Re-imagining Community Healthcare Services

Executive Summary

Background

The Monash Health Community Services Strategy Project is developing a strategy for providing services to the community. Agreement on the types and design of the community services Monash Health will provide into the future, how and where the services will be delivered and how each service interfaces with health, social and education services provided by other organisations will need to be planned.

To inform decision making evidence was obtained about how national and international health organisations had developed innovative planning for community healthcare services to meet future needs.

Objective

To identify evidence to guide innovative thinking and planning in developing a community-based health service suitable for future healthcare needs of consumers.

Search Strategy

Grey literature databases and multiple Advanced Google searches were undertaken to identify relevant evidence. Material was screened and selected according to the inclusion criteria in Appendix 1. Only articles in English published after 2014 were included.

Results

The evidence included in this review represents information and research from both international and Australian settings and reports a diversity of issues depicted in the figure below.
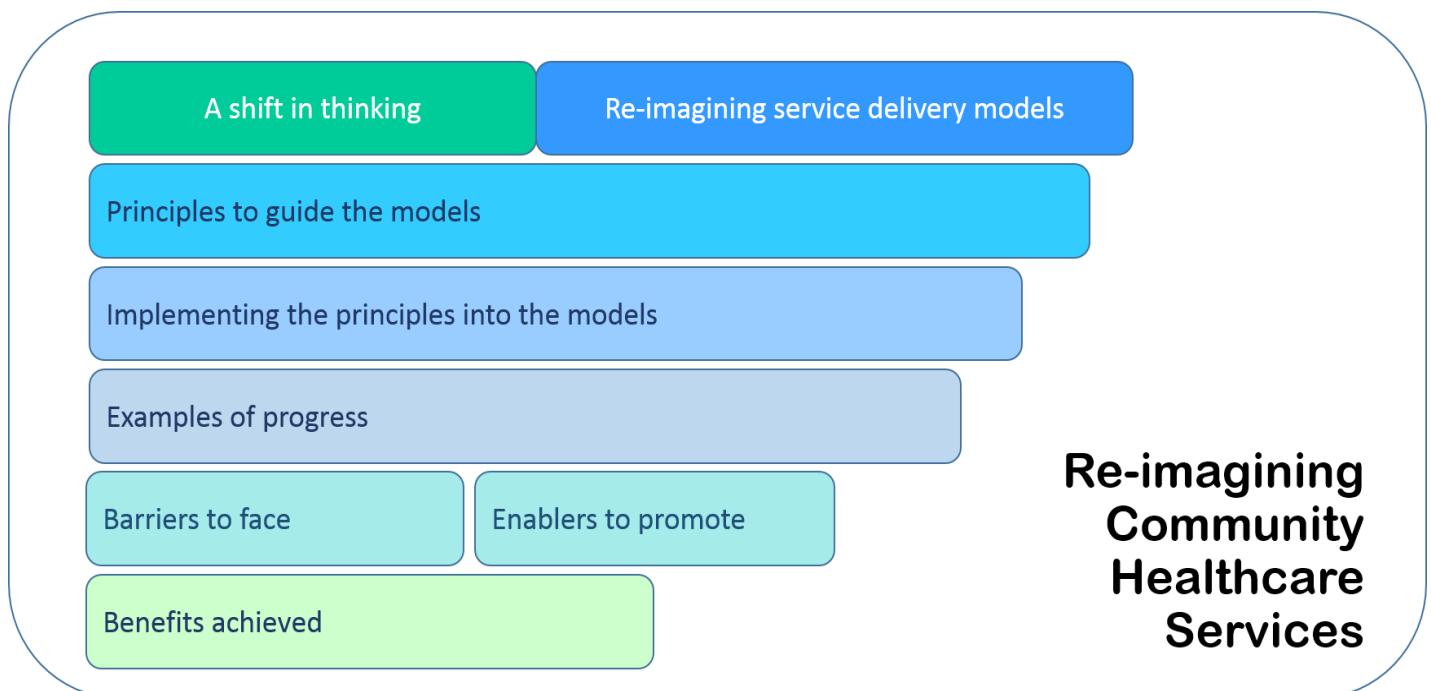
A Shift in Thinking

The need to transform healthcare to meet future population health needs is well documented both internationally and in Australia [1-4]. In an innovative approach to re-imagining community services, the Kings Fund [4] signal that a radical transformation of community services is needed which involves increasing the share of budget allocation, making use of all community assets at a local level, breaking down silos between services and reducing fragmentation in service delivery. The focus must be on improving population health as well as integrating care [1, 3-6].

