services for East Gippsland<br>2.2. Progressively develop a more robust medical specialist workforce model |

| Goals | Strategies |
|---|---|
| | 2.3. Formalise and further develop clinical relationships with LRH, and Melbourne-based health services for core clinical services as a first priority |
| **3. Enhance the current under-developed primary and community-based services** | 3.1. BRHS and GLCH to collaboratively support the increased provision of GP services in Bairnsdale to address very low primary medical access<br>3.2. Expand locally available specialist medical clinics in East Gippsland. Priority developments would be in geriatrics, general surgery and specialist medicine |
| **4. Support the development of innovative service models for East Gippsland** | 4.1. Provide specialist (acute and complex care) health services into community settings, including patients' homes, supported by new home monitoring technologies<br>4.2. Support locally developed service models for targeted patient cohorts including adolescents, Aboriginal clients and alcohol and drug clients |
| **Internal Medicine – Acute Care for the Elderly** | |
| **5. Formalise and enhance a 'Well Ageing' program** | 5.1. Develop a model of care that has a specific focus on ACE patients based on a RAPU model, and include:<br>5.1.1. Clear criteria for patient selection<br>5.1.2. The physical co-location (clustering) of RAPU-type patients on the medical ward<br>5.1.3. A MDT approach with consistent general physician input and comprehensive geriatrician assessment<br>5.1.4. Joint nurse and allied health assessments<br>5.1.5. Pharmacy assessment/review<br>5.1.6. Clinical and non-clinical (electronic) discharge planning<br>5.2. Enhance geriatric specialist capacity at BRHS<br>5.3. Examine the most effective use of a NP in the Well Ageing program |
| **Internal Medicine – Cancer Services** | |
| **6. Continue to enhance access to oncology services** | 6.1. Support the GRICS plan for clinical referral pathways to tertiary cancer services at LRH, and for the development of regional treatment models<br>6.2. Maintain local access to chemotherapy at 81% self-sufficiency which will require a marginal increase in |

| Goals | Strategies |
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| | the frequency of visits by medical oncologists to BRHS from LRH<br>6.3. Ensure progressive workforce training in chemotherapy nursing as demand increases<br>6.4. Develop a service model that:<br>6.4.1. Ensures close clinical liaison (nurse) between East Gippsland cancer patients and the CCC at LRH, Melbourne cancer services, and GPs<br>6.4.2. Coordinates patient consultations, planning sessions and therapies that minimise travel and patient inconvenience<br>6.4.3. Provides clinical and social support services for referred patients<br>6.4.4. Refers back to BRHS for ongoing chemotherapy in a timely manner<br>6.5. Support integrated cancer services information technology and data bases that enable:<br>6.5.1. Efficient referral and patient tracking<br>6.5.2. Remote patient monitoring of chemotherapy patients |
| **Internal Medicine – General Medicine** | |
| 7. **Strengthen general medicine capacity** | 7.1. As a key initiative, implement a specialist general physician model at BRHS that supplements and operates alongside the current GP physician model<br>7.2. Improve self-sufficiency from 76% to 80% for non-sub-speciality medicine<br>7.3. Support the provision of specialist physician services at Orbost and Lakes Entrance |
| **Internal Medicine – Renal** | |
| 8. **Consolidate renal services in Gippsland** | 8.1. In collaboration with LRH, and other Gippsland health services, examine the feasibility of establishing a single renal hub provider |
| **Internal Medicine – Neurology/Stroke** | |
| 9. **Manage higher complexity neurology/stroke patients at BRHS** | 9.1. Develop and maintain strong clinical links and pathways with LRH as the regional referral hospital, and with quaternary services in Melbourne<br>9.2. Ensure that the specialist medical assessment and management of stroke patients meets the national |

