aspex consulting

Omeo District Health

Strategic Services Plan - Omeo District Health

Final Report

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List of Abbreviations

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 Services
CCC	Comprehensive Cancer Centre
CDM	Chronic Disease Management
CGHS	Central Gippsland Health Service (Sale)
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 Programs
HITH	Hospital in the Home
HSP	Home Service Package
ICC	Integrated Community Care

IMG	International Medical Graduate
LGA	Local Government Area
LRH	Latrobe Regional Hospital
MBS	Medicare Benefits Schedule
MCRG	Major Clinical Diagnosis 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 Services
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

1 Purpose, context and approach

1.1 Purpose

The purpose of this report is to provide a strategic services plan for Omeo District Health (ODH). The plan for ODH has been developed as part of as part of a broader sub-regional strategic services plan.

The plan encompasses the range of acute health services and primary care provided by ODH including acute services, urgent care services, primary health and community-based care. 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. Residential aged care services are out of scope of this strategic services plan.[1]

Although this services plan is specific to ODH, 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), Gippsland Lakes Community Health (GLCH) 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, and also between ODH with the broader Gippsland region.

1.2 Context

ODH is a small rural health service that provides broad-based health and support services to the towns of Omeo, Benambra, Swifts Creek, Ensay, Dinner Plain and surrounding areas. The service profile comprises:

- Acute/subacute, 4 beds
- Residential aged care services, 14 beds
  - 10 high level
  - 4 low level beds
- Ambulatory and home-based services
  - Urgent care centre service
  - GP services
  - Dental services
  - Allied Health and community services
  - District nursing services
  - HACC services

[1] The scope of the East Gippsland Strategic Services plan excluded residential aged care services with the exception of RACS services provided by Orbost Regional Health.

- Visiting services including maternal and child health, continence, wound consultant, ophthalmologist and cardiologist services.

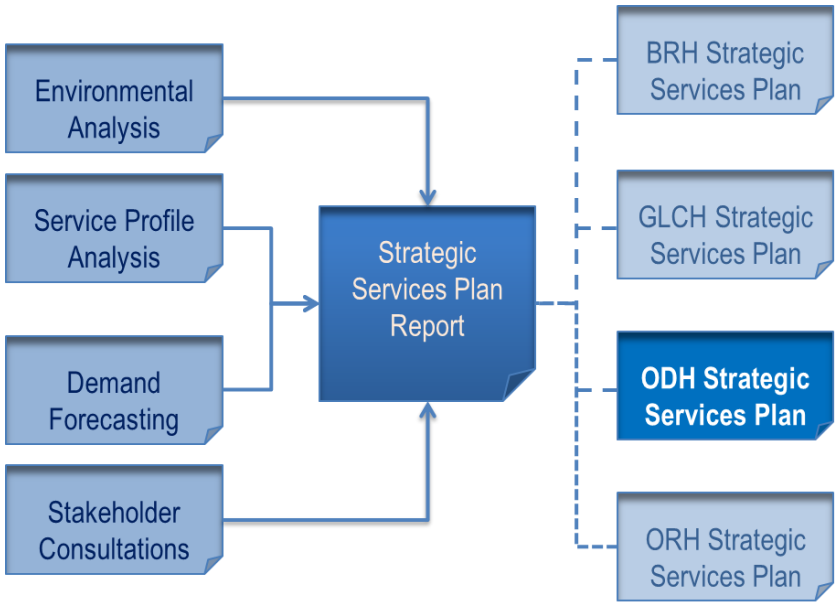
1.3 Approach

This plan is premised on analysis of important baseline information in the *Environment & Service Profile Analysis Report (August 2016),* including:

- Environmental factors that are likely to influence East Gippsland health providers such as the policy context at state and federal level, the demography of the catchment population, the socio-economic profile of the population and the health status of the population;
- The current service profile of ODH 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;
- Projected increases in demand for services at ODH; and
- A consultation program that involved a broad range of stakeholder discussions in the sub-region.

The ODH 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 ODH. This section outlines the more significant factors that have shaped the SSP.

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 ODH;
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 service 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*.
- Health care services should be as close to residents home or community as possible when this is safe to do so.
- The future service profile for ODH 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 ODH and in the region that are able to:
  - Progressively respond and adapt to changes in need as circumstances change over the next 10 to 20 years;
  - Nurse-led service model development; and
  - Support the local community and home-based services, particularly services that:
    - Substitute for inpatient admissions or urgent care presentations;

  - Deliver effective primary and secondary level health services that are close to where people live; and
  - Assist people to age in place.
- 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.

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 investments 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 Victorian hospitals.