Re-imagined Models with Guiding Principles

In order to guide the development of new models of integrated, community-based healthcare services the review identified key design principles [1, 2, 4, 6-8] that include:

- organising and coordinating care around people's needs
- enabling professionals to work together across boundaries

- focusing on improving population health and wellbeing
- involving families, carers and communities in planning and delivering care.

The evidence suggests that the principles to guide future models of care for community align with what consumers want from their community healthcare services [4].

System and community wide transformation in care delivery requires leadership at all levels aligned with the aim of supporting people to live independently in their own homes and communities and reducing the reliance on care in hospitals and care homes where appropriate [4]. Well thought out and credible implementation plans are needed that reflect the inherent complexity of healthcare systems while avoiding being paralyzed by these complexities [4].

Barriers to Face; Enablers to Promote

Re-imagining community healthcare services for the future will be met with barriers and challenges however a number of enablers were identified in the literature to support the implementation of new strategies and models of care. Empowering consumers [1, 2], addressing health inequity [1], unlocking the value of digitised data [1], supporting integrated and precision health solutions [1], integrating with the global sector [1, 2] and strong leadership [2] will all enable the change required to improve care for the future.

Examples of Progress

There are a number of examples in the literature that demonstrate both large and small scale innovative models of community healthcare. These system reforms and initiatives are in line with the principles to guide future models of care. The identified examples include; Practical innovation: Closing the social infrastructure gap in health and aging [2]; New care models: Vanguards – developing a blueprint for the future of NHS and care services [9]; 'New Care Models' paper [9] summarising 50 vanguard projects and, New Zealand Health Strategy: Future Direction [6]. Details of aims, strategies and associated projects and are explained in the full report [2, 6, 9].

Benefits Achieved

The potential benefits that re-imagined community healthcare services could have on tertiary services was drawn from anecdotal evidence that indicated improvements in reduction of presentations to emergency departments, improving staff satisfaction and patient satisfaction with access and experience of care [1, 4, 8].

Conclusion

The evidence directs decision makers to the issues that are important considerations when developing a new strategic plan for Monash Health Community. It outlines internationally recognised design principles to guide new models of care, implementation strategies for success and barriers and enablers for planning future services.

The literature intertwines the requirements of transformational change for the health system as a whole and for community healthcare services – it sees the future of healthcare being pushed towards community based care and decentralising healthcare services so that much of the burden is directed back out into the community.

Planning for this change is critical and requires making a range of hard infrastructure investments, identifying and reducing wasteful expenditure and or unnecessary treatments, implementing straightforward prevention and early intervention initiatives, supporting remote and rural locations, establishing high quality health and social system data and investing in a workforce for the future [5].

Integrated, person-centered and community-based healthcare, that considers the needs of its users and staff are not new ideas however, is consistently emphasised throughout the literature as important in order to move forward and to meet the community's needs for the future and successfully developing strategies to provide appropriate services.

Full Report

Background

The Monash Health Community Services Strategy Project is developing a strategy for providing services to the community. Agreement on the types and design of the community services Monash Health will provide into the future, how and where the services will be delivered and how each service interfaces with health, social and education services provided by other organisations will need to be planned.

Evidence was requested to facilitate this decision making to identify if other national and international health organisations had started down the path of re-imagining community healthcare services to meet future needs.

Objective

To identify evidence to guide innovative thinking and planning in developing a community-based health service suitable for future healthcare needs of consumers.

Search strategy

Grey literature databases, Medline and multiple Advanced Google searches were undertaken to identify relevant evidence. Papers were screened and selected according to the inclusion criteria in Appendix 1. Only articles in English published after 2014 were included.

Results

The literature search identified twelve papers. Government reports, commissioned papers, health service reports and white papers make up the evidence included in this review.

A Shift in Thinking – Re-imagining Community Healthcare & Changing to meet future needs

The need to transform healthcare to meet future population health needs is well documented both internationally and in Australia [1-4].

In late 2018 the CSIRO published the 'Future of Health' report and provided an aspirational vision for Australia's health sector in 15 years' time. It suggests the need for a major shift in the health system where value is rewarded over volume, consumers are empowered and viewed as a valuable health resource, humanity and relationships viewed as essential elements of care, and the use of technology being central to decrease costs and increase access to care [1].

A change in focus from treating patient illness to managing consumer health and wellbeing, accepting one-size-fits-all to precision health solutions, a change from a reactive system to a holistic and predictive approach and extending life to improving quality of life over a lifetime is where Australia's health system is moving to accommodate our future health needs [1].

Enabling the shift to a well-functioning system involving empowering consumers, addressing health inequality, unlocking the value of digitised data, supporting integrated and precision health solutions and integrating with the global sector will have consequences for the way in which community healthcare services are delivered and interface with other services [1].