| Goals | Strategies |
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| | *Clinical Guidelines for Stroke Management* (National Stroke Foundation) in 100% of cases. BRHS to be part of the Victorian Stroke Telemedicine program at the Florey Institute |
| | 9.3. Enhance integration and patient flow between ED, acute, sub-acute and community rehabilitation (SACS) for stroke patients, as well as pathways to primary care |
| **Internal Medicine – Other** | |
| **10. Consolidate and strengthen self-sufficiency in selected sub-specialty medicine** | 10.1. Improve self-sufficiency for:<br>10.1.1. Clinical Cardiology from 87% to 91%<br>10.1.2. Endocrinology from 81% to 85%<br>10.1.3. Gastroenterology from 76% to 81%<br>10.1.4. Haematology from 79% to 89%<br>10.1.5. Immunology & Infections from 78% to 83%<br>10.1.6. Respiratory from 78% to 80%<br>10.1.7. Alcohol & Drug from 86% to 90% |
| **General Surgery** | |
| **11. Strengthen the core capacity for general surgery for BRHS** | 11.1. Increase general surgery by around 2.7% per annum to modestly increase market share from 72% to 74% in the primary catchment<br>11.2. Enable a staged increase in general surgeons from the current 1 to around between 2 and 3 surgeons<br>11.3. Support and cultivate the 'general surgeon' model as the predominant and most sustainable model for specialist surgery cover |
| **Sub-Specialty Surgery** | |
| **12. Enhance sub-specialty surgery to address gaps** | 12.1. Through traditional sessional VMO models increase:<br>12.1.1. ENT market share from 53% to 70%<br>12.1.2. Gynaecology market share from 53% to 70%<br>12.1.3. Ophthalmology market share from 47% to 70%<br>12.1.4. Orthopaedic surgery market share from 51% to 64%<br>12.1.5. Urology market share from 68% to 70% |

| Goals | Strategies |
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| | 12.2. Develop community-based diversion and substitution programs to reduce admissions and reinstitute an OAHKS program<br>12.3. Develop a nurse-led cystoscopy clinic<br>12.4. Consider strategic alliances between BRHS, LRH and quaternary services in Melbourne (including with the Royal Victorian Eye & Ear Hospital) regarding the future provision, and clinical network support, for ENT and Ophthalmology |
| **Women's & Children's – Maternity** | |
| 13. **Continue to provide a sub-regional maternity service, and improve access to community maternity clinics** | 13.1. Provide a level 3 maternity service at BRHS<br>13.2. Formalise agreements with LRH as the (prospective) Level 5 service in the region, and with referral and transfer arrangements for escalation to Monash Health as the quaternary (Level 6) service<br>13.3. Establish a 'greater sub-regional' obstetrician – Clinical Governance appointment to consolidate clinical governance of maternity services<br>13.4. In collaboration with Sale, develop joint appointments and specialist obstetrician cover for the predominantly GPO workforce at BRHS<br>13.5. Support a new model of care based on a two-tiered approach. The tiers are delineated by the relative complexity of care, i.e. low complexity and moderate complexity births. This model supports a model of care between GPOs and consultant specialists at BRHS<br>13.6. Maintain market share for obstetrics in East Gippsland at around 80%<br>13.7. Continue to provide obstetric consultation and midwifery advisory services by BRHS to support the ORH maternity service<br>13.8. Continue the midwifery training model<br>13.9. Broaden the current private GP maternity services through a specialist multi-disciplinary model involving a specialist obstetrician for more complex ante- and post-natal patients (supported in part by MBS funding). Facilitate outreach or telehealth clinics to Lake Entrance, Omeo and Orbost |
| **Women's & Children's – Neonatal** | |

| Goals | Strategies |
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| **14. Continue to provide a sub-regional neonatal service** | 14.1. Provide a Level 2 neonatal service at BRHS that aligns with the Level 3 maternity service<br>14.2. Maintain the market share for neonatal services in the primary catchment at around 10% |
| **Women's & Children's – Paediatrics** | |
| **15. Maintain a viable specialist paediatric service** | 15.1. Retain a model of care to minimise paediatric admissions and focus on ambulatory and home-based care<br>**15.2. Support improved access to paediatric clinics in East Gippsland as part of the broader strategy to enhance specialist medical services**<br>15.3. Maintain specialised paediatric allied health workforce, improving access in Bairnsdale and support access for Orbost and Omeo through workforce developing. |
| **Clinical Support – Anaesthetics** | |
| **16. Progressively expand and enhance the capability of anaesthetics services commensurate with service developments and growth** | 16.1. Undertake judicious anaesthetist recruitment consistent with increased surgical lists<br>16.2. Develop a specialist anaesthetist profile, consistent with increased self-sufficiency in sub-specialty services. Operate a hybrid specialist anaesthetist and GP anaesthetist model for BRHS. Review the efficacy of the model at this time<br>16.3. Consider a fractional appointment of a sub-regional Specialist Anaesthetist role in Clinical Governance, supporting clinical practice and patient safety in the greater sub-region of Central and East Gippsland<br>16.4. Engage a senior consultant in a future HDU and as part of the chronic pain management ambulatory service team with rehabilitation |
| **Clinical Support – Other** | |
| **17. Expand and enhance the capability of strategic clinical support services commensurate with service developments and growth** | 17.1. Plan to progressively develop the clinical capability of a ***high dependency unit*** as the service develops over the next ten years to avoid critical care becoming a significant constraint on meeting the service expectations of a sub-regional role<br>17.2. Examine the potential (new) areas where ***allied health*** professionals can have the most significant impact on patient outcomes (and reducing LOS) and |