In April 2016, the Council of Australian Governments abandoned the *White Paper on the Reform of Federalism.* Furthermore, it made an historic commitment to explore fundamental changes that seek to reassure commitment to the universal health system and have implications for publicly funded health care. This included a Heads of Agreement for public hospitals from 1 July 2017 to 30 June 2020 that sees the Commonwealth providing an estimated additional $2.9 billion capped at 6.5 per cent per annum. More significantly, the Agreement preserves parts of the existing system, including activity based funding and the national efficient price, which had previously been mooted to revert to block funding, indexed according to population growth and the consumer price index. 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,*[2] 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*[3] 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 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.

As important as population growth is, a more directly relevant indicator of demand for health services is utilisation rates, that is, the rates at which the population use public health services. In relation to acute admissions, utilisation rates for the primary catchment (East Gippsland Shire) have been at 555.4 separations per 1,000 people in Victoria (ranked 4 of 79 LGAs), and is extremely high even for rural Victorian rates and is high within the Gippsland region.[4]

The demand for acute and subacute services has been just over 24,000 in 2014/15 increasing to 42,700 separations by 2036/37. This represents an increase in inpatient

2. Duckett, S et.al. *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care*, October 2016, Victorian Government
3. Deloitte, DHHS, *Design, Service and Infrastructure Plan for Victoria's Rural & Regional Health System*, September 2016
4. DHHS - LGA profiles, 2012-13

demand of ~18,700, or an average of 2.6% per annum between 2014/15 and 2036/37, and 78% in aggregate to 2036/37. Most of the growth is expected to occur at BRHS.

In 2014/15, East Gippsland had a self-sufficiency of ~68% if all public and private hospitals are included. BRHS was the main contributor with 63%, followed by ORH with 5%, and ODH with 0.2%.[5]

Self-sufficiency increases to 76% if only public hospital separations are included in the analysis. Public hospital self-sufficiency comprises 69% for BRHS, and 0.1% for ODH.

For the primary catchment of ODH, Omeo District, the acute public hospital market share for ODH (excluding dialysis and chemotherapy) has reduced from 2.7% in 2010-11 to 1.4% in 2014/15. Market share for BRHS for Omeo District has increased from 62.0% to 65.1% over the same period

Based on demand modelling for acute public hospital separations, excluding chemotherapy and dialysis, there is a projected increase from 1,980 to 3,226 separations for the Omeo District, or 2.24% per annum growth from 2014/15 to 2036/37. There is projected to be a further growth in market share for BRHS from 65.1% to 73.0% and further reduction in market share for ODH from 1.4% to 1.0%.

ODH's acute separations are projected to remain relatively stable, increasing from 32 to 35 acute separations over the projection period.

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 health and community-based services are deficient, the flow on effects to inpatient and Emergency Department and UCC services will be significant. A key driver for this plan is to strengthen ambulatory services, to support their pivotal role as reliable and accessible parts of an integrated service system, and to articulate a specific role for ODH.

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;
- Ensuring ***patient safety***; and
- ***Entity viability*** for ODH.

5. Self-sufficiency refers to the share of hospital activity from a catchment area that is treated at local hospitals within the catchment.

3 Role

The data analysis and the stakeholder consultations indicate that there is no fundamental change proposed to the current role of ODH.

ODH will continue to operate as a Small Rural Health Service.

As a Small Rural Health Service, ODH is expected to provide a service mix that best meets local needs. The current service mix includes:

- Low level acute medical services, subacute services (including maintenance care and palliative care services);
- Residential aged care;
- Urgent care;
- Primary medical care; and
- Community-based services.

Although not necessarily a core service of a small rural health service, ODH also provides primary medical services, an important service for the town Omeo and surrounding townships.

Whilst the role for ODH is not proposed to change, there is likely to be some evolution of its service mix over time. ODH would continue to be supported by BRHS for both clinical and non-clinical services.

Based on the emerging sub-regional roles being developed by the department, it is likely that planning for clinical support to ODH will include:

- Telehealth for emergency/urgent care presentations at ODH;
- Secondary consultations by specialists in relation to acute and non-acute inpatients at ODH;
- Arrangements for on-site and telehealth allied health support;
- Telehealth radiology;
- Community dental services;
- Remote pharmacy; and
- Staff exchange across a range of areas would be possible with sufficient planning; amongst other services.

The non-clinical support could include the full range of services as agreed, including Medical Director Services, maintenance, food services, finance, payroll, human services, medical records, IT support, and business intelligence.

4 Service development and models of care

This section describes important areas where services will be enhanced over the next five to 10 years, and provides the basis for more strategic service development over the next 20 years. In particular, it includes a discussion of each of the main service streams:

- Primary health, and community-based services;
- Acute services; and
- Urgent Care services.

In general, each section contains a summary discussion of the main issues and challenges, and the proposed strategies for the development and service models.