The Australia Governments 'Shifting the dial: 5 year productivity review' [3] mirrors the above thinking and highlights that the ideal ingredients of a well-functioning health system include consumers having the power to make decisions, being able to get the outcomes that matter to them, accessing affordable care, having good experiences of care and accessing data and knowledge [3]. The productivity commission sees this occurring within a system of efficient, responsive and quality service providers where collaboration and coordinated care is valued; innovation and diffusion of best practice is championed; prevention and management of chronic diseases is prioritised; IT infrastructure and data sharing is available; the workforce is flexible, skilled and ethical in their practice; and reimbursement is provided for both value and results [3]. See Figure 1.

Figure 1: The ingredients of a well-functioning system [3]

As these components are all highlighted for transforming the health system as a whole they should also be considered when transforming and planning for community healthcare services for the future.

In a report published by the Kings Fund in 2018 "Re-imagining community services – Making the most of our assets" [4], the authors signal a radical transformation of community services. This, they explain, would involve increasing the share of budget allocation, making use of all community assets "the positive capabilities within communities that can promote health" at a local level, breaking down silos between services and reducing fragmentation in service delivery. They emphasize that the focus must be on improving population health as well as integrating care [4].

In order to transform community services the emphasis needs to be on doing things differently rather than delivering more of the same. This includes supporting people to live independently in their own homes and communities and reducing reliance on care in hospitals and care homes where appropriate. To do this healthcare services need to draw on the energies and ideas of staff providing care and on the experiences of people and communities needing care [4].

Re-imagined Models with Guiding Principles

Making the change through Integrated, Patient-centered and Community-based health models

Integrated care coordinates the actions of multiple factors that affect a person's health needs. It includes care managers, GPs and allied health services, acute care services, local community groups, research institutions and even businesses lying outside the health system. At the clinical level this model of care is usually supported by information systems and incentives that are aligned to efficient service delivery. A key goal of an integrated care system is prevention of disease, and where illness is present, the goal is to cost effectively minimise its impact on the person and society [3]. The essential elements of integrated care are pictured below in Figure 2.

The international and Australian experiences with integrated care indicates that, if properly implemented, it leads to gains in health outcomes for patients, improvements in the patient experience of care, reductions in costs, and improved job satisfaction for clinicians [3].

In order to modernise the way they provide healthcare products and services and to address the growing strains on existing health systems, Canada [5] (and peers around the world [1, 3, 4, 6]) are moving towards community-based healthcare and connected healthcare in order to provide the best possible care in the most affordable and efficient manner [5]. In a paper focused towards transforming health for the future (system wide) the authors place a vast emphasis on community-based healthcare, defining it as '*decentralizing healthcare*' by moving care out of resource-intensive institutions (such as hospitals), and into models of care delivery and even self-management in the home and community [5, 6]. There is also an acknowledgement of '*Connected healthcare*' where using healthcare information technologies and processes to connect all parts of a healthcare delivery system, seamlessly, so that critical health information is available when and where it is needed will be required into the future [5].
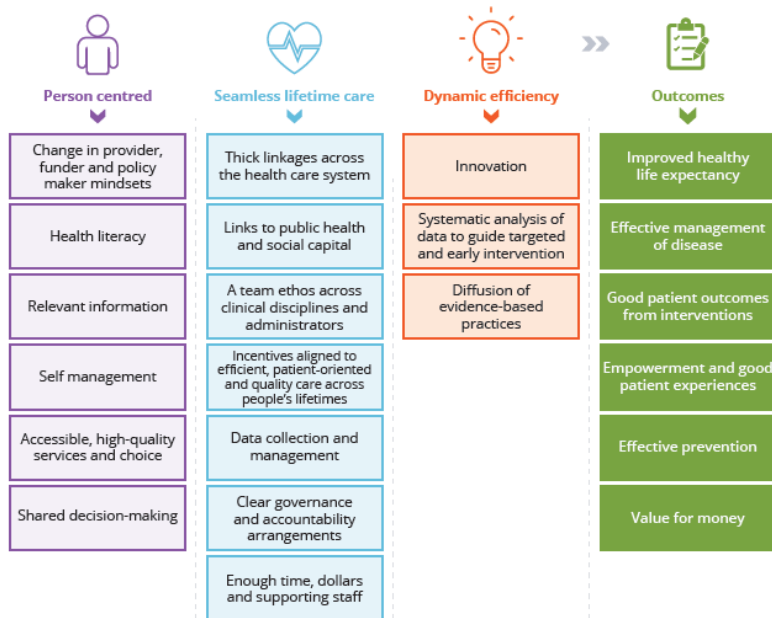
Person centred
- Change in provider, funder and policy maker mindsets
- Health literacy
- Relevant information
- Self management
- Accessible, high-quality services and choice
- Shared decision-making

