Change and opportunity in ambulatory care

Mark L Wahlqvist, Neil Boyce, Jill Howard, Chris Wright and Syd Allen

Abstract

Non-inpatient care is assuming greater importance within the Australian health system. The management of the delivery of health services is becoming a responsibility of clinicians. Clinicians, nurses, managers and academics need to come together to advance these issues. This paper outlines the thinking at Monash Medical Centre, a new 747-bed tertiary hospital situated in the south-eastern suburbs of Melbourne.

Changing nature of health services

The overall health care system includes primary and secondary care facilities and larger hospitals for the assessment and management of emergencies and complex medical problems.

Within inpatient facilities, the nature of the work has changed. Public hospitals have differentiated themselves into community-type hospitals, which may be affiliated with university medical schools, and so-called tertiary referral hospitals which are always affiliated with medical schools and other teaching institutions. Private hospitals have similarly started to differentiate into those that provide more straightforward care and those that can cope quite capably with more 'tertiary' care. We hope that the private hospitals, being an important and integral part of the total health system, will see the need and advantages of becoming affiliated with our teaching hospitals.

Mark Wahlqvist is Professor of Medicine at the Monash Medical Centre

Neil Boyce Director of Clinical Immunology at the Monash Medical Centre

Jill Howard is Director of Nursing—Ambulatory Care Services at the Monash Medical Centre

Chris Wright is Director of Medical Informatics at the Monash Medical Centre

Syd Allen is Executive Director—Medical Services at the Monash Medical Centre

Multiple factors have emerged which are changing the nature of the provision of services in this latter group of institutions, including:

- patient preference (if there is the required community support)
- economic considerations
- ethnological feasibility.

Over recent years, it has been possible to reduce bed-based care and move into the ambulatory setting. Notable examples include the reduction in diabetic ketoacidosis through education and better ways of stabilising glycaemic control with intercurrent illness or surgery so that those with diabetes need spend less time in hospital. The advent of day surgery is another example.

The average length of inpatient stay at Monash Medical Centre is now 4.7 days. This reflects in part the increase in short-stay patients, including day surgery. In 1982, the average length-of-stay at one of our parent hospitals, Prince Henry's Hospital, was 7.1 days. The number of non-inpatient consultations for 1982 and 1992 cannot be compared, as such statistics across public outpatients and private consulting rooms are not available, but the scope of such work has obviously increased.

Nomenclature of 'ambulatory care'

Ambulatory care is a widely used term elsewhere in the world and is increasingly being used in this country. From our point of view, ambulatory care is all care undertaken outside of inpatient facilities. There are, of course, grey areas—home care (in bed) is neither inpatient nor ambulatory, but may well be claimed by ambulatory care professionals. The Society for Ambulatory Care Professionals of the American Hospitals Association to which two of us belong (Syd Allen and Jill Howard), is such a claimant. Even short-stay care (two to three days) is claimed by them.

In Australia, ambulatory care in the broader sense is predominantly composed of:

- preventive care or health promotion
- primary care—essentially general practice
- secondary consultative ambulatory care—work done by specialists in their rooms or clinics or some hospital outpatient clinics
- tertiary consultative ambulatory care—work done by specialists of a complex or multidisciplinary nature in hospital outpatient settings or sometimes in a private setting
- day surgery
- emergency departments of public or private hospitals

- day treatment centres of various types, for example, endoscopy centres, cancer centres, renal dialysis, cardiology centres, infusion centres, rehabilitation centres
- investigative centres of various types, for example, imaging, cardiology.

Ambulatory care, especially consultative ambulatory care, ought to be seen in terms of clinical need rather than the historic 'public or private' dichotomy. The term 'outpatients', on the Australian scene, regrettably carries with it notions of the 'sick poor', the 'needy', long waiting times, unpleasant physical surroundings and less than ideal doctor–patient relationships, along with nursing careers with limited opportunity. It has been a mode of patient service which has been neither patient centred nor professionally satisfying. The ambulatory care approach goes a long way towards removing the stigma of an outpatient centre as an unpleasant place where the poor are processed in an uncaring way. In our view, all patients should fit into a system which spans a wide spectrum of ambulatory facilities and all should be part of a teaching and research endeavour with the expected quality assurance activities.