| Goals | Strategies |
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| | extending scope of practice to substitute aspects of care currently delivered by medical specialists<br>17.3. Develop an evaluation framework that assesses the relative impact of ***allied health*** services on patient outcomes and patient flow<br>17.4. Systematically assess the relative resourcing of each ***allied health*** discipline across divisions and service streams, including allied health assistants, and then assess recruitment options or innovative models that can address minimum needs in the short to medium term<br>17.5. For ***pharmacy***, examine the potential impact on patient safety and cost for extended 7-day ***pharmacy*** services to match clinical service growth, improve patient discharge on weekends and clinical governance<br>17.6. Undertake an audit (followed by a specific plan) relating to the ***bariatric needs*** across acute health services |
| **Specialist Acute Clinics** | |
| 18. **Develop specialist acute ambulatory services on a viable basis that better meets community demand** | 18.1. Develop an outpatient plan in collaboration with the Department of Health & Human Services that:<br>18.1.1. Transitions the existing undifferentiated grant to an activity-based grant, consistent with larger health services<br>18.1.2. Enhances the number of specialist outpatient clinics and activity levels of existing services through the expansion of public clinics for high volume specialties and MBS clinics supported by a 100% donation model for low volume clinics<br>18.2. Provide (approximately 8) specialist consultation/ treatment spaces in the Integrated Community Care Hub<br>18.3. Develop a program of specialist outreach and telehealth specialist clinics at Lakes Entrance, Omeo and Orbost<br>18.4. Support the development of diversion and substitution clinics such as OAHKS |
| **Sub-acute Bed-based Services** | |

| Goals | Strategies |
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| **19. Improve the inpatient service model** | 19.1. Review the service model for sub-acute inpatient services to enable:<br>19.1.1. Intensity of care/treatment consistent with care plans, and ALOS<br>19.1.2. Patient flow to SACS<br>19.1.3. A 'pull model' from ED and acute beds<br>19.2. Given that future specialist medical input for subacute services is likely to be no more than 0.5 FTE, develop a nurse practitioner model to support the effective operational needs of a subacute inpatient service<br>19.3. Provide input into the ACE program<br>19.4. Develop key performance indicators that demonstrate relative efficiency |
| **Sub-acute Ambulatory Care Services** | |
| **20. Progressively extend the capacity of SACS and community palliative care** | 20.1. Develop an outreach service model to provide clinical support and advice to Lakes Entrance<br>20.2. Enable direct referrals to SACS from ED and Outpatients<br>20.3. Develop a falls & balance clinic over time<br>20.4. Develop a pain management clinic over time<br>20.5. Develop innovative home-based rehabilitation services |
| **Emergency Department** | |
| **21. Improve service access and enhance the patient experience of BRHS ED** | 21.1. Achieve NEAT targets<br>21.2. Maintain the high 92% market share from East Gippsland for ED attendances<br>21.3. Develop a medical model for ED based on senior medical cover on each shift<br>21.4. Improve the model of care through the enhanced and timely use of diversion and substitution strategies, including:<br>21.4.1. A RAPU-like service for acute elderly patients<br>21.4.2. HARP and HITH with 7-day availability<br>21.4.3. Direct admissions to sub-acute beds based on clear protocols<br>21.4.4. Access to a responsive clinical mental health service |

| Goals | Strategies |
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| | 21.4.5. Continue to have a flexible use of the SSU<br>21.5. Undertake regular case reviews<br>21.6. Ensure appropriate treatment spaces for mental health patients and paediatric patients<br>21.7. Ensure the continuation of the Aboriginal friendly access to ED<br>21.8. As the 10th highest PCT rate in the state, develop diversionary services through the availability of GPs, and more effective use of the Nurse Practitioner;<br>21.9. BRHS to continue to support the UCC presentations at Orbost and Omeo as required, including through telehealth/video-conferencing<br>21.10. Maintain the current UCC models at ORH and ODH<br>21.11. Establish a 'Clinical Council' model that brings together the key personnel in the region to actively manage emergency medicine services in the Central and East Gippsland sub-regions |
| **Closing the Gap** | |
| **22. Proactively develop targeted health services that support the local ACCHOs, and ensure accessible generic services to Aboriginal patients** | 22.1. Continue to build on the very successful aboriginal programs by GLCH and BRHS. The specific focus will be on:<br>22.1.1. Consolidating referral pathways to and from the ACCHOs<br>22.1.2. Acute coronary syndrome through the current initiative using the Heart Foundation assessment tool<br>22.1.3. Renal failure prevention for diabetes patients<br>22.1.4. Optometry (and treatment of eye diseases) mainly from diabetes<br>22.1.5. Audiology services, principally for children; and<br>22.1.6. Oral hygiene & dental services<br>22.2. Establish 'closing the gap' outcomes monitoring in collaboration with ACCHOs |
| **Mental Health** | |
| **23. Enhance local access and integration of mental health services** | 23.1. Develop a specific service agreement with LRH AMHS relating to mutual service expectations<br>23.2. Continue to build/strengthen capability of BRHS, ORH and ODH clinical staff in the care and treatment |