Seamless lifetime care
- Thick linkages across the health care system
- Links to public health and social capital
- A team ethos across clinical disciplines and administrators
- Incentives aligned to efficient, patient-oriented and quality care across people's lifetimes
- Data collection and management
- Clear governance and accountability arrangements
- Enough time, dollars and supporting staff

Dynamic efficiency
- Innovation
- Systematic analysis of data to guide targeted and early intervention
- Diffusion of evidence-based practices

» Outcomes
- Improved healthy life expectancy
- Effective management of disease
- Good patient outcomes from interventions
- Empowerment and good patient experiences
- Effective prevention
- Value for money

Figure 2: The essential elements of integrated care [3].

Considering Value-Based Healthcare

Value-based care is a model that has been promoted to improve understanding of clinical variation to more effectively implement outcomes‑based funding models, which include the incorporation of patient‑reported experiences and outcomes that can be shared through a national outcomes database [1]. As an approach that aligns supporting integrated and precision health solutions it is an important consideration for the future of community healthcare services. Australia's existing fee-for-service funding model risks incentivising volume over value and treating illnesses rather than the overall health of an individual. Increasing the accountability of medical professionals through a shift to value-based care – focusing on the outcomes that are achieved relative to the cost of achieving them – is one way to align the incentives of health professionals and consumers and improve clinical practice. A shift to value-based care may also reduce public hospital admissions and emergency department costs of approximately $3.5 billion annually [1].

Principles to guide future models of community healthcare

Based on a review of the literature, stakeholder workshops and examples from across England and other systems the Kings Fund developed 10 design principles to guide future models of integrated, person-centered and community-based care [4]. The principles outlined by the Kings Fund [4] are also echoed by others [1, 2, 6-8, 10]. Some of these are focused on system wide principles which can be adopted for community healthcare strategy thinking. These principles are important to consider when planning for future models of care. Table 1 maps out the concept overlap that was described across the literature and enables a prioritised list of key principles for implementation (highlighted in grey).

Table 1: Mapping principles to guide future models of care

Principles to guide future models of care	[4]	[7]	[2]	[8]	[1]	[6]
• Organise and co-ordinate care around people's needs • Coordination of services – moving care outside of hospitals where appropriate	▲	▲	▲	▲	▲	▲
• Understand & respond to people's physical health, mental health and social needs	▲		▲			▲
• Make the best use of all the community's assets to deliver care to meet local needs	▲			▲	▲	
• Enable professionals to work together across boundaries • Developing fit for purpose facilities that enable integrated ways of working	▲	▲	▲	▲	▲	▲
• Build in access to specialist advice and support	▲		▲			
• Focus on improving population health and wellbeing; Investment in prevention, early intervention, supporting health literacy & personal accountability	▲		▲	▲	▲	▲
• Empower people to take control of their own health and care	▲		▲		▲	
• Design delivery models to support and strengthen relational aspects of care (integrated care)	▲		▲		▲	▲
• Involve families, carers and communities in planning and delivering care	▲		▲	▲	▲	
• Make community-based care the central focus of the system.	▲		▲	▲		
• Reduce wasteful expenditure			▲		▲	
• Focus on individuals and populations rather than specific conditions			▲	▲	▲	
• Maximising the use of technology to support consumers and the wider health and social care team				▲	▲	▲

The consumer perspective

The evidence suggests that the principles to guide future models of care for community should align with what consumers want from their community healthcare services [4]. These being:

- services to meet the whole of their needs, and to support their overall wellbeing and independence
- care to be joined up across different services
- support to make better choices and take control of their health and wellbeing
- services to focus on prevention and promoting independence
- easy access to help when they need it, in a way that fits around their lives
- more information about services to make it easier to navigate the system
- more services to be available in the community, as long as they are safe, high quality, cost effective and do not make it harder for them to access hospital care
- less local variation in the availability of services.

In an ideal world the New Zealand Southern Primary and Community Care Strategy (2018) sees the consumer and their families experience of primary and community care in three areas, the consumers home, Health Care Homes and the Hospital [8]. At home they can access:

- peer support groups online and in my community
- personal health information from home including certified self-care resources
- the information they need to seek the right care at the right time
- real-time advice from health professionals 24/7 by phone, email or video
- home monitoring and wraparound support to feel safe living at home with a disability or significant long-term condition(s).