Ambulatory care at Monash Medical Centre

The Monash Medical Centre's contribution to 'consultative' ambulatory care is in the form of tertiary consultative ambulatory care. Secondary consultative ambulatory care has been positioned within our specialists' own rooms or clinics, and primary consultative care within the surgeries of our Family Medicine Division members and their other GP colleagues.

When the patient with a complex condition requires the assemblage of diagnostic and therapeutic expertise that is available at a tertiary referral hospital, it is appropriate for care to take place at that hospital, even if inpatient care is not required. Similarly, there may be cases when the form of accommodation could be different from the traditional inpatient bed. Several centres overseas have motel-style accommodation available to meet the needs of this intermediate group of patients. An ageing population, combined with increasing ability to prolong survival in a number of chronic diseases, necessitates a redeployment of resources in that part of ambulatory care centred around major teaching hospitals. This is not only a matter of disease complexity, but also a matter of the diversity of services required by the patient—services which may be termed 'multidisciplinary'.

When the patient's problems require the input of several different specialty groups it is appropriate to bring them all to the patient, rather that vice-versa. This is the justification for multidisciplinary ambulatory care programs. Our own experience with this kind of activity in a condition such as osteoporosis has indicated that a great deal of progress is possible when assessment by an endocrinologist, a rheumatologist, and physical educationist can be made conjointly. In such a setting, adequate time for

immediate follow-up consultation and planning with colleagues must be allocated (see figure 1).

Though complex ambulatory care tends to operate within an existing specialty or sub-specialty, the multidisciplinary forms of programs which are required to address contemporary health care problems will require the development of new categories, disciplines and training programs.

Examples of these which we have developed at the Monash Medical Centre, under the auspices of the Clinical Nutrition and Metabolism Unit, include:

- osteoporosis—involving rheumatologists, endocrinologists and orthopaedic surgeons, along with physical educators, dietitians, physiotherapists and clinical nutritionists
- nutritional support—involving gastroenterologists, general surgeons, clinical nutritionists, dietitians and nursing staff
- eating and body composition disorders—involving psychiatrists, clinical nutritionists, and gastroenterologists
- inherited disorders of metabolism and complex metabolic disorders—involving paediatricians, adolescent physicians, clinical nutritionists and endocrinologists.

Traditional outpatient centres also provided for group consultation, that is, specialists from the same discipline meeting and interacting with each other so that patients could benefit from their collective wisdom. We are creating ways in which such group consultations can operate in relation to the Monash Medical Centre, within the private sector, as separate entities, but linked by staff appointments and common medical records in addition to those records maintained by the consultants in the private sector.

Tertiary clinics — the nursing contribution

At Monash Medical Centre, the nursing division of Ambulatory Care Services functions both through solo practitioners and through the nursing component of stand-alone units. The latter include emergency services, day hospital care, short-stay diagnostic and therapeutic services and tertiary consultative ambulatory care. The nursing staff at Monash Medical Centre have had to adjust to a changing health care environment, with a redefinition of their role and the scope of services they provide. The major focus of the division is to assist in the development and implementation of a collaborative model of ambulatory care.

Historically, the professional role of nurses in some ambulatory care settings has been well recognised—midwifery, diabetes education and end-stage renal care come to mind. Nurses working in traditional outpatient centres have not enjoyed the same

Figure 1: An ambulatory care session timetabled for cross-consultation and patient education, investigation and informatics

professional profile or satisfaction. The restructuring of clinics at Monash Medical Centre into multidisciplinary or tertiary consultative clinics has provided nurses with the challenge to redesign their roles and systems to support professional practices in the clinic settings.