4.1 Primary health and community-based services

4.1.1 OVERVIEW OF SERVICES IN THE CATCHMENT

As summarised in Table 4-1, ODH provides a range of ambulatory, primary health and community-based services including:

- Acute ambulatory;
- GP primary care;
- Community dental;
- HACC allied health and nursing;
- Home-based care; and
- Other primary and community-based services.

Table 4-1: Ambulatory, primary health and community-based services, ODH, 2015/16

PROGRAM	UNIT	GLCH	BRHS	ORH	ODH	TOTAL
Acute (Tier 2 or other ambulatory)	Contacts		8,316		49	8,365
HIP/Chronic disease management	Contacts		17,587	1,333		3,675
GP primary care	Contacts	36,816		25,273	3,804	65,893
Community dental[1]	DWAU		2,222	2,995	200	5,417
Other primary & community	Contacts	8,031	1,512	7,972	319	17,834
HACC allied health	Hours	10,947	5,932	974	510	18,363
HACC nursing	Hours	2,204	7,364	1,871	385	11,824
Other HACC and home-based care	Hours	75,344	38,745	17,905	4,228	136,222
Community Palliative Care nursing	Contacts	2,590	2,342			2,590

PROGRAM	UNIT	GLCH	BRHS	ORH	ODH	TOTAL
Community nursing	Hours	9,517	1,467	232		9,749
Early Health services	Clients	611		3,877		4,488
Drug Treatment services	Episodes	787				787
Supported accommodation & housing support	Episodes	243		1,314		1,557
Integrated family services	Hours	12,497		1,775		14,272
Family violence	Clients	487				487
Indigenous family violence	Clients	167				167
Reconnect, Youth Justice, Disability & other DHHS	Clients	501				501
School health & counselling	Contacts			380		380

Notes:
[1] Community dental units for ORH are 'visits' vs DWAU for BRHS and ODH

Whilst the above description provides an overview of the currently available services at ODH (and the other three health services in East Gippsland) 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.

In addition, there are community based services and social support services provided by ODH that have not aligned with the general sub-regional mix of services described above. These include:

- Coordinating the use f the local supported accommodation and housing support service;
- Integrated family services support;
- Family violence support; and
- Support to the Bush Nursing Centres (including a GP clinic).

4.1.2 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[6], which is only marginally lower than the state average of 0.3 occasions per 1,000 population.

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

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:

- 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%[7]; 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 4-2: FTE Rates for Oral Health Practitioners in East Gippsland - 2014[8]

Profession	East Gippsland			Victoria		
	FTE[9] Number Public	FTE Number Private	FTE Rate[10]	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

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

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

9 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.

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

Implications

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

4.1.3 ACCESS TO GENERAL PRACTICE AND SPECIALISTS

The analysis identified that coupled with a relatively lower access to primary and secondary health services, East Gippsland also 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.

The quantitative analysis summarised above is consistent with stakeholder feedback from the consultations. There was widespread acknowledgement that access to primary medical services in East Gippsland is difficult.

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;*
- *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 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. The catchment projections are modelled through reference to the change in the age profile of their respective local catchment: Omeo for ODH.

Table 4-3 summarises the results of the projected demand 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%.

Table 4-3: 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%
Supprt'd 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

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;*
- *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**. Population ageing is particularly marked at ODH and this will create further challenges for this site in relation to clinic-based services and home-based services.***

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 (and 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 patient/client level).

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.

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:

- *Clinical governance.* There are significant opportunities to collaborate in relation to clinical governance and clinical appointments for community-based services. These measures would be part of the broader collaborative clinical governance systems and structures;
- *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;
- *Diversion and substitution services.* There are opportunities to enhance the capability and capacity of SACS and related services.
- *Alcohol and drug services*. All four health services to collaborate – potentially with third parties – to establish a residential rehabilitation service for alcohol and other drugs, and fill this service gap.
- *ICT*. There are opportunities to innovatively exploit ICT to maximise the flexibility of service delivery and patient 'reach', to ensure reliable and accurate patient information is accessible from remote sites and in patient's homes, and to develop effective IT support between the four health services.

- *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 Home Care Support Programs requires unprecedented strategic positioning by all East Gippsland health services.