In Health Care Homes is a model that promotes a team-based model of care led by primary care with strong strategic and operational relationships aligned with community, hospital and specialist services. The intent with this model is to provide the right level of proactive, comprehensive and continuous healthcare to patients. It translates to consumers being able to access:

- a care journey that is smooth and easy to understand when my needs are complex
- a trusted care provider who understands me and my family
- services in culturally safe settings
- specialised assessment and care close to home
- a same-day appointment when their needs are urgent
- holistic support from a range of carers

In hospital, the models translate to consumers being able to get rapid access to specialist care when they really need it and being able to quickly return home or to their local hospital through improved communication and support [8].

Implementing the principles to develop new models of care for community

System and community wide transformation in care delivery requires leadership at all levels aligned with the aim of supporting people to live independently in their own homes and communities and reducing the reliance on care in hospitals and care homes where appropriate [4]. Well thought out and credible implementation plans are needed that reflect the inherent complexity of healthcare systems while avoiding being paralyzed by these complexities [4].

Implementing the principles to guide future models of community care require [4]:

- Developing a compelling narrative and vision – bringing about change is never easy so letting people know why the change is necessary and the benefits it will deliver is essential.
- Combining national leadership and local action – transformation of community must happen at a local level however these efforts need to be supported by national and regional leadership to achieve wide spread change.
- Leading change in a complex system – both top down system leadership and bottom-up distribution leadership.
- Building alliances and partnerships – work towards integration.
- Investing in and changing the workforce – transforming care is first and foremost about transforming how staff work with each other and with patients and service users – eg more generalist roles, advanced clinical practice and agreed common skills.

- Working differently in primary care – work towards a future where community-oriented primary care becomes a reality by building on strengths of practices working individually and collectively.

- Engaging clinicians in leading change – changes in how services are delivered rest on the willingness of the staff providing care to work differently – clinicians are the most important source of innovations – releasing the time of clinicians to work to transform care and providing them with training and support must be at the heart of implementation.

- Engaging people and communities – to avoid mistake of the past people and communities need to be involved meaningfully and consistently.

- Putting in place financial models to facilitate change.

- Commissioning and contracting differently.

- Exploiting innovations in technology.

- Developing quality and improvement skills – Improving performance in healthcare services and transforming care on a sustainable basis depends in part on building capabilities for quality improvement among the staff delivering care.

- Getting the basics right – capacity to engage with stakeholders and measure and monitor progress.

- Evaluation and learning about change – ensure flexibility in bringing about change and a willingness to evaluate what is happening and adapt in the light of experience.

- Allowing time for change to become embedded – Importance of the 'constancy of purpose' among those leading change and a willingness to stay the course even in the face of setbacks and disappointments.

- Working with complexity – consideration towards context and starting points, change will be emergent rather than planned and will require leaders to cope with ambiguity and uncertainty.

Consideration of barriers and enables for a reimagined community health service for the future

Enablers, barriers and challenges to changing the health system for the future are reported. These are written from the perspective of a system wide change but also come from the view of changing the system to be person and community-centered [1, 2, 5, 11]. These are listed below in Table 2.

Table 2: Enablers, Barriers and Challenges to change in the health system

Enablers	Barriers/Challenges
- Empowering consumers [1, 2] - Addressing information asymmetry - Expanding telehealth services and improving consumer controlled devices [2] - Personal budgets [11] - Personalised care and support planning [11] - Addressing health inequity [1] - Providing community‑tailored solutions for digital and health literacy [2] - Maintaining and strengthening Aboriginal and Torres Strait Islander health - Social Prescribing [11] - Unlocking the value of digitised data [1] - Facilitating electronic health record (EHR) engagement - Ensuring interoperability [2] - Creating trust in digital tools - Supporting integrated and precision health solutions [1] - Accelerating the move to integrated care - Moving to models of value-based care (funding for outcomes [2]) - Improving the quality of predictive analytics - Preparing the future health professional [2] - Supporting bridging roles (health trainers, community navigators, health champions) [11] - Integrating with the global sector [1, 2] - Improving international collaboration - Improving pathways to market for novel health management solutions	- Existing hospital and physician-centric paradigm [5] - A medical model mindset and inertia [2] - Complexity of care coordination [5] - Availability of relevant and timely health information [5] - Capacity [5] - Political and legislative challenges [2] - Funding and incentives as a critical barrier to change [2] - Lack of quality information – data availability [5]

Enablers	Barriers/Challenges
• Leadership [2] o Shared accountability and incentives to provide integrated support and care across jurisdictions	

Examples of progress towards new models of care for community healthcare services

There are a number of examples in the literature that demonstrate both large and small scale innovations reimagined for community healthcare into the future. These system reforms and initiatives are in line with the principles to guide future models of care. Some of these programs of work are described below.