In parallel with this redesign comes the need to put in place systems to ensure the delivery of quality services to our patients. These systems need to focus on productivity, staff and patient satisfaction, documentation of outcomes of care, operational efficiency and effectiveness and (perhaps the most difficult) the appropriateness of service.

Although the model of tertiary clinics is still in its developmental stage, early evaluation indicates that the patient visit has progressed to become more of a quality event, not only for the patient, but also for the multidisciplinary team. The continuing challenge for nursing within the ambulatory care setting is to articulate the contribution of nursing care to patient outcomes, patient satisfaction and the organisation's goals.

Coping with fragmentation in services delivery

An increasing difficulty for patients with medical problems requiring the involvement of multiple disciplines is the geographical and temporal separation of components of their care. A related problem is communication between health care providers. By bringing such specialists to the patient, much of this difficulty could be overcome and more effective approaches to management achieved.

Opportunities can also be identified where the three levels of health care can interact at the one time and place. For example, primary health care doctors could be in attendance at some ambulatory care programs. Again, in a nutritional support ambulatory care program, we are involving health professionals from nursing homes in the secondary level of our health care system.

On-site relationships between the primary, secondary and tertiary levels of health care delivery will clearly not be enough. We believe that it is increasingly important for the patient to possess a personalised medical record. Such a record will be carried from one health care professional to the next and from one level of care to another. For the moment, this can be in the form of a booklet such as is presently used in programs of diabetes care and in home-based chronic renal failure programs. Further development of these shared care booklets—with required entry by all attendants—could improve communication and standards of care and provide new opportunities for teaching and research. In due course, it will be possible for this information to be included on a 'smart card', about the size of a credit card. Already it is possible to have

80 or 100 A4 pages on such a card. The security issues with such a system must be addressed to ensure patient and doctor confidentiality.

Ambulatory care and medical informatics

The re-emergence of ambulatory care is occurring at an exciting period in the development of medical informatics. It is likely that with new developments in communication systems we will be able to transcend geographical boundaries within the next five to ten years. It should be possible for consultation to take place at a distance (see figure 2). At the Monash Medical Centre we plan to introduce a clinical computing infrastructure which will make possible a 'wide area network' of computer systems. Clinicians will then have patient data available to them irrespective of which campus of Monash Medical Centre the patient is on, and irrespective of which campus the clinician is on.

It will be some time yet before fully computerised medical records become available, but in the interim, we are investigating the possibility of using so-called 'shadow' records, which contain a summary of the patient's history. We hope in the future to use similar technology to facilitate communication between the various primary, secondary and tertiary care providers in our area.