4.1.7 SERVICE GAPS

An important issue for consideration is that access to primary health services should be 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;
- *HIP specialist clinics*. There is a need to expand the range of specialist clinics beyond continence services. Areas for priority include specialist falls; and specialist pain management;
- *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 patients, including intravenous cannulation, and PICC line management;
- *HITH, RIR and Complex Care.* These are established services but all are under-developed. HITH in particular requires a viable service model that does not rely on active GP support to increase its utilisation;
- *SACS rehabilitation program*. The SACS program is not operating as a fully effective multi-disciplinary service. It provides a lower intensity of service than would be expected and is not as closely integrated with the admitted subacute sector as would be expected to promote patient flow and treatment in the least restrictive setting;
- *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 BRHS and GLCH, 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.* There are service deficits for access to 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 the East Gippsland sub-region; and
- *Community mental health.* The capacity and responsiveness of community mental health is not meeting service expectations of stakeholders. It is proposed to consider an alternative model for Bairnsdale and Lakes Entrance that develops the role of community-based psychiatrists to a far greater extent. This service model would entail the 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 provided:

- 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; and
- A workforce framework that enables joint prioritisation of community health workforce appointments.

4.1.9 INFORMATION AND COMMUNICATION TECHNOLOGY

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 diseases and to support access to specialist consultations.

4.2 Acute services

Table 4-4 summarises the clinical specialties, or MCRGs, that comprise the acute services casemix at ODH. The top 5 MCRGs in 2014/15 by volume of separations, accounting for 78% of the total episodes, were:

- Orthopaedics, 9 separations;
- Respiratory medicine, 6 separations;
- Clinical cardiology, 4 separations;
- Non-subspecialty surgery, 3 separations; and
- Psychiatry, 3 separations.

Table 4-4: Acute separations by MCRG, 2014/15 to 2036/37, ODH

MCRG	2014/15	2036/37
Orthopaedics	9	8
Respiratory Medicine	6	6
Clinical Cardiology	4	2
Non Subspecialty Surgery	3	3
Psychiatry	3	6
Immunology & Infections	2	2
Non Subspecialty Medicine	2	4
Drug & Alcohol	1	1
Gastroenterology	1	1
Upper GIT Surgery	1	0
Neurology		1
Rheumatology		0
Urology		0
Total	**32**	**35**

4.2.1 IMPROVING ACUTE CARE FOR OLDER PATIENTS

The consultation process has further reinforced the need for a greater focus on care for older persons because they are more likely to have a range of co-morbidities (and have more limited cognition, societal factors such as limited home support and inadequate alternatives to acute hospital care), which makes care more complex and lengthens hospital stay. Longer length of time in hospital not only requires more resources; it can also have an adverse impact on frail elderly patients as they are at risk of de-conditioning in an acute setting.

Therefore, a major focus over the next decade is to have a patient-centric (holistic) approach to the care for older persons in hospital as part of the broader '*Improving Care for Older*

Persons' across all care settings. This patient-centred approach is intended to be the platform for ***service redesign*** *that:*

- Ensures good patient flow between UCC, acute and community-based services; and
- Ensures that there is an active clinical pathway that enables early and comprehensive assessment of the patient's needs when admitted to any of the three bed-based health services.

4.3 Urgent care services

ODH's UCC is open 24 hours per day for 7 days per week with nursing staff coverage principally reliant on nurses from ODH's bed-based services (acute beds and aged care beds). ENs attend the UCC to support RNs as required within their scope of practice. Medical workforce is reliant on GP availability from the co-located Omeo Medical Practice. GPs are not available in Omeo from Friday afternoons through to Sunday morning, and during these times patients may attend the UCC for nurse-led care or travel to Bairnsdale.

There are three RIPERN trained nurses at ODH. The nurses have the ability to provide a defined range of medications and to undertake patient assessment and management in accordance with defined health management protocols.

Table 4-5 summarises current and projected demand for UCC attendances at ODH. There is a small projected increase in demand of 1.43% per annum from 555 attendances in 2015/16 to 696 in 2031/32. This growth in demand is associated with population ageing and the increased prevalence of chronic disease in the Orbost District catchment.

Table 4-5: Demand for UCC attendances, ODH, 2015/16 to 2031/32

CLINICAL STREAM	2015/16	2031/32	CHANGE SINCE 2015/16	% CHANGE P.A. SINCE 2015/16
Urgent care	555	696	141	1.43%

The current and emerging issues for urgent care services are:

- *Model of care* – The current UCC service model requires nursing staff from the acute ward to attend the UCC and according to urgency, GPs provide medical care from the GP clinic. Accordingly, the service model requires that nursing staff have training in advanced life support (ALS). Given the presence of comorbidities with the increased prevalence of chronic disease for many patients attending the UCC, there is also a requirement for nursing management of presenting comorbidities and for effective referral protocols to ODH's primary care and disease management programs;
- *Training* – Continued expansion of the number of nurses at ODH who have completed RIPERN training is important to further enhance service capability in the provision of nurse-led urgent care; and
- *Telehealth* – Telehealth capacity has been developed at ODH with links to BRHS, ARV, and RCH. These links should be consolidated to further support the UCC service capability.

4.4 Clinical support services

4.4.1 ALLIED HEALTH

Allied health services in the form of physical therapies (physiotherapy, occupational therapy, speech pathology, audiology) and other allied health including dietetics, psychology, social work, amongst others, provide necessary ancillary clinical services that support (and sometimes drive) medical and nursing care and treatment. Allied health professionals are integral to a multi-disciplinary approach to care and should be involved in the episode of care from the outset.

Allied health professionals have a potentially significant impact on the rates of improvement, functionality and psychological state of patients in UCC, inpatients, residential aged care services and in community-based settings. The role of the allied health professional is potentially important to driving changes in the health care system based on innovative ways of treating and caring for patients.

Current and emerging issues for allied health are generally incorporated into the specific service strategies identified elsewhere in the report. Nevertheless, some key issues are identified below:

- *Role and enhanced scope of practice*. There is potential over the coming years for the role of several allied health disciplines to be expanded, including enhanced scope of practice. This means substituting experienced senior *credentialed* allied health practitioners to undertake some aspects of care/treatment that would otherwise be undertaken by a medical practitioner. This allows for innovative models of care.
- *Workforce*. The difficulties of recruiting and retaining allied health practitioners in rural areas more broadly are well documented. As a joint project with GLCH, it is proposed to systematically assess the relative resourcing of each allied health discipline across inpatient and ambulatory service streams, including allied health assistants. It would then be appropriate to assess options for innovative models that can address minimum needs including the contracting of services, and partnership arrangements.
- *Professional support*. The consultations indicated that allied health professionals can operate in units where there are only a few practitioners in their discipline. It is important that there is a professional support link that is explicit and clear based on established frameworks for allied health professional supervision and mentoring.

4.4.2 MEDICAL IMAGING

ODH has a general digitised X-ray machine that is operated by nursing staff as required, since most GPs do not have an X-ray licence. There is often a requirement for patients to travel to BRHS for medical imaging services, a travel time of one and half hours.

4.4.3 PHARMACY

Access to pharmacy services is necessary to provide:

- A dispensing service to inpatients, RACS and primary health services; and
- A counselling and advisory role for both staff and patients.

Whilst there is no pharmacy in Omeo, there is a remote pharmacy depot that can fill most common prescriptions, and prescriptions can be 'ordered' before 1pm for same day delivery from Bairnsdale.

4.4.4 PATHOLOGY

Private contractors operate the respective pathology services at each health service.

In the interests of ongoing probity of public funding, it is proposed that pathology services will be tendered over the life of this service plan. Consideration of joint tendering with other health services, including CGHS, should also be examined.

4.5 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, reflecting the requirements of people across the lifespan. 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.

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*. There is a fundamental shift towards recovery oriented service delivery. This is supported by the new National Mental Health Standards, which require services to:
  - Promote recovery oriented values and principles in policies and practices;
  - Recognise the lived experience of consumers and carers and support their personal resourcefulness, individuality, strengths and abilities;
  - Encourage and support self-determination and autonomy of consumers and carers; and
  - Promote social inclusion of consumers and advocate for their rights of citizenship and freedom from discrimination.

  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 palliation of symptoms. LRH continues to assimilate theses (and other) changes, which are legislated.

The direct and more immediate implications for BRHS, and to a lesser extent the other three health services, will be the on-the-ground 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. *It will be necessary that BRHS, GLCH, ORH and ODH also integrate the likely impacts on current service models*.

- *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;
  - Increased demand for community mental health services;
  - The limited medical support for the Bairnsdale pharmacotherapy service. This needs to be developed either as part of an enhanced GP service in Bairnsdale or in conjunction with a local specialist physician;
  - The availability of Consultation-Liaison psychiatry to BRHS VMOs; and
  - In general, GP liaison activity has helped to better stem and/or manage demand for adults and children/adolescents. Nevertheless, the community mental health services available for children and youths 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.

  Another important aspect of integration and partnership is for the development of a service model for the PARC service that demonstrates its effectiveness in terms of patient outcomes and effective use of mental health resources.
- *Primary prevention.* Primary mental health and prevention services enhance the capacity of primary care providers (especially general practitioners 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 to 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 GPHN);
    - Psychology support services (through Access to Allied Psychological Services); and
    - Community mental health 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.

4.6 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.

To complement the community-based service, BRHS has established a specialist Nurse Practitioner who supports a response to ED presentations as well as the effective utilisation of a dedicated 'AOD bed' in the subacute unit that provides a clinically appropriate response for detoxification for the more acute/complex conditions.

Notwithstanding the relative successes of this collaboration, 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 contracted to Australian Community Support Organisation (ACSO)). 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 at 'at risk' groups in the community, particularly youth (and specifically aboriginal youth);
- *GP Access.* Access to GPs is a perennial difficulty. **For ODH, the issue of GP access is compounded by the lack of continuity of GPs who work on the GP locum roster**; and
- *Demand.* Research into a more accurate analysis of (expressed and latent) demand for different types of AOD services.

5 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

5.1 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 5-1, 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 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 with the poorest access identified in 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 5-1: 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.

5.1.1 GP SERVICES

It has been demonstrated on a regular basis and for several sources that there is a paucity of GP services in Bairnsdale. Despite discussions with current GPs to expand their practices and improve primary health care access, this has been difficult to achieve. A key enabling strategy to address this service gap is to support the establishment of another GP practice in Bairnsdale, preferably in close proximity to BRHS. The development of the integrated community health hub is likely to be important in its development. Such a strategy may also support additional capacity for outreach to ODH.

5.1.2 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, which targets advanced practice nursing, and nurse assistants, in areas of workforce deficiency.
- *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). These areas include:
  - Consideration where allied health practitioners would engage, or extend current levels of engagement, in diversion and substitution programs;
  - Developing specific nurse-led models of care for clinical areas of identified service gaps;
  - Involvement in ACE assessments; and
  - Examination of specific areas where allied health assistants would be clinically appropriate and economical.

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 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 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 4.1.5. 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*.

5.2 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 plan envisages that there will be a strong collaborative network between the for health services in East Gippsland, namely BRHS, GLCH, ODH and ORH. This would include, but should not be confined to:

- An inter-agency agreement for GLCH to be 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 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 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 includes:
  - 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 the procedures/ treatment;
  - Clinical workforce development, including medical specialist recruitment across a number of disciplines based on a mutually supportive and collaborative approach; and
  - Development of an understanding/agreement in relation to the level and responsiveness of mental health services to the BRHS ED;
- ***Central Gippsland Health Service***. This will be particularly important for specialist acute services, including maternity care;
- ***Melbourne quaternary hospitals*** in relation to formal and/or informal clinical support and advisory services (preferably in collaboration with LRH) in relation to:
  - Emergency medicine (which currently includes the specialist retrieval services);
  - Critical care;
  - Gerontology;
  - Nephrology; and
  - Paediatrics.
- Local ***Aboriginal Community Controlled Health Care organisations*** including GEGAC. This involves continuing the excellent ATSI programs by BRHS and GLCH in particular, and building on this base to have an impact on *'Closing the Gap'*; and
- ***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/UCC;
  - Cross education of ambulance officers and nurses in ODH and ORH; and
  - Protocols relating to the transfer of mentally ill patients.

Outreach

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

- Geriatrician outreach by BRHS;

- Specialist clinic and HITH outreach by BRHS; and
- GP outreach to smaller communities including:
  - Swifts Creek and Ensay.

5.3 Information communication technology

The role of ICT in health (eHealth) has been an important part of the progressive development of health services over the last decade or more, particularly for rural Victoria. This applies to acute, subacute, emergency care and primary health care.

Technology is expected to be able to support higher acuity patients in their own homes. The expectation of health care professionals and patients will be a higher level of health care delivery through electronic interactions including real time vital sign monitoring, medication infusions, tele-presence amongst other ICT that will enable better patient access, patient convenience, and improved system efficiency. The full potential of models of care using ICT are yet to be realised.

The ageing population and increasing prevalence of chronic disease creates challenges for the health sector to efficiently provide for the care needs of an ever-increasing patient cohort. eHealth technologies allow a mutually beneficial collaboration and involvement of patients and medical professionals in the prevention and treatment of chronic diseases amongst other health services. eHealth technologies empower patients to take more responsibility for their own health and quality of life, and they lead to improved efficiency in the health sector. Overall, ICT can be used to ensure better health care outcomes.

The next ten years will see the continued convergence of technologies and access due to significantly improved network capacity, creating new opportunities to develop services and to change service models in ways that have not previously been possible nor feasible. The significance of these changes will not simply be in the way services are provided and where, but also in what it means to the culture of healthcare and the relationship of health care providers with its community. Information access will lead to more empowered patients and encourage better information sharing and greater connectedness among providers.

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 information systems that improve the patient experience, and improve productivity and business systems including:
  - Connectivity with, and effective utilisation protocols for BRHS ED and GLCH, ORH and ODH;
  - Connectivity and real time services by aboriginal health services with GLCH and BRHS;
  - Progress 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;
  - 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.

5.4 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 the fabric of health services. East Gippsland will be no exception.

Over the next five to ten years there are nine strategic priorities across three key service domains with respect to teaching and research for the sub-region.

Clinical Transition Services

- Further develop the *structures and partnerships* that would:
  - Expand a nurse practitioner program;
  - Extend the training available for clinical nurse specialists in a number of areas (possibly including infection control, stomal therapy and/or wound management);
  - Develop advanced practice allied health positions in specified programs and clinics (most notably in OAHKS).

- Expand a nurse practitioner program. Such a program needs to be tailored and focused on areas where there a service gaps and areas where the Nurse practitioner skills set is not narrowly developed;
- 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.

5.5 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.

6 Goals and strategies

This section summarises the main goals and related strategies for both ODH and more broadly for the East Gippsland SSP. Those that relate directly or indirectly to ODH 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 BRHS and GLCH. This requires partnership arrangements that *delineates roles and responsibilities for defined services* 1.2. Develop capacity to meet the expected substantial growth in demand across the range of ambulatory programs, including specialist community-based services; 1.3. 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 ACSCs, and high ED PCT attendances. *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 2.2. Progressively develop a more robust medical specialist workforce model; and 2.3. Formalise and further develop clinical relationships with LRH, and Melbourne-based health services for core clinical services as a first priority

Goals	Strategies
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 3.2. Explore the type and level of support need to have a sustainable GP service in Omeo and Orbost 3.3. 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 4.2. Support locally developed services models for targeted patient cohorts including adolescents, Aboriginal health, and alcohol and drugs
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: 5.1.1. Clear criteria for patient selection; 5.1.2. The physical co-location (clustering) of RAPU-type patients on the medical ward; 5.1.3. A MDT approach with consistent general physician input and comprehensive geriatrician assessment; 5.1.4. Joint nurse and allied health assessments; 5.1.5. Pharmacy assessment/review; and 5.1.6. Clinical and non-clinical (electronic) discharge plan. 5.2. Enhance geriatric specialist capacity at BRHS with outreach to ORH. 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 6.2. Maintain local access to chemotherapy at 81% self-sufficiency which will require a marginal increase in

Goals	Strategies
	the frequency of visits by medical oncologists to BRHS from LRH 6.3. Ensure progressive workforce training in chemotherapy nursing as demand increases 6.4. Develop a service model that: 6.4.1. Ensures close clinical liaison (nurse) between East Gippsland cancer patients and the CCC at LRH, Melbourne cancer services, and GPs; 6.4.2. Coordinates patient consultations, planning sessions and therapies that minimise travel and patient inconvenience; 6.4.3. Provides clinical and social support services for referred patients; and 6.4.4. Refers back to BRHS for ongoing chemotherapy in a timely manner 6.5. Support integrated cancer services information technology and data bases that enable: 6.5.1. Efficient referral and patient tracking; 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 7.2. Improve self-sufficiency from 76% to 80% for non-sub-speciality medicine 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 9.2. Ensure that the specialist medical assessment and

Goals	Strategies
	management of stroke patients meets the national *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: 10.1.1. Clinical Cardiology from 87% to 91% 10.1.2. Endocrinology from 81% to 85% 10.1.3. Gastroenterology from 76% to 81% 10.1.4. Haematology from 79% to 89% 10.1.5. Immunology & Infections from 78% to 83% 10.1.6. Respiratory from 78% to 80%; and 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 11.2. Enable a staged increase in general surgeons from the current 1 to around between 2 and 3 surgeons 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: 12.1.1. ENT market share from 53% to 70% 12.1.2. Gynaecology market share from 53% to 70% 12.1.3. Ophthalmology market share from 47% to 70% 12.1.4. Orthopaedic surgery market share from 51% to 64% 12.1.5. Urology market share from 68% to 70% 12.2. Develop community-based diversion and substitution

Goals	Strategies
	programs that reduce admissions and reinstitute an OAHKS program
	12.3. Develop a nurse-led cystoscopy clinic
	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
	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
	13.3. Establish a 'greater sub-regional' obstetrician – Clinical Governance appointment to consolidate clinical governance of maternity services
	13.4. In collaboration with Sale, develop joint appointments and specialist obstetrician cover for the predominantly GPO workforce at BRHS
	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
	13.6. Maintain market share for obstetrics in East Gippsland at around 80%
	13.7. Continue to provide obstetric consultation and midwifery advisory services by BRHS to support the ORH maternity service
	13.8. Continue the midwifery training model
	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

Goals	Strategies
Women's & Children's - Neonatal	
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 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 15.2. Support improved access to paediatric clinics in East Gippsland as part of the broader strategy to enhance specialist medical services
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 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 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 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 17.2. Examine the potential (new) areas where ***allied health*** professionals can have the most significant impact on patient outcomes (and reducing LOS), and extending scope of practice to substitute aspects of care currently delivered by medical specialists