| Goals | Strategies |
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| | of mental health patients through training from the AMHS<br>23.3. Address specific service gaps in relation to:<br>23.3.1. Response/presence in ED<br>23.3.2. Consultation-Liaison psychiatry<br>23.3.3. The consolidation/extension of the community mental health services including nursing and psychological services<br>23.4. Support the development of a community mental health nurse practitioner model over the next five years for East Gippsland |
| **24. Support the development of alcohol and other drug services to the East Gippsland sub-region** | 24.1. Support and advocate for the development of a community residential AOD service in East Gippsland Shire<br>24.2. Support a service model that makes access to AOD services simpler and client-friendly through the triage (gatekeeper) process<br>24.3. Strengthen the development of pharmacotherapy services in the East Gippsland sub-region. |
| **Primary & Community Based Care – Service Gaps** | |
| **25. Progressively plan and deliver services in identified service gaps** | 25.1. Seek to mitigate the low level of access to primary medical services (GPs) through a coordinated response from public health services (BRHS and GLCH) in collaboration with the Gippsland PHN<br>25.2. Develop a program of service development that enhances access to:<br>25.2.1. Acute outpatients<br>25.2.2. Podiatry in Orbost<br>25.2.3. Complex care services for elderly patients across the sub-region<br>25.2.4. Social work<br>25.2.5. Community health and social support services for children/adolescents<br>25.2.6. Targeted and culturally sensitive services that support the local ACCHOs |
| **Primary & Community Based Care – Diversion and Substitution** | |
| **26. Further develop and relaunch a sustainable** | 26.1. Revitalise a HITH program with the following characteristics: |

| Goals | Strategies |
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| **HITH service (with support delivering appropriate community based care)** | 26.1.1. Provide a 7-day HITH service<br>26.1.2. Clinical lead for HITH to be undertaken by ED<br>26.1.3. Care/treatment pathways for each of the clinical conditions - supported by physicians/surgeons<br>26.2. Periodic (and clinically valid) evaluation of clinical processes and patient outcomes of HITH |
| **27. Consolidate Complex Care and RIR services** | 27.1. Progressively develop a seven day Complex Care and RIR service |
| **Residential Aged Care – Orbost** | |
| **28. Redevelop the ORH site** | 28.1. Undertake a master plan for the Orbost site that:<br>28.1.1. Integrates the acute and RACS beds;<br>28.1.2. Develops an optimal number of RACS beds of 37 in the short to medium term and making provision for an additional 10 beds beyond 2031<br>28.2. Develop the community packages available to ORH |

# Appendix 1 Sub-Regional Services

Outlined below is a previous Departmental document *'Rural Directions for a Better State of Health (2009)'* provides the only definition of a sub-regional service. The levels specified in the descriptions represent 'complexity categorisations' that may have been superseded over time.

It is important to note that the Department of Health and Human Services are currently undertaking a broader planning project, and that the role of sub-regional services (or potentially outer rural regional services) may change.

**The following description should be taken as indicative only.**

*"Sub-regional hospitals provide the same range of core clinical services as regional hospitals, including some services at the same level of complexity.*

*"Sub-regional hospitals in Group 2 usually provide:*

1. *24-hour emergency departments on-site and full complement of clinical staff;*
2. *Procedural services are provided at Level 3;*
3. *Birthing services at Level 3, providing for both primary and secondary levels of care;*
4. *High dependency nursing care;*
5. *Neonatal care is at Level 2 low dependency special care nursery;*
6. *Renal dialysis as a satellite service;*
7. *Cancer treatment will be provided, including chemotherapy. Sub-regional services are key participants in the regional integrated cancer services;*
8. *Sub-regional hospitals provide sub-acute services, including rehabilitation and geriatric evaluation & management;*
9. *Palliative care is provided at Level 2.*

*"To meet their additional sub-regional role all these hospitals are also lead providers for a range of clinical specialties, particularly those where specialist services require a critical mass of volume and complexity to support ongoing provision."*