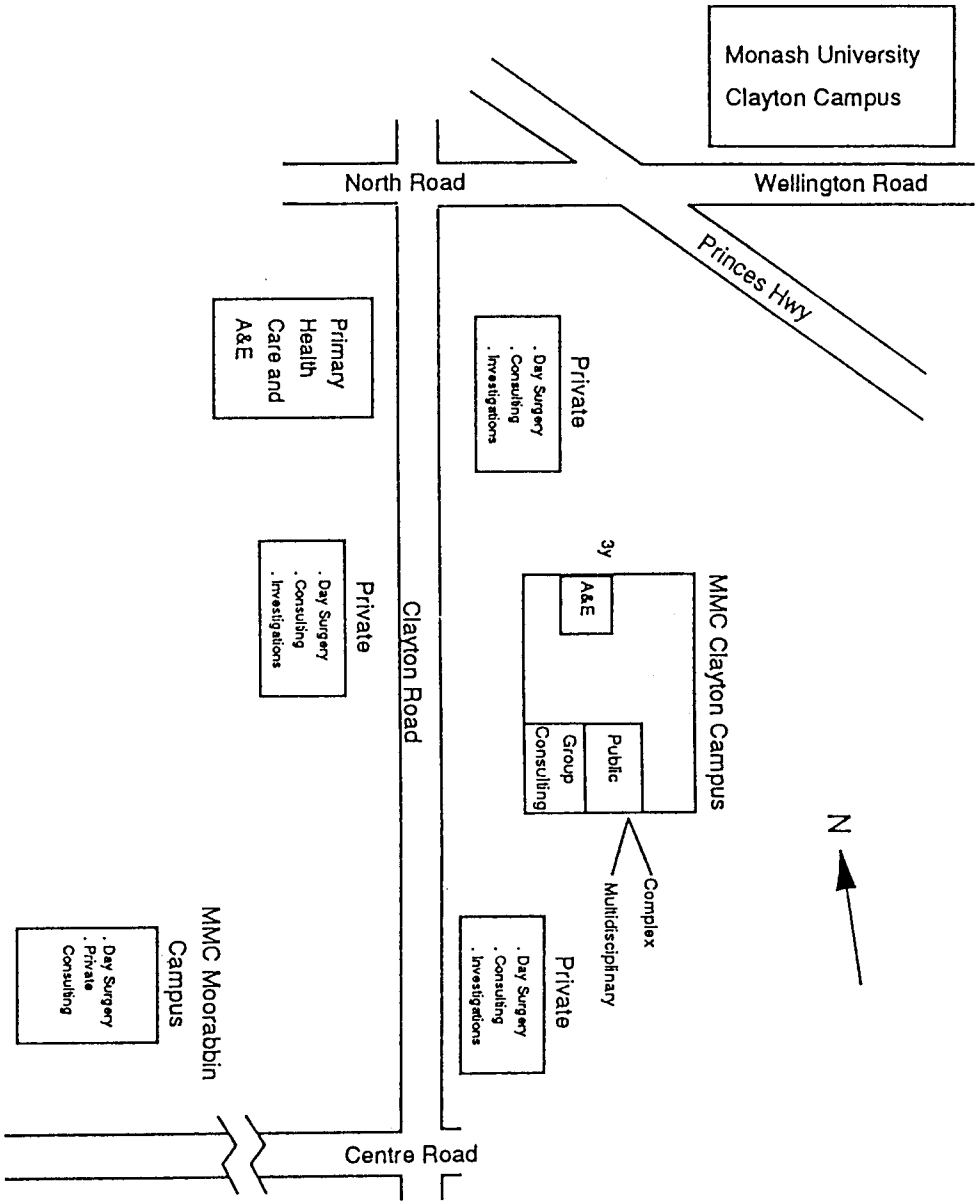
These developments are particularly exciting for Australia and the Asia–Pacific area generally, as the isolation from health care expertise that vast distance brings may be partially overcome. This technology will increasingly lead to a 'geographically transparent' health care delivery structure.

Appropriate use of ambulatory care facilities requires an understanding of the distribution of health problems in the community which the tertiary health institution serves. Such a database, generated at the population and institution level, could provide a new and powerful way of considering and furthering ambulatory care services. It may be possible to make better clinical decisions in accordance with probability analysis and overall need. The development of such information systems will require both technical and clinical epidemiological input.

Conclusion

In the 1990s health care institutions will be forced to adapt to changing social and economic pressures. Those with a clear vision of their role in non-inpatient care will be best placed to meet these challenges. For tertiary referral centres, this may involve a rethinking of the place of traditional outpatient, and a renewed interest in the provision of multidisciplinary or complex care.

Figure 2: Semi-diagrammatic locations of ambulatory care facilities in relation to Monash Medical Centre, Melbourne



Australian Health Review

Volume 16
Number 4
1993

Registered by Australia Post
Number NBP 3887

A publication of the Australian Hospital Association

A.C.N. 008 528 470

This journal is supported by the Australian College of Health Service Executives and distributed to all its members

All correspondence to:
Australian Hospital Association
42 Thesiger Court
Deakin ACT 2600
Phone (06) 285 1488
Fax (06) 282 2395

ISSN 0156–5788

Production: Green Words, Canberra
Printing: Union Offset, Fyshwick, ACT.