Wingecarribee health service model for transitional care

ANNETTE JARVIS AND SIMON GRANT

Annette Jarvis is Research Consultant for Wingecarribee Health Service, and is employed by Jarwin Projects & Consultancy. Simon Grant is Director of Medical Services for Wingecarribee Health Service. Both authors are members of the Wingecarribee Health Service Transitional Care Working Party.

Abstract

The Wingecarribee Health Service (WHS) has developed a program of ambulatory care different from the commonly accepted models. The program provides a "whole service" approach to care, with integration of hospital, allied health and community services in partnership with other key stakeholders such as general practitioners (GPs) and non-government organisations (NGOs). It departs from the medical model and embraces the health service's commitment to a wellness approach to care. The program is focused on providing the most appropriate care, in the most appropriate location by the most appropriate provider.

Background

Hospitals are no longer the only setting used to treat acutely ill people (Gardner 2000, Hensher et al 1999, Caplan et al 1999), and the boundaries of where specific treatments are provided are becoming blurred. Support for ambulatory care has been increasing in recent years.

Community nursing has always existed, but now the interface is changing to accept more acute episodes of care therefore changing its role, the care given and the location of care. Gardner (2000) discusses whether home is the best place to offer treatment, with its association of security and peace. He considers home should be seen as an opportunity to care for people in a preferred environment.

Hensher et al (1999) found many inappropriate admissions could be managed outside acute settings. Caplan et al (1999) suggest treatment in the home may be a safer alternative for elderly clients, than treatment in hospital especially when there are no other acute medical problems. They found treatment for a range of diseases could be managed safely outside an acute hospital.

Hughes (1999) assessed the performance of community support programs through a review of the professional literature, with emphasis on clinical outcomes, cost-effectiveness, and consumer satisfaction. He argues that for managed behavioural health organisations to serve disabled customers adequately, community support is required. He found that social workers are uniquely qualified to adapt proven interventions from model community support programs to the mission of managed behavioural health organisations, with the potential to remedy problems of access, continuity, and accountability in providing treatment for serious and persistent mental illness (Hughes 1999).

Montalto (1997) found some people view hospital in the home (HITH) as encroaching on community health and some routine community nursing is renamed just to maximise income. Patients are willing to accept well-organised alternatives to hospitalisation. HITH allows appropriate technologies into community practice whilst ensuring the hospital is still responsible (Montalto 1997).

Local demography

The WHS is part of the South Western Sydney Area Health Service (SWSAHS). It services the Southern Highlands of NSW, a rural area approximately 1.5 hours south of Sydney. The local service covers approximately 31 townships including the towns of Bowral, Mittagong and Moss Vale.

The area has a population of 36777 (based on 1996 census data) comprising 18016 males and 18761 females. The population growth rate between 1991 and 1996 was 10.4%. This accounted for a slight decline among adults aged 20-34 years, but an increase among most age groups older than 35 years, for both males and females (SWSAHS, 1999).

An ambulatory care program called the Transitional Care Programme (TCP) was developed in 1998 as a joint project between the Bowral and District Hospital, the Wingecarribee Community Health Service and the Division of General Practice. The goal of the project was to provide a consumer focussed integrated care program, allowing care for patients in their own home through a seamless continuum of services provided to patients and carers. This would also hopefully reduce length of stay and avoid unnecessary admissions.

Program development

The need to change models of health care is an issue everywhere. This has been driven by a number of factors including increasing numbers of patients, increased expectation of outcomes, changes in technology and knowledge but at the same time with resource restrictions and increased accountability.

Recognising that environment with demand for increased efficiencies, whilst still providing a 'compassionate' level of care, the WHS had conducted several projects trying to identify specific deficiencies and possible improvements that could be made cope with the future. They included a 'Community Liaison' project and an 'Unplanned Admissions Survey'. The community liaison project identified the need to build relationships between the hospital and community health service and carers as well as the patients. The project found that discharge planning was at best ad hoc, with hospital nurses being narrