Hospital Avoidance and Substitution Health Service Plan

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Metro South Health

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1   Introduction

The Hospital Avoidance and Substitution Health Service Plan is the first comprehensive health service plan for hospital avoidance and substitution services in Metro South Health (MSH) over the short (5 years) and medium (10 years) term. It is a key directional plan and supports and enables our Strategic Plan.

Hospital avoidance services are aimed at reducing unplanned presentations, admissions or readmissions to acute care facilities. As such, they are usually provided in an ambulatory setting—either home or community-based—and are targeted to people with the highest risk of unplanned presentations, admissions or readmissions. However, some hospital avoidance strategies may also be implemented in the acute care setting, where the aim is to reduce both the length of the patient's stay in hospital and the acute phase of their health care.

Hospital substitution strategies deliver care and services in the home[1] that would otherwise be provided only in hospital. As such, they differ from hospital avoidance strategies which aim to avoid (or reduce the length of) the acute phase of health care.

The development of the Hospital Avoidance and Substitution Health Service Plan has been undertaken in accordance with the Department of Health *Guide to Health Service Planning—version 2 2012[i]* and included the following components within the planning process:

- profile the demography and health status of the MSH population
- profile current hospital avoidance and substitution service arrangements in MSH
- identify and prioritise future service needs for hospital avoidance and substitution through:
    - analysis of relevant service utilisation data and service activity projections
    - consideration of current policy and planning context and evidence-based models of care and service strategies.
- develop hospital avoidance and substitution service directions and service strategies to address prioritised health service needs in MSH.

The Health Service Plan has been informed by a number of Queensland Government and Metro South Health key policy and planning documents including the *Blueprint for better healthcare in Queensland[ii]*, the *Health Priorities Paper 2014–15[iii]* and the *Metro South Hospital and Health Service Strategic Plan 2012–2016[iv]*. These documents clearly advocate for an increase in hospital avoidance and substitution service models to deliver quality health outcomes for our community, as detailed in Appendix A.

Stakeholder engagement has been an essential element in the development of the Health Service Plan. Over 150 key stakeholders from MSH and the Greater Metro South Brisbane Medicare Local (GMSBML) were consulted during the development of the Health Service Plan, as detailed in Appendix B. The draft Health Service Plan will be subject to validation with our community representatives and key service partners through a public consultation process, prior to the release of the final Hospital Avoidance and Substitution Health Service Plan.

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[1] In this context, "home" refers to the patient's permanent or temporary place of residence, and may include a variety of residential facility types.

2   Service Needs

Service needs amenable to improvement using hospital avoidance and substitution strategies in MSH have been identified through extensive data analysis, literature review and consultation. The service need identification and prioritisation process is outlined in Appendix C.

The service needs are:

- Decrease potentially preventable hospitalisations
- Decrease the burden of chronic disease in our community
- Strengthen partnerships with other health care providers
- Decrease emergency department (ED) GP-type presentations and re-presentations, as well as avoidable inpatient admissions from ED
- Improve the health literacy of our population
- Improve discharge planning and follow-up care
- Decrease hospital re-admissions
- Improve access to community and home-based health services
- Improve early identification and monitoring of populations at increased risk of hospitalisation
- Improve end-of-life care planning
- Disinvest from non-core services and/or low-value practices and treatments.

These service needs are detailed below.

2.1   Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPHs) are defined as "conditions where hospitalisation is thought to be avoidable if timely and adequate non-hospital care had been provided." In 2011/12, approximately 13 per cent of all hospitalisations (26,766) for MSH residents were PPHs. The conditions with the highest PPHs are diabetes complications, pyelonephritis, chronic obstructive pulmonary disease, dehydration and gastroenteritis, cellulitis and congestive heart failure.[v]

2.2   Burden of Chronic Disease

Burden of disease and injury is measured using disability adjusted life years (DALY). The DALY measure combines fatal and non-fatal outcomes into a single measure by summing years of healthy life lost due to disability and years of life lost due to premature death. Chronic diseases (all non-communicable diseases) caused 90 per cent of the total burden of disease in MSH in 2007. Cancer, mental disorders, cardiovascular disease and neurological disorders were the leading causes, combining to account for almost 70 per cent of the chronic disease burden.[vi] People with chronic disease also experience higher rates of readmission to hospital—in 2013, there were 753 28-day readmissions for chronic disease patients in MSH.

Future estimates indicate that while Queenslanders are living longer due to improved medical management of diseases and the reduction of risk factors over time, they will experience a longer period of relative poor health due to the disability burden associated with living with chronic disease.[vii]

2.3   Partnerships with other healthcare providers

Strengthening partnerships with other health care providers can prevent hospital admissions and presentations to emergency departments, as well as enable timely discharge for patients. Opportunities for collaboration exist to:

- improve the capability of primary health care providers to manage complex patients (e.g. aged, disabled, chronic disease, co-morbidities), including the provision of support to informal carers and families
- improve referral pathways and processes from the primary to acute care sector, including clarification of referral criteria, work ups required, transfer of relevant information
- support residential aged care providers to better manage patient acute needs in the nursing home
- partner with other care providers to improve discharge planning processes so that patients are transitioned to more appropriate care arrangements as needed (e.g. Disability Services Queensland (DSQ), residential aged care facilities (RACFs), non-government organisations (NGOs)).

2.4   Emergency Departments

GP-type presentations to EDs are monitored as one indicator of the effectiveness of hospital avoidance strategies in the community. While GP-type presentations as a proportion of total MSH ED activity have shown a decreasing trend in recent years, there were still 44,615 such presentations to MSH EDs in 2012/13 (19 per cent of ED activity).

Re-presentations to EDs within 28 days are another indicator of the need for hospital avoidance strategies in the community. In 2012/13, re-presentations accounted for 16 per cent of all ED activity in MSH. Mental illnesses are the leading diagnosis group for re-presentations. Anecdotally, people with disabilities (physical and/or cognitive) are also a high-risk group for ED re-presentations.

There is a widely-held view that reduced access to GP services in the community puts pressure on public ED services. Within MSH, barriers to accessing GP services appear to include not only a lack of services after hours and part-time work patterns of GPs, but also a lack of awareness in the community as to the range of GP-type services that are available that may differ from the traditional "family practice" model with which many people are most familiar.

Evidence suggests that opportunities exist to reduce admission rates from ED for certain conditions, such as chest pain and "transient attacks". For example, "transient attacks" (syncope, transient ischaemic attacks, self-limiting seizures and falls) are conditions associated with high admission rates from EDs, despite significant evidence that the vast majority can be safely and effectively managed as an outpatient or in an ambulatory environment, when appropriate diagnostic, process and referral pathways are in place.[viii]

2.5   Health literacy

The self-reported prevalence of a variety of behavioural and chronic disease risk factors in MSH reveals a need to improve the health literacy of our population. In 2011-12, MSH residents reported that:

- 54 per cent of people are overweight or obese
- 28 per cent have high blood pressure and 29 per cent have high blood cholesterol levels
- Less than 10 per cent consume the recommended daily quantities of fruits and vegetables
- 55 per cent achieve sufficient physical activity for health benefit each week

- 14 per cent smoke daily.[ix]

There is a need for ongoing public health awareness campaigns to encourage people to adopt a healthy lifestyle by increasing awareness of the risk of chronic diseases and promoting personal responsibility for choosing healthy behaviours.[iii] For people who have been diagnosed with chronic disease, improving health literacy around the self-management of their conditions has been shown to be effective in reducing hospitalisations.[x]

Healthy literacy also includes literacy regarding navigation of the health system itself. Our residents need to know where and when to access health care at different stages across the health continuum. The role of acute hospitals in this process needs to be reinforced.

2.6   Discharge planning and follow up care

Effective discharge planning needs to not only be timely (to reduce length of stay) but also incorporate linking to appropriate follow-up care in the community to prevent avoidable re-admissions. Service needs include:

- Improve compliance rates in GP follow-up appointment access and attendance
- Better community-based case management/ follow up after discharge
- Close -to-facility step-down care needed for rural and remote patients, as well as patients without adequate home support, following acute admission (e.g. non-weight bearing patients)
- Improve consistency of access to community-hospital transition services across all MSH facilities
- Improve handover to primary health care providers or other care providers such as DSQ, RACFs, NGOs, as appropriate.

2.7   Hospital re-admissions

In 2012/13, one-fifth of multi-day, unplanned admissions to MSH facilities were re-admissions within 28 days. Re-admissions are most common amongst the 65 years and over age group. The leading diagnostic groups for re-admissions are chest pain and chronic obstructive airway disease (COAD).

2.8   Access to community and home-based health services

Within MSH there exists a wide variety of community and home-based health services. Nevertheless, the following opportunities to improve service access are perceived to exist:

- Improve referral processes to community-based services. There are many different services with different scopes of activity and different access criteria and approvals required.
- Develop clear intake guidelines for out-of-HHS and private patients and cost recovery processes for these patients
- Streamline the structure and governance (functional and clinical) of community and home-based services
- Service scope, location and operating hours need to match population health care needs (and include consideration of transport/parking issues)
- Improve awareness of available services—MSH staff, other service providers (e.g. GPs) and the community.

2.9 Early identification and monitoring of at-risk populations

The early identification of risk factors, illness and acopia is crucial to implementing effective care pathways and achieving optimal health outcomes, which may include avoiding hospitalisation. At-risk populations in MSH include older persons, people with a disability, people diagnosed with or at risk of developing chronic disease or mental illness and people with a history of hospital re-admission. The proactive monitoring and management of at-risk populations in a community setting is important to ensure that health status does not deteriorate unchecked, often resulting in a preventable hospitalisation. Families or carers share an important role with health care providers in this area; especially for people with diminished capacity for making decisions about their own health care.

2.10 End-of-Life care planning

Modern medicine has a long history aimed at curing disease and prolonging life. Clinicians and scientists have been extraordinarily successful at this, however it has come with long periods of decline for patients and often the absence of quality of life. This can result in patient and family distress and clinical tensions, as well as placing addition financial burden on an already strained public health care system.

End-of-life care planning is "yet to be embedded in routine clinical practice or public consciousness."[xi] There have been various unsynchronised projects occurring across MSH that are attempting to address the need for improvements in end-of-life care. These activities are occurring against a background of state and national initiatives to address this issue.

2.11 Disinvestment

Disinvestment means prioritising or reassessing services in order to provide safe, effective and appropriate health care for all patients, and is an important concept to consider in the context of hospital avoidance and substitution.

Transparent and evidence-based processes are needed for evaluating treatments to determine the value they provide to patients and making recommendations regarding the most appropriate care for particular conditions. This is particularly relevant when new (usually high-cost) technology is being considered. The opportunity cost of continuing practices that have been shown to be of low or no value to patients also needs to be considered.

In addition, it is necessary to be clear about the scope of MSH's role in providing public health services, and to disinvest from services for which we are either not funded (such as certain primary health and aged care services) or can be delivered more effectively by other providers, such as NGOs or the private sector.

3 Challenges

The following challenges have been identified as impacting on the ability of MSH to meet service needs in relation to hospital avoidance and substitution:

- *Acceptance of changed models of care:* From reactive, episodic and predominantly medical-centred health care delivery to proactive, holistic, preventative models of care, with much greater allied health and support services input. Challenge to gain acceptance from communities and clinicians alike.

- *Funding*: Redress the imbalance of investment across the continuum of care—sufficient services need to be purchased in each part of the care continuum to allow patients to flow through the various care settings in order for the health system to work efficiently and effectively. Current funding models may not support alternative service provision, particularly in a community setting, leading to perverse incentives to continue inefficient service delivery for funding gain. Furthermore, finite resources are a reality in the face of ever growing demand for public health services.
- *Workforce:* Need realignment of the workforce to match service redesign for hospital avoidance and substitution services. Full scope of practice not currently utilised for nursing and allied health staff.
- *Infrastructure:* Need realignment of infrastructure strategy to match service redesign. Greater shift of services out of traditional hospital facilities to community and home-based settings.
- *Information and communication technology:* The development and implementation of a centralised data collection and information management system for community health services has been slow, hindering corporate reporting of outcomes, quality and activity. Development in this area is needed to support improved service planning and the effective use of resources. Significant opportunities exist across MSH to increase the use of mobile health, telehealth and remote health monitoring technologies to support the provision of health services in non-hospital settings and/or in non-tertiary hospital settings.
- *Performance measurement:* Need an agreed set of hospital avoidance performance indicators and a process for continuous and transparent measurement of our performance against these to ensure that improvements in health outcomes are achieved.

4   Vision

Metro South Health's vision is to be renowned worldwide for excellence in health care, teaching and research.

5   Overarching Metro South Health principles

Metro South Health has developed overarching principles to guide development of all its Health Service Plans. These principles align with the MSH Strategic Directions (2012-2016) and have been categorised as 'short term priorities' for implementation.

Business model

1. MSH is the main public health service provider in the Brisbane South, Redland and Logan–Beaudesert region.
2. MSH provides community health services for rehabilitation, oral health, mental health and screening services.
3. Residential aged care is not the core business of MSH. However, MSH is committed to providing appropriate 'specialised' services for residential aged care.
4. MSH will continue to support and encourage academic relationships through research programs and centres of excellence, as well as joint appointments with universities.

Catchment

1. MSH recognises itself (including hospitals and community health services) and its people as one catchment.

2. People in the MSH catchment should be able to receive best possible service within the catchment, and where possible at their local hospital.
3. MSH will develop a centralised waiting list across the catchment for specialist outpatient services to better manage demand and waiting lists times.
4. MSH will continue to appoint clinical staff (including medical, nursing and allied health) in a conjoint fashion between at least 2 MSH hospitals to promote continuity of services across the catchment.
5. MSH will also encourage public-private joint appointments of staff e.g. with the Mater or Greenslopes private hospitals. IT supports needs to be developed to better manage payment of conjoint appointment to reduce the administrative burden.

Model of care

1. MSH will undertake clinical redesign reviews to improve access to services and improve the patient journey.
2. MSH will implement new and innovative models of care to manage the growth in per capita health expenditure to ensure that health services and outcomes are affordable and sustainable.
3. MSH will work to develop models of care that promote hospital avoidance where possible/ appropriate.

6 Service Directions and Strategies

Service directions and strategies for hospital avoidance and substitution services in MSH have been selected following consideration of:

- Alignment to health service directions, plans and priorities—Commonwealth, State and MSH
- Evidence-based analysis of models of hospital avoidance and substitution used by other organisations
- Stakeholder-identified solutions
- Health service needs identified through data analysis, literature review and stakeholder consultation.

The service directions and strategies identification and prioritisation process is outlined in Appendix D.

The key service directions are:

1. Coordinate and strategically expand the delivery of home and community-based services across MSH.
2. Coordinate care across the healthcare continuum to support early identification and treatment of at-risk populations, as well as facilitating discharge planning and follow-up care.
3. Collaborate with other healthcare providers and our community to improve home and community-based care and avoid hospitalisations.
4. Implement clinically-appropriate length of stay reduction strategies to optimise the efficient use of inpatient beds.
5. Implement hospital avoidance strategies in EDs to redirect activity to more appropriate models of care.
6. Expand the strategic use of allied health-led pathways to better manage specialist outpatient waiting lists and improve health outcomes
7. Integrate end-of-life care as a core element of MSH's services.
8. Expand the use of information and communication technologies to facilitate the provision of hospital avoidance and substitution services.

The service directions and proposed strategies are detailed below.

6.1 Coordinate and strategically expand the delivery of home and community-based services across Metro South Health.

Strategy:	Establishment of MetroSouthHealth@Home (MSH@Home)

Home and community-based hospital avoidance and substitution services will be coordinated and strategically expanded under the MetroSouthHealth@Home program. MSH@Home will:

- Streamline organisational structure, clinical governance and functional reporting lines across MSH
- Redesign clinical processes to enhance service integration and efficiency, including enabling direct referrals from Inpatients, EDs, Outpatients, GPs and RACFs
- Increase integration with Chronic Disease and Allied Health services
- Develop clear intake guidelines for out-of HHS patients
- Develop a cost-recovery framework for out of HHS patients, and patients with private health insurance
- Plan for workforce realignment to meet service redesign, including consideration of nurse practitioner and allied health expanded scope of practice models.

Strategy:	Expand the use of Hospital In The Home (HITH) and Post-Acute Care services (PACS)

The HITH and PACS models of care will be strategically expanded across MSH, both in clinical and geographical scope, according to the needs of each facility.

HITH interventions will include consideration of:

- Chemotherapy
- Total hip and knee reconstruction, fracture neck of femur—post-operative care
- Hydration for contrast (pre and post-operative care)
- RACFs—congestive cardiac failure, COPD
- Development of clinical pathways for all common HITH presentations
- Review of anti-microbial stewardship processes in HITH

PACS interventions will include consideration of:

- Wound care
- Catheter care
- Anticoagulant drug management—pre and post-surgery
- Stoma care
- Insulin stabilisation and self-management education
- Subcutaneous injections for cancer treatment
- Support for self-administered intravenous antibiotics.

Strategy:	Establish a central governance framework for innovation leadership and performance management of home and community based services

A clear framework will be established for evaluating and endorsing clinical innovations (including necessary funding approvals), and leading HHS-wide implementation as appropriate.

A MSH performance dashboard of hospital avoidance indicators will be established in consultation with

clinicians, to regularly monitor and report our performance towards achieving desired health outcomes.

6.2 Coordinate care across the healthcare continuum to support early identification and treatment of at-risk populations, as well as facilitating discharge planning and follow-up care.

Strategy:	Implement a whole of continuum care model for the management of chronic disease and complex conditions, from prevention to treatment and care management

- Balance the approach to chronic disease and complex care to include both multi-disciplinary disease-specific programs, as well as case management-model healthcare coordination for individuals who access multiple community and/or home-based programs
- Expand the scope of chronic disease programs to include emerging chronic diseases in addition to the existing scope of cardiac, diabetes and respiratory programs
- Increase the implementation of standardised pathways across MSH for chronic disease patients, with the goal of achieving whole of continuum coordinated care
- Increase the prevention focus of chronic disease interventions in MSH, especially for patients diagnosed with coronary artery disease
- Increase referrals to The COACH Program for patients diagnosed with coronary artery disease, type 2 diabetes, pre-diabetes and/or COPD
- Increase access to chronic disease services, as applicable, for patients with a diagnosed mental illness
- Patient education programs will be carer-inclusive, and disease-specific where appropriate, including the expansion of education resources in other languages to suit our population, e.g. Pacific Islander

Strategy:	Establish a Central Community Health Referral Hub to streamline referrals and coordinate access to home and community-based services in MSH

Referrals will be accepted:
- from MSH staff, external health providers (e.g. GPs), patient/ family/ friend
- at any stage of the health care continuum, i.e. not only post-discharge from an acute inpatient admission.

Strategy:	Expand and standardise the scope of Community Hospital Integration Program (CHIP) services provided across all facilities in MSH

The redesign of CHIP services will include consideration of a multi-faceted peri-discharge program, staffed by discharge co-ordinators at ward or unit level, comprising:

- Risk assessment on admission
- Pre-discharge patient education and self-management
- 14–21 day post-discharge management plan, which includes telephone contact, patient/carer coaching, co-ordination of post-discharge GP follow-up and community-based services (through Central Community Health Referral Hub), and cross-sectoral hand-over of discharge plans and summaries.

Strategy:	Establish a MSH-wide model for facilitated placement of nursing home-type

patients from inpatient settings
The model of service delivery will be subject to contestability review.

Strategy: **Expand community-based programs to avoid hospitalisation for mental health patients**
- Establish the mental health community-based Logan Well-Being Program to assist in early identification and treatment of at risk individuals, including engagement with primary care providers   - Expand the mental health "Alternatives to Hospitalisation" model via establishing a 15-bed mental health step up/step down facility in the Redlands.

Strategy: **Establish a community-based program to improve healthcare coordination for people with disabilities and avoid hospitalisations**
- Improve case management in the community for people with disabilities, focussing on self-management education and healthcare coordination   - Develop and implement staff training program around carer-inclusive client centred care for people with disabilities   - Improve the identification of people with disabilities in patient management systems to enable improved care coordination.

6.3   Collaborate with other healthcare providers and our community to improve home and community-based care and avoid hospitalisations.

Strategy: **Expand the CARE-PACT model of partnership with RACFs to a recurrent program across all facilities in MSH**
- Ongoing identification of specific acute treatments able to be performed by RACF staff, e.g. gastronomy tube management   - Investigate feasibility of in-reach services from RACFs into MSH acute facilities to "pull" their patients for early discharge as appropriate.

Strategy: **Expand the use of collaborative care models with primary care providers to facilitate early intervention and hospital avoidance for patients**
- Expand "beacon clinic" model of care to other disease categories and locations in MSH   - Increase the use of existing funding models for follow-up case conferencing between GPs and clinical consultants, utilising phone or telehealth functionality   - Encourage GPs to proactively identify need and initiate advanced care planning and aged care assessments for at-risk patients   - Facilitate the provision of disease-specific patient education resources to primary care providers   - Collaborate with primary care representatives to implement a program of joint MSH and GP continuing professional development events.

Strategy: **Engage with industry groups and the community to identify opportunities for partnerships to meet hospital avoidance and substitution goals**
Increase service awareness and promotion programs regarding:

- most appropriate services to access at each stage of the health continuum
- available service alternatives to Emergency Departments for GP-type presentations
- scope of hospital avoidance and substitution services in MSH and the referral processes to access them.
- Implement a MSH industry liaison strategy to standardise the application of contestability guidelines to meeting service needs
- Establish a regular program of strategic engagement with DSQ to facilitate community-hospital service integration for patients with a disability
- Increase engagement with community groups for health promotion opportunities
- Continued engagement with community and patient representatives to review the effectiveness of hospital avoidance and substitution services in MSH.

6.4 Implement clinically-appropriate length of stay reduction strategies to optimise the efficient use of inpatient beds.

Strategy:	Expand the use of outpatient Specialised Day Units to replace admitted care—for patients requiring short term assessment, coordinated care and/or ambulatory management of conditions for which home and community-based services are not appropriate
Strategy:	Implement a MSH-wide strategy for the ongoing and consistent analysis of Health Round Table data to monitor performance against peer hospitals and prioritise areas for investigation for improvement
Strategy:	Investigate the feasibility of a Medi-hotel co-located with the Princess Alexandra Hospital to safely reduce lengths of stay for rural and remote patients, as well as other patient cohorts requiring pre or post-acute care where the home environment is unsuitable

6.5 Implement hospital avoidance strategies in emergency departments to redirect activity to more appropriate models of care.

Strategy:	Expand the use of Medical Assessment Units, located in or near EDs, across MSH to improve access to short term acute care with reduced lengths of stay and improved discharge planning
Strategy:	Expand the implementation of the Accelerated Chest Pain Risk Evaluation (ACRE) model of care across MSH
Strategy:	Establish a trial of the 4F Pathway model of care to more effectively treat "transient attack" presentations to EDs
Strategy:	Investigate the options for improving access to 24/7 primary care clinics close to EDs to reduce GP-type presentations to EDs
Strategy:	Refocus ED service directions across MSH on the provision of higher acuity emergency care, ceasing the perpetuation of GP models of care by MSH staff in EDs

Strategy:	Increase referrals from EDs across MSH to the Positive Care program for chronic disease management

6.6 Expand the strategic use of allied health-led pathways to better manage specialist outpatient waiting lists and improve health outcomes.

Strategy:	Expand the strategic use of allied health-led pathways to better manage specialist outpatient waiting lists and improve health outcomes

- Allied health led conservative management pathways are an effective and cost efficient way to reduce outpatient wait lists and improve clinical outcomes, while disinvesting from potentially high cost and low value treatments for patients, e.g. orthopaedic consultations for back pain [xii]
- A MSH-wide approach is needed to target the coordinated use of these pathways by facility and specialty area.
- Opportunities exist for the use of these pathways in gastroenterology, ear nose and throat, paediatric development, orthopaedic and neurology clinics.

6.7 Integrate end-of-life care as a core element of Metro South Health's services.

Strategy:	Develop and implement a MSH End-of-Life Strategy that will: - Increase awareness of the benefits of end-of-life planning - Establish robust systems to support end-of-life planning - Embed end-of-life planning in usual practice.

6.8 Expand the use of information and communication technologies to facilitate the provision of hospital avoidance and substitution services.

Strategy:	Implementation of an integrated electronic medical record (ieMR) for community health services
Strategy:	**Expand the use of mobile telehealth technologies in the home and community setting to enhance integrated service delivery**
Strategy:	**Establish a trial project to demonstrate the value of using remote health monitoring technologies, integrated with telehealth consultations, to provide chronic disease services to out-of-HHS patients on a cost-recovery basis.**

7 Resource and funding implications

Several of the strategies outlined in this Health Service Plan will require additional resources for full implementation. The inclusion of these strategies in the Health Service Plan does not represent a commitment from Metro South Health to provide any or all of the additional funding that may be required.

Additional funding to support these strategies must be sought through the usual funding application processes.

8 Implementation, monitoring and review

The Service Planning Accountability Framework outlines responsibilities for implementing, monitoring and reviewing this Health Service Plan, as shown in Figure 1

Figure 1: Service planning accountability framework

Service planning accountability framework

		Responsibilities	Key controls
1	**Priorities** » Overall HHS content and priorities	» Executive Planning Committee	» MSH Strategic Plan » MSH Service Agreement » *Hospital and Health Boards Act*
2	**Development** » Develop key service directions » Develop key strategies } Engage and consult	» Clinical stream leaders » Clinical leaders » Director, Planning » Director, Engagement	» ACHS standards » Safety and quality standards » Demand » Models of care » Policy
3	**Draft** » Draft plan } Engage and consult	» Clinical stream leaders » Clinical leaders » Director, Planning » Director, Engagement	
4	**Endorsement** » Finalise and endorse plan	» Executive Planning Committee » HSCE	
5	**Communicate** » Communicate plan	» Clinical stream leaders » Clinical leaders » Director, Media and Communications	
6	**Implement** » Develop action plan » Deliver as per idenfitied action officers } Engage and consult	» Director, Planning » As per action plan	» Endorsement by Stream Leader
7	**Monitor and Review** » Monitor » Review	Executive Planning Committee via Director, Planning	» Endorsement by Stream Leader

Appendix A: National and State Policy and Planning Context

National Health Reform

National Healthcare Agreement Indicators

The National Healthcare Agreement 2011[xiii] between the States and the Commonwealth identifies the following measures of hospital avoidance as indicators of improved health services:

- Selected potentially preventable hospitalisations
- Selected potentially avoidable general practitioner type presentations to emergency departments
- Unplanned/unexpected readmissions within 28 days of selected surgical admissions.

Aged Care Reform

From 1 July 2015, the Australian Government will launch the Commonwealth Home Support Programme (CHSP). The existing Commonwealth HACC Program will be combined with other aged care services under the single stream-lined CHSP to provide basic maintenance, care, support and respite services for older people living in the community, and their carers.[xiv]

The main impacts to MSH services are:

1. Assessment services to be provided by My Aged Care, not CHSP
2. Alignment to new CHSP outcomes/service types, including any transition requirements for activities no longer within scope.
3. Contestability process will be implemented for service provision under the CHSP, as well as for the provision of assessment services under My Aged Care.

National Chronic Disease Strategy

The *National Chronic Disease Strategy[xv]* was endorsed by the Australian Health Ministers' Conference in 2005 and identifies four key action areas, supported by key directions, to meet the challenges arising from increasing prevalence of chronic disease:

1. Prevention across the continuum
2. Early detection and early treatment
3. Integration and continuity of prevention and care
4. Self-management

Queensland Health Reform

Queensland Government
The Queensland Plan[xvi] outlines Queenslanders' 30 year vision for Queensland. From a health and well-being perspective, the vision includes:
- Balance between prevention and treatment
- Decline in lifestyle diseases
- Regular engagement in healthy activities and make healthy food choices.

The Queensland Plan includes a target for Queensland to have the lowest incidence of preventable disease and injury in Australia, including reductions in obesity, smoking, diabetes and avoidable death rates and an increase in fruit and vegetable consumption.

The *Blueprint for better healthcare in Queensland[ii]* identifies the need to increase local, community-based preventative health services. In addition, it advocates for strategies which enable earlier discharge of patients to promote patient flow, cut waiting times and eliminate service delays. In this respect, better coordination with primary healthcare and the development of health partnerships are key strategies. The traditional default to building more hospitals and opening more beds is not always the best approach.

The *Health Priorities 2014–15[iii]* paper identifies actions to be undertaken to effectively manage future demand on the Queensland public healthcare system. It advocates the following hospital avoidance and substitution strategies:

- Balancing the system—sufficient services need to be purchased in each part of the care continuum to allow patients to flow through the various service streams in order for the health system to work effectively and efficiently.
- Preventative and primary health—addressing risk factors for chronic disease in the "at risk" population. Sustained and expanded activity in health promotion in the areas of obesity, smoking, alcohol and sun safety to reduce risk factor levels in the population and reinforce positive health messages for good health and well-being. Partnerships with Medicare Locals and other providers.
- Improve health literacy—increase people's control over their health, their ability to make informed choices to reduce health risk and increase quality of life. Social marketing campaigns are advocated.
- Maximise participation in assessment and screening programs—Newborn, post-natal and child health programs. Cancer screening in adults (especially breast, bowel and cervical cancer). Earlier detection of health problems so as to prevent or favourably alter their course or consequences. Note that this will increase the demand for follow up treatments such as endoscopies.
- Improved demand management of outpatient services—consistent and standardised criteria for referral and prioritisation, increased use of mobile technology in patient management e.g. mobile phone applications for patient reminders, expanded use of allied health screening/treatment to reduce specialist outpatient demand, central referral and booking processes, development of criteria for discharge from ongoing patient review to enable junior/nursing staff to discharge patients and free up capacity for new case referrals, expanded use of telehealth.
- Emergency care—work in partnership with Queensland Ambulance Service (QAS) to progress QAS pre-hospital initiatives.
- Providing services in alternative settings—Hospital in the Home (HITH) and Hospital in the Nursing Home (HINH) models of care to alleviate bed pressure and the high costs of in-hospital health care delivery. Shift from inpatient to home and outpatient/community settings of care for diabetes[xvii] and renal services[xviii], according to the stage of the disease. Maintenance care (sub-acute) is not considered a core health service for the State—there is a need to partner with other service providers to find alternative care solutions for patients in a more appropriate setting. Fully utilising the Transition Care program is one option to improve patient flow through the sub-acute sector.
- Technology—Improved information technology solution to capture community health activities to enable quantification of activities and improve planning and use of resources. Use of mobile health, telehealth and remote health monitoring technologies to support the provision of health services in non-hospital settings and/or in non-tertiary hospital settings.
- Disinvestment—Disinvestment from primary and community health services that lack evidence for cost-effective improved patient outcomes and/or reduced hospitalisations. Discontinuing

practices/treatments that have been shown to be of low or no value to patients. Some examples include:
- o adenoid removal in children with recurrent otitis media with effusion
- o arthroscopic knee surgery for osteoarthritis
- o hysterectomy as first-line treatment for heavy menorrhagia
- o imaging in cases of low back pain.

The *Health Priorities 2014–15* paper will inform decisions related to healthcare purchasing for the 2014–15 financial year, including the following purchasing initiatives[xix] which are designed to encourage hospital avoidance and substitution:

- Chronic disease readmissions—incentivise a reduction in readmission rates for the selected chronic conditions of asthma, congestive cardiac failure, diabetes complications, chronic obstructive pulmonary disease (COPD) and angina. The target is 8 per cent (at a whole of HHS level) with incentive payments payable once the HHS reaches the minimum threshold of 10 per cent. In 2013, MSH was at 10.1 per cent. Under this initiative, the potential maximum reward available to MSH is $4,542,121.
- Telehealth—*for non-admitted outpatients*: any additional telehealth activity above actual volumes for the equivalent period in the previous year will not contribute to the QWAU purchased cap in the Outpatient Itemised Schedule in HHS contracts, and will be paid. *For admitted inpatients*: payment will be made for each in-scope telehealth event, and will not contribute to the purchased inpatient QWAU activity level.
- HITH—benchmark of 1.5 per cent of all inpatient separations to be undertaken as HITH. In 2013/14, the MSH HITH proportion of all acute separations was 0.7 per cent. There are 3 non-complex DRGs where there is a strong evidence base for total care by HITH (E61B, J64B and F63B); as such, all episodes with these DRGs will be funded at 85 per cent of the DRG price weights. All other DRGs that involve a HITH component and do not exceed the DRG inlier period for the total acute admission will be paid 100 per cent of the DRG price, including HITH days.
- Pre-operative beddays—incentivise a reduction in unnecessary pre-operative bed days by reducing funding. For elective surgical episodes that have both pre-operative days and long stay days, the number of long stay days actually paid will be reduced by the number of pre-operative bed days, up to a maximum of 3 days. In 2013-14, this translated to approximately 282 unfunded beddays in MSH.
- Out of scope—no funding for procedures identified in the policy document *Scope of Publicly Funded Services[xx]* as being of low clinical value or cost effectiveness in an acute hospital setting. Such procedures include vasectomies, reversal of vasectomies and laser refraction.

Recent statewide plans and strategies have advocated the use of hospital avoidance and substitution models of care:

- *Cancer care statewide health service strategy 2014[xxi]*—strong links between services in different settings are needed to reduce the rate of unplanned hospitalisation at the end stages of illness (last 6–12 months of life)
- *Diabetes services statewide health service strategy 2013[xvii]*—promote use of telehealth service provision as well as use of information technology for greater self-management. Work with primary and community healthcare providers to reduce referrals for non-complex cases into the public system and improve coordination of patient transfers from hospital to home or community care.

Metro South Health

The *Metro South Hospital and Health Service Strategic Plan 2012–2016*[iv] identifies nine strategic objectives; one of which is to "increase hospital avoidance and substitution programs and services to reduce admissions to hospitals."

There are three strategies articulated to achieve this objective:

- research and develop a formal plan (for hospital avoidance and substitution in MSH)
- promote opportunities for patients to receive the most appropriate healthcare in the most appropriate healthcare setting as close as possible to where they live
- identify and facilitate innovations that support alternatives to hospital.

The specific actions advocated by the Strategic Plan to achieve MSH hospital avoidance and substitution goals are:

- explore best practice models of hospital avoidance and substitution
- prepare a MSH hospital avoidance and substitution plan that incorporates best practice
- implement MetroSouthHealth@Home program
- expand Hospital in the Home services across MSH
- establish the MSH Central Referral Hub to reduce outpatients waiting times
- optimise the use of integrated diabetes HHS specialist: general practice clinics in the GP Super Clinics at Annerley and Logan and extend the model to other chronic disease groups e.g. respiratory medicine and cardiology
- assist the Greater Metropolitan South Brisbane Medicare Local to implement the Positive Care project across Redland and Logan City catchments
- support patients to improve the self-management of their chronic disease
- establish a call centre for GPs to discuss patient management and avoid presentation to hospital
- extend the use of advanced allied health practitioner screening clinics to reduce specialist outpatient waiting lists by identifying and diverting patients who require non-specialist management, e.g. orthopaedic physiotherapy, orthopaedic, podiatry and speech pathology / audiology ENT screening clinics
- support discharge planning and transitions home from acute hospital admissions to reduce unnecessary emergency readmissions back into hospital
- support healthcare delivered in residential aged care facilities (RACFs) via CARE-PACT innovation project
- support end of life care planning.

The following progress has been made against these actions:
- establishment of health service planning project for MSH hospital avoidance and substitution services
- establishment of MetroSouthHealth@Home steering committee and project
- commencement of MSH Central Referral Hub on 5 May 2014
- commencement of CARE-PACT project on 10 March 2014
- initiation of end of life care planning project to coordinate end of life care strategies across MSH.

Appendix B: Stakeholder engagement

Over 150 stakeholders were consulted to assist in identifying and prioritising health service needs and strategies for hospital avoidance and substitution services in MSH, as detailed in Table 1.

Table 1: Stakeholder consultation register

Name	Position	Method of Consultation
Dr Peter Adkins	GPLO Support (Clinical Advisor), GMSBML	Online Survey
Dr Richard Ashby	Chief Executive, MSH	Face to face
Brett Bricknell	Executive Director, Logan-Bayside Health Network	Face to face
Wendy Carter	Nurse Unit Manager, Redlands Residential Care	Face to face
Dr Rosalind Crawford	Facility Manager and Director, Medical Services, Redland Hospital	Face to face
Professor David Crompton	Executive Director, Addiction and Mental Health Services	Face to face
Dr Michael Daly	Executive Director, Clinical Governance	Face to face
Jodie Duggan	Director, Metro South Health@Home	Face to face
David Eastgate	Director, Health Equity and Access Unit	Online Survey
Dr Kate Fawcett	GPLO, MSH and GMSBML	Online Survey
Dr Catherine Franklin	UQ Centre for Intellectual and Developmental Disability	Online Survey
Dr Judy Flores	Clinical Stream Leader, Medicine and Chronic Disease Services	Face to face
Tania Hobson	A/Facility Manager, QEII Hospital and Sub-Stream Leader - Allied Health, Emergency and Clinical Support Services	Face to face
Katie Jefford	Nursing Director, Redland and Wynnum Hospitals	Face to face
William Kingswell	Executive Director, Mental Health Alcohol and Other Drugs Branch, Department of Health	Face to face
Alan Lam	Director, Medicine, QEII Hospital	Face to face
Lynette Loy	Director, Pharmacy, PAH	Face to face
Donna Lynagh	Director, Chronic Disease, Medicine and Chronic Disease Services	Face to face
Dr Chris May	Clinical Stream Leader, Emergency and Clinical Support Services	Online Survey
Sue Pager	Principal Engagement Officer, Planning Engagement and Reform	Face to face
Dr Geoffrey Playford	Director, Infection Management Services	Face to face
A/Professor Ian Scott	Director of Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital	Face to face
Karen Slater	Assistant Director of Nursing, Infection Management and Public Health	Face to face
Stephanie Smith	Social Worker, Princess Alexandra Hospital	Email
Leanne Stone	Assistant Director of Nursing, Cancer Services	Face to face
Sally Taranec	Clinical Stream Leader, Patient Flow Program	Face to face
Professor Euan Walpole	Clinical Stream Leader, Cancer Services	Face to face
Various	Chronic Disease Services Nursing Leadership Team	Face to face
Various	Various MSH staff (128 survey responses)	Online Survey

Appendix C: Service needs identification and prioritisation

Health Service Needs

The draft list of health service needs integrates the prioritised list of preliminary service needs—identified during a desktop analysis, and prioritised by stakeholder consultation—with the feedback received during the stakeholder engagement process. The draft list of 11 health service needs for the Hospital Avoidance and Substitution Health Service Plan is outlined in Table 2, and discussed in further detail in Section 2.

Table 2: Draft health service needs

Health Service Need
Decrease potentially preventable hospitalisations
Decrease the burden of chronic disease in our community
Strengthen partnerships with other health care providers
Decrease emergency department (ED) GP-type presentations and re-presentations, as well as avoidable inpatient admissions from ED
Improve the health literacy of our population
Improve discharge planning and follow-up care
Decrease hospital re-admissions
Improve access to community and home-based health services
Improve early identification and monitoring of populations at increased risk of hospitalisation
Improve end-of-life care planning
Disinvest from non-core services and/or low-value practices and treatments

Needs identification and prioritisation process

A desktop analysis was undertaken, which involved the development of the following four detailed background papers relating to Hospital Avoidance and Substitution services in MSH:

1. Population and Health Status Profile
2. Current Service Profile
3. Current and Projected Service Activity Report
4. Planning Context and Trends in Health Service Delivery

The desktop service needs analysis (data and literature review) identified 15 preliminary service needs in MSH amenable to improvement through hospital avoidance and substitution strategies. These service needs were subjected to validation from over 150 stakeholders during a subsequent stakeholder engagement process, which included a number of face to face consultations, as well as an online survey available to all staff. During the online consultation (October 2014), stakeholders were asked to prioritise the preliminary service needs.

The 15 preliminary service needs identified during the desktop service needs analysis and prioritised by the online consultation are detailed in Table 3.

Table 3: Preliminary health service needs, prioritised by stakeholders

Health Service Need	Priority
Decrease potentially preventable hospitalisations	1
Decrease the burden of chronic disease	2
Improve collaboration with other health service providers, including primary health care providers, other government and non-government organisations and the private sector	3
Decrease GP-type emergency department presentations	4
Improve health literacy in at-risk populations	5
Improve discharge planning	6
Decrease hospital re-admissions	7
Improve access to services closer to home	8
Improve access to outpatient services	9
Improve use of technology to deliver services more effectively	10
Decrease emergency department re-presentations	11
Decrease lengths of stay	12
Improve access to inpatient services	13
Disinvest from low or no value practices and/or treatments	14
Close the gap in Aboriginal and Torres Strait Islander health status	15

The stakeholder engagement process identified a number of additional and related health service needs. These needs are listed—according to priority as indicated by the number of stakeholders who identified or provided additional information on the need—in Table 4.

Table 4: Additional and related health service needs identified by stakeholders

Health Service Need	Detail
Improve access to community and home based health services *(34)*[*]	• Improve referral processes to community-based services. Many different services with different scopes of activity and different access criteria and approvals required. • Develop clear intake guidelines for out-of-HHS and private patients and cost recovery processes for these • Streamline the structure and governance (functional and clinical) of community and home-based services • Align service scope, location and operating hours with population health care needs (include consideration of transport/parking issues) • Improve awareness of services.
Strengthen partnerships with other health care providers *(33)*[*]	• Improve skills of primary health care providers to manage complex patients (e.g. aged, disabled, chronic disease, co-morbidities) including provide support to informal carers • Improve referral pathways and processes from primary to acute care sector (clarify referral criteria, work ups required, transfer of relevant information)

Health Service Need	Detail
	• Support residential aged care providers to better managed patient acute needs in the nursing home • Partner with other care providers to improve discharge planning processes so that patients are transitioned to more appropriate care arrangements as needed (e.g. DSQ, nursing homes, NGOs).
Improve the health literacy of our population *(14)*[*]	• Health promotion • Promote greater individual responsibility and more education on self-management of health needs • Improve awareness of different health services and when to access (e.g. roles of GPs, EDs, inpatient, and community-based care).
Improve discharge planning and follow-up care *(13)*[*]	• Improve compliance rates in GP follow-up appointment access and attendance • Better community-based case management/ follow up after discharge • Increase access to step-down care near acute facilities for rural and remote patients as well as patients without adequate home support following acute admission (e.g. non-weight bearing patients) • Improve consistent access to community-hospital transition services across all MSH facilities • Improve handover to primary health care providers or other care providers such as DSQ, nursing homes, NGOs, as appropriate.
Improve early identification and monitoring of at-risk people in the community *(11)*[*]	• At risk people: aged, disabled, chronic disease, mental illness, dementia, history of illness. • Importance of involving family and/or carers especially for people with diminished capacity for decision-making.
Decrease ED re-presentations, GP-type emergency presentations and avoidable inpatient admissions from ED *(6)*[*]	• Especially mental health and addiction, and disabilities patients • Reduce short-term admissions from ED (e.g. for chest pain and transient attacks).
Improve healthcare coordination services for people with disabilities to decrease emergency presentations and hospital admissions *(5)*[*]	• Improve primary health care coordination • Improve discharge planning • Likely to be over-represented in ED presentations and inpatient admissions.
Improve access to GP-type medical assessment services that provide an alternative to ED presentation, especially after-hours *(5)*[*]	• Lack of access to GP services puts pressure on public ED services • Improve awareness of service alternatives.
Continuous and transparent measurement of our performance against agreed hospital avoidance indicators to ensure that improvements in health outcomes are achieved *(4)*[*]	
Decrease lengths of stay *(2)*[*]	• Especially for nursing home type patients.

Health Service Need	Detail
Increased advanced care and end-of-life planning *(2)*[*]	• Major deficiency in advanced care planning within community • Education deficit regarding benefits vs risks of invasive care/hospitalisation for patients with chronic medical conditions (e.g. significant cardiorespiratory illness) • Often hospitalisation/expensive care is given to patients that may well not want them.
Disinvest from delivering services which are considered non-core functions of the public hospital system or low-value in terms of delivering safe, effective and appropriate health care for all patients *(2)*[*]	• Consider implications of Department of Health Primary and Community Health Services Reform Project, regarding non-state obligations.

Notes:

*   Number of number of stakeholders who identified or provided additional information on the need during consultation.

Appendix D: Service directions and strategies identification and prioritisation

Service directions and strategies

The draft health service directions and strategies for the Hospital Avoidance and Substitution Health Service Plan are outlined in Table 5, and are discussed in further detail in Section 4.

Table 5: Draft health service directions and strategies

Service Directions	Service Strategies
Coordinate and strategically expand the delivery of home and community-based services across Metro South Health.	- Establishment of Metro South Health@Home - Expand the use of HITH and PAC services - Establish a central governance framework for innovation leadership and performance management of home and community based services.
Coordinate care across the healthcare continuum to support early identification and treatment of at-risk populations, as well as facilitating discharge planning and follow-up care.	- Implement a whole of continuum care model for the management of chronic disease and complex conditions, from prevention to treatment and care management - Establish a Central Community Health Referral Hub to streamline referrals and coordinate access to home and community-based services in MSH - Expand and standardise the scope of CHIP services provided across all facilities in MSH - Establish a MSH-wide model for facilitated placement of nursing home-type patients from inpatient settings - Expand community-based programs to avoid hospitalisation for mental health patients - Establish a community-based program to improve healthcare coordination for people with disabilities and avoid hospitalisations
Collaborate with other healthcare providers and our community to improve home and community-based care and avoid hospitalisations.	- Expand the CARE-PACT model of partnership with RACFs to a recurrent program across all facilities of MSH - Expand the use of collaborative care models with primary care providers to facilitate early intervention and hospital avoidance for patients - Engage with industry groups and the community to identify opportunities for partnerships to meet hospital avoidance and substitution goals
Implement clinically-appropriate length of stay reduction strategies to optimise the efficient use of inpatient beds.	Expand the use of outpatient Specialised Day Units to replace admitted care—for patients requiring short term assessment, coordinated care and/or ambulatory management of conditions for which home and community-based

Service Directions	Service Strategies
	services are not appropriate • Implement a MSH-wide strategy for the ongoing and consistent analysis of Health Round Table data to monitor performance against peer hospitals and prioritise areas for investigation for improvement • Investigate the feasibility of a Medi-hotel co-located with the Princess Alexandra Hospital to safely reduce lengths of stay for rural and remote patients, as well as other patient cohorts requiring pre or post-acute care where the home environment is unsuitable.
Implement hospital avoidance strategies in emergency departments to redirect activity to more appropriate models of care.	• Expand the use of Medical Assessment Units, located in or near EDs, across MSH to improve access to short term acute care with reduced lengths of stay and improved discharge planning • Expand the implementation of the Accelerated Chest Pain Risk Evaluation (ACRE) model of care across MSH • Establish a trial of the 4F Pathway model of care to more effectively treat "transient attack" presentations to EDs • Investigate the options for improving access to 24/7 primary care clinics close to EDs to reduce GP-type presentations to EDs • Refocus ED service directions across MSH on the provision of higher acuity emergency care, ceasing the perpetuation of GP models of care by MSH staff in EDs • Increase referrals from EDs across MSH to the Positive Care program for chronic disease management.
Expand the strategic use of allied health-led pathways to better manage specialist outpatient waiting lists and improve health outcomes	• Expand the strategic use of allied health-led pathways to better manage specialist outpatient waiting lists and improve health outcomes

Integrate end-of-life care as a core element of Metro South Health's services.	• Develop and implement a MSH End-of-Life Strategy that will:
	  • Increase awareness of the benefits of end-of-life planning
	  • Establish robust systems to support end-of-life planning
	  • Embed end-of-life planning in usual practice.

Expand the use of information and communication technologies to facilitate the provision of hospital avoidance and substitution services.	• Implementation of an integrated electronic medical record (ieMR) for community health services • Expand the use of mobile telehealth technologies in the home and community setting to enhance integrated service delivery • Establish a trial project to demonstrate the

Service Directions	Service Strategies
	value of using remote health monitoring technologies, integrated with telehealth consultations, to provide chronic disease services to out-of-HHS patients on a cost-recovery basis.

Service directions and strategies—identification and prioritisation process

A desktop analysis was undertaken, which involved the development of the following four detailed background papers relating to Hospital Avoidance and Substitution services in MSH:

1. Population and Health Status Profile
2. Current Service Profile
3. Current and Projected Service Activity Report
4. Planning Context and Trends in Health Service Delivery

The desktop service strategies analysis (current service profile and literature review) identified 12 preliminary service strategies to address hospital avoidance and substitution service needs. These service strategies were subjected to validation from over 150 stakeholders during a subsequent stakeholder engagement process, which included a number of face to face consultations, as well as an online survey available to all staff. During the online consultation (October 2014), stakeholders were asked to prioritise the preliminary service strategies.

The 12 preliminary service strategies identified during the desktop service strategies analysis and prioritised by the online consultation are detailed in Table 6.

Table 6: Preliminary health service strategies, prioritised by stakeholders

Service Strategies	Priority
Allied health and nursing led screening and assessment clinics	1
Multidisciplinary, team-based, disease-specific primary care programs	2
Hospital in the Home	3
Community-hospital transition programs	4
Home and Community Care programs	5
Medical Assessment Units (or similar), located near or in emergency departments	6
Post-acute care services	7
Programs that support healthcare delivered in residential aged care facilities (e.g. CARE-PACT, Dementia Outreach Service)	8
Health literacy programs	9
Remote health monitoring technologies (e.g. to remotely monitor patients with chronic disease such as cardiac failure, diabetes, COPD)	10
Telemedicine	11
Medi-hotels	12

The stakeholder engagement process also identified a number of additional and related health service strategies. During the analysis of the individual strategies, service directions emerged, which have been used to group together related strategies, as outlined in Table 5.

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