Example 1 Practical innovation: Closing the social infrastructure gap in health and aging [2]

Based on international examples of success, design principles and advisory group discussions, high level elements of a potential future health system were developed and include [2]:

- *Primary focus on health and wellbeing*: The system should focus on keeping people as well as possible for as long as possible. Community initiatives are designed to support wellbeing, based on evidence of risk factors that lead to illness. There needs to be considerable investments in prevention, early intervention and supporting health literacy and personal accountability to keep people well as long as possible. A focus on determinants of health and wellbeing, such as education and social support networks, will require support outside of the healthcare sector as well. Impacts on people's health and wellbeing should be a consideration for all policy development [2].

- *Targeted support for those that need it:* The future system must have the capacity to support those that are at high risk of poor health outcomes and high needs care, such as people with chronic disease, mental health challenges and the ageing population, with the goal to keep them as well as possible and out of hospital. Integrated, multidisciplinary teams (which may include professionals outside of the health system, such as social care workers) should be much more widely available than they currently are, to assess and support those at/with high risk and complex care needs. Holistic and integrated health with early intervention initiatives can help keep people out of acute care. Support is designed to incorporate what people value (eg independence for older people) and outcomes such as wellbeing, patient experience and hospital avoidance are more important and measured than volume of services (activity) alone [2].

- *Optimise effective high needs care:* Acute and high care (eg dementia) services will always be required. The risks and negative impacts or experiences from high-level care should be minimised and efficiency and effectiveness maximised. In these cases, therefore, very high quality care should be provided to support people to reach optimal health as soon as possible and be supported to recover in the community where appropriate. Acute and high care resources should be for those with the highest and emergency needs [2].

This proposed future model of health is shown in Figure 3.

Wellbeing focus for everyone
- Aim to keep people as well as possible for as long as possible
- Community and primary care initiatives designed to support wellbeing, beyond just health
- Prevention and early intervention
- Personal accountability in health and wellbeing

Targeted support for higher needs
- Aim to keep people out of hospital/care homes and maximise wellbeing
- Targeted response and support based on risks to wellbeing
- Predictive analytics and risk stratification tools to identify those with higher support needs
- Integrated, multidisciplinary teams work WITH people
- Outcomes, experience and preferences are important

Optimise effective care for acute needs
- Aim to minimise need for care in hospitals/care homes and move people back to targeted support
- Minimise negative impacts or experiences for those with the highest care needs
- Invest in high quality care and support outside of hospitals/care homes
- Informed choice for care options

Figure 3: Summary of proposed future model [2]

Example 2 New care models: Vanguards – developing a blueprint for the future of NHS and care services [9]

The NHS are in the process of supporting improvement and integration of services through inviting individual organisations and partnerships to apply to become 'vanguards' for the new models of care program [9].

There are five vanguard types – integrated primary and acute care systems; enhanced health in care homes; multispecialty community providers; urgent and emergency care and acute care collaborations.

Integrated primary and acute care systems join up GP, hospital, community and mental health services, whilst multispecialty community providers move specialist care out of hospitals into the community. Enhanced health in care homes offer older people better, joined up health, care and rehabilitation services. Urgent and emergency care vanguards are developing new approaches to improve the coordination of services and reduce pressure on A&E departments and acute care collaborations aim to link hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency [9].

These vanguards are being supported by the NHS in nine areas to enable them to make the changes they want effectively and at pace. It also aims to maximise the sharing of learning across the vanguards and spread good practice nationally across the wider NHS and care system [9]:

1. Designing new care models – working with the vanguards to develop their local model of care, maximising the greatest impact and value for patients;

2. Evaluation and metrics – supporting the vanguards to understand – on an ongoing basis – the impact their changes are having on patients, staff and the wider population;

3. Integrated commissioning and provision – assisting the vanguards to break down the barriers which prevent their local health system from developing integrated commissioning;

4. Governance, accountability and provider regulation – helping the vanguards develop the right organisational form and governance model, as well as understand the impact on how they are regulated;

5. Empowering patients and communities – working with the vanguards to enhance the way in which they work with patients, local people and communities to develop services;

6. Harnessing technology – supporting the vanguards to rethink how care is delivered, given the potential of digital technology to deliver care in radically different ways. It will also help organisations to more easily share patient information;

7. Workforce redesign – supporting the vanguards to develop a modern, flexible workforce which is organised around patients and their local populations;

8. Local leadership and delivery – working with the vanguards to develop leadership capability and learn from international experts; and

9. Communications and engagement – supporting the vanguards to demonstrate best practice in the way they engage with staff, patients and local people.

Example 3: The 'New Care Models' paper [9] summarises the 50 vanguard projects and outlines the key benefits they hope to achieve. These include:

- Improving health and wellbeing outcomes

- Reduce the reliance on emergency, health and care services

- Local and personal support as well as more care delivered in community and primary care settings will help reduce unnecessary hospital admissions

- A focus on prevention and self-care will help support independence and reduce the need for interventions from health or social care services

- Access to skilled advice helps people plan better for their future and take more direct control over their care

- Improved standards of care and reduced variation will help reduce health inequalities

- Improving patients' and service users' experience as a result of coordinated, streamlined care through a single point of access and agreed shared electronic care records

- Better joined up systems will Supports the future efficiency and financial stability of the health and social care system as a whole.

- Patients will be kept safely at home for longer and receive care closer to home instead of in hospital

- Placing people at the centre of their own care, enabling them to access the right care, at the right time, in the right place.

- Staff will feel empowered to deliver better services through improved working relationships and processes taking a patient centered approach

- Improved access through a reshaped first point of contact where care coordinators are supported by community based volunteers and professionals in a range of disciplines

- Hospital, community, mental health and social care services to work more closely together to provide patients with safer, faster, and better care seven days a week

- High quality community and home-based care will benefit those people who need it most and who use the most health and social care services in the city

- Supporting the spread of specialist care over wider areas, bringing care closer to home

Example 4 New Zealand Health Strategy: Future Direction [6]

The New Zealand government devised their health strategy for future direction and report under five key themes for what 'great' can look like in 2026 [6]. The following is a summary of relatable points for community healthcare services.

A vision for people-powered health

- People are able to take greater control of their own health by making informed choices and accessing relevant information when they need it; for example, through electronic patient portals.

- Everyone who delivers and supports services in the health and disability system understands the needs and goals of the individual they are supporting as well as their family, whānau (extended family) and community, and focuses on the person receiving care in everything that they do.

- People access practical, evidence-based health advice from a range of service providers that makes it easier for them to make healthy choices and stay well.

- Technology tools such as mobile devices, smartphones and wearable devices are options for everyone to use.

- New Zealand has a reputation for having innovative and effective health and disability services that are designed with the input of the people who use them.

- People receive high-quality, timely and appropriate services in the most convenient way, from the most appropriate service provider.

Closer to home

- People are safe, well and healthy in their own homes, schools, workplaces and communities.

- Our health system contributes to lifelong health and wellness through its support for parents, children, families, whānau and older people.

- We have well-designed and integrated pathways for the common journeys people take through our health and disability system (eg, cancer, maternity, diabetes), starting and finishing in homes.

- Our workforce in primary and community-based services has the capability and capacity to provide high-quality care as close to people's homes as possible.

- We have adapted the way our services are configured (at all levels) so that we can get efficiencies of scale where appropriate and take advantage of cross-government partnerships, as well as public and private partnerships.

- The health system works effectively with other agencies to improve outcomes in areas such as housing, social development and corrections for all children and young people, and particularly those at risk. It works through strong community links with early childhood centers, schools, marae, churches, local authorities and other social service agencies.

Value and high performance

- The health system provides high-quality, accessible healthcare services that help people live well, stay well, get well, at the lowest cost it can and within the resources available.

- The system uses its resources skilfully so that services reach people who need them. As a result, people trust the system and it is more sustainable both financially and clinically.

- All New Zealanders enjoy good health, and population groups that were previously disadvantaged, such as Māori, Pacific peoples and people with disabilities, experience a clear lift in health outcomes.

- All involved in delivering and supporting services strive for excellence and improvement, supported by evidence, research and analysis

- The health system minimises harm to people, by openly tracking harm when it occurs, and learning from mistakes, so that the system as a whole can improve.

- Funding approaches consider a range of 'bottom lines' as part of the system's commitment to a social investment approach.

- The health system constantly monitors its performance and scans the environment to check that it is functioning well, maintaining its strategic direction and responding to changes.

One team

- The health system is more than the sum of its parts, with each part clear on its role and working to achieve the aims of the system as a whole.

- New Zealanders experience joined-up care that clearly shows different organisations and professionals working as one team.

- The system has competent leaders who have an unwavering focus on the system's goals, and a culture of listening carefully and working together in the interests of people's ongoing wellbeing.

- New Zealand offers coherent pathways for developing leadership and talent that inspire and motivate people already working in the health system, and those considering health work as a career.

- We invest in the capability and capacity of our workforce, including in NGOs and the volunteer sector, and make sure that investment fosters leadership, flexibility and sustainability.

- New Zealand and international research, best practice and local innovations are shared freely and used to make improvements nationally.

Smart System

- A culture of enquiry and improvement exists throughout the health system, which has seamless links to research communities. The system learns and shares knowledge and innovation rapidly and widely.

- New Zealand is systematically evaluating and making appropriate use of emerging technologies in fields such as robotics, genomics and nanotechnology.

- Data is used consistently and reliably, with appropriate safeguards, to continuously improve services.

- New Zealanders use patient portals regularly and effectively to access their health information and improve their interactions with their doctor and other healthcare providers.

- When people attend a health service for the first time, the provider already knows their details. Their journey and scheduling are integrated.

- People at risk of particular conditions have easier access to follow-up tests and services and benefit from more individually tailored treatment and management plans.

- The quality of healthcare is high as health workers spend quality time with people, make fewer errors and make better decisions.

Potential benefits to the hospital setting when re-imagining community healthcare services

Emerging evaluation data from examples of health systems that have made progress towards a vision of building a community-based approach to care indicate that it may be possible to improve demand for hospital care by strengthening services in the community [4] as well as improving patient satisfaction with access and experience of care [8].

Innovative models for community healthcare have shown early signs of success [8] in:

- Improved workforce satisfaction resulting in better recruitment and retention of staff
- Increased capacity within primary and community care as evidenced by more consumer interactions within similar resources
- Reducing urgent care, polypharmacy, acute hospitalisations, hospital bed-days, entry into aged-related residential care [8].

The CSIRO's [1] 'Future of Health' report describes the benefits seen in the utilisation of telehealth, mobile health and self-monitoring devices [1]. Two to three telehealth consultations can be completed in the same time it takes to do one 10 minute face-to-face consultation, resulting in a 95% satisfaction rate for consumers [1]. Mobile health and self-monitoring device use, in a large scale trial, showed a 53% reduction in hospital admissions, a 76% reduction in length of hospital stay, and a reduced patient mortality rate of over 40 percent [1]. This trial also warned that despite the potential benefits, continual monitoring and assessment can also create psychosocial risks and hypochondria for consumers [1].

The evidence for the effectiveness of community case management and care co‑ordination is mixed, particularly in terms of the impact on secondary care utilization and costs. However, some studies – particularly those evaluating models involving a functional multidisciplinary team and a strong focus on case management – have found that they lead to reduced hospital use and improved patient experience [4].

In another example, an evaluation of a primary care home model found at three rapid test sites, decreases in the rates of A&E attendances and emergency admissions, reductions in prescribing costs, shorter GP waiting times and improved staff satisfaction and retention [4].

The benefits mentioned above are anecdotal and have not been taken directly from evaluation papers so should be interpreted with caution. A commentary published early 2019 echoes this sentiment and suggest that we shouldn't bank on the prospect of significant savings or improved outcomes in the shorter term without good evidence suggesting otherwise. We need to stop being over-optimistic about likely financial benefits, especially from reductions in hospital activity. Often, doing more for patients is going to cost more, not less [12].

Conclusions

The evidence directs decision makers to the issues requiring consideration for the development of a new strategic plan for Monash Health Community. It outlines internationally recognised design principles to guide new models of care, implementation strategies for success and barriers and enablers for planning future services.

The literature intertwines the requirements of transformational change for the health system as a whole and for community healthcare services – it sees the future of healthcare being pushed towards community based care and decentralizing healthcare services so that much of the burden is pushed back out into the community.

Planning for this change is critical and requires making a range of hard infrastructure investments, identifying and reducing wasteful expenditure and or unnecessary treatments, implementing straightforward prevention and early intervention initiatives, supporting remote and rural locations, establishing high quality health and social system data and investing in a workforce for the future [5].

Integrated, person-centered and community-based healthcare, that considers the needs of its users and staff are not new ideas however, are stressed throughout the literature as important in moving forward and meeting the community's needs for the future and successfully developing strategies to provide appropriate services.

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Appendix 1

Information Sources and Search Terms

Information sources		
Google	Kings Fund	Harvard Business Review
Health Foundation	Sax Institute	Cleveland Clinic
Advisory Board	Medline	
Search Terms		

- Community health services strategy
- Framework community services
- Community services principles
- Best practice models of community healthcare delivery
- Best practice models of Community Services Strategies
- Non-inpatient care frameworks/strategies/models
- Community health service planning
- Value based healthcare
- how should we provide health services to community in the next 10 years

Inclusion Criteria

Types of services	Community based health services including all from prevention to rehabilitation
Context	Within the community, at home or at dedicated hubs
Topic	Model of care, strategy, framework, evaluation, implementation, transforming care, modes of delivery etc
Types of information	Peer reviewed literature, grey literature
Publication Dates	2014 – Current