Goals	Strategies
	17.3. Develop an evaluation framework that assesses the relative impact of ***allied health*** services on patient outcomes and patient flow
	17.4. In collaboration with all health services in the sub-region, 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
	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
	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: 18.1.1. Transitions the existing undifferentiated grant to an activity-based grant, consistent with larger health services 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
	18.2. Provide (approximately 8) specialist consultation/ treatment spaces in the Integrated Community Care Hub
	18.3. Develop a program of specialist outreach and telehealth specialist clinics at Lakes Entrance, Omeo and Orbost
	18.4. Support the development of diversion and substitution clinics such as OAHKS

Goals	Strategies
Sub-acute Bed-based Services	
19. Improve the inpatient service model	19.1. Review the service model for sub-acute inpatient services to enable: 19.1.1. Intensity of care/treatment consistent with care plans, and ALOS; 19.1.2. Patient flow to SACS; and 19.1.3. A 'pull model' from ED and acute beds 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 19.3. Provide input into the ACE program 19.4. Enhanced discharge planning at each health service 19.5. Develop key performance indicators that demonstrate relative efficiency
Sub-acute Ambulatory Care Services	
20. Progressively extend the capacity of BRHS' SACS	20.1. Develop an outreach service model to provide clinical support and advice to Lakes Entrance 20.2. Direct referral to SACS from ED and Outpatients 20.3. Develop a falls & balance clinic over time 20.4. Develop a pain management clinic over time 20.5. Develop innovative home-based rehabilitation services
Emergency Department/UCC	
21. Improve service access and enhance the patient experience of BRHS ED	21.1. Achieve NEAT targets 21.2. Maintain the high 92% market share from East Gippsland for ED attendances 21.3. Develop a medical model for ED based on senior medical cover on each shift 21.4. Improve the model of care through the enhanced and timely use of diversion and substitution strategies, including: 21.4.1. Establish a RAPU-like service for acute elderly patients 21.4.2. HARP and HITH with 7-day availability 21.4.3. Direct admissions to sub-acute beds based on clear protocols

Goals	Strategies
	21.4.4. Access to a responsive clinical mental health service 21.4.5. Continue to have a flexible use of the SSU 21.5. Undertake regular case reviews 21.6. Ensure appropriate treatment spaces for mental health patients and paediatric patients 21.7. Ensure the continuation of the Aboriginal friendly access to ED 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; 21.9. BRHS to continue to support the UCC presentations at Orbost and Omeo as required, including through telehealth/video-conferencing 21.10. Maintain the current UCC models at ORH and ODH 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 BRHS and GLCH. The specific focus will be on: 22.1.1. Consolidating referral pathways to and from the ACCHOs 22.1.2. Acute coronary syndrome through the current initiative using the Heart Foundation assessment tool 22.1.3. Renal failure prevention for diabetes patients 22.1.4. Optometry (and treatment of eye diseases) mainly from diabetes 22.1.5. Audiology services, principally for children; and 22.1.6. Oral hygiene & dental services 22.2. Establish 'closing the gap' outcomes monitoring in collaboration with ACCHOs

Goals	Strategies
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 23.2. Continue to build/strengthen capability of BRHS, ORH and ODH clinical staff in the care and treatment of mental health patients through training from the AMHS 23.3. Address specific service gaps in relation to: 23.3.1. Response/presence in ED; 23.3.2. Consultation-Liaison psychiatry; and 23.3.3. The consolidation/extension of the community mental health services including nursing and psychological services 23.4. Plan to co-locate the Bairnsdale clinical mental health team in the Integrated Community Health Hub 23.5. 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 24.2. Support a service model that makes access to AOD services simpler and client-friendly through the triage (gatekeeper) process 24.3. Strengthen the development of pharmacotherapy services in Bairnsdale
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 25.2. Review sustainable GP service models in small rural communities 25.3. Develop sustainable NP models across the sub-region 25.4. Develop nurse-led clinics 25.5. Develop a program of service development that enhances access to: 25.5.1. Acute outpatients

Goals	Strategies
	25.5.2. Podiatry in Orbost; 25.5.3. Mobile dental services 25.5.4. Complex care services for elderly patients across the sub-region 25.5.5. Social work 25.5.6. Community health and social support services for children/adolescents 25.5.7. Targeted and culturally sensitive services that support the local VACCHOs deliver services
Primary & Community Based Care – Diversion and Substitution	
26. Further develop and relaunch a sustainable HITH service	26.1. Revitalise a HITH program with the following characteristics: 26.1.1. Provide a 7-day HITH service 26.1.2. Clinical lead for HITH to be undertaken by ED 26.1.3. Care/treatment pathways for each of the clinical conditions - supported by physicians/surgeons 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: 28.1.1. Integrates the acute and RACS beds; 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 28.2. Develop the community packages available to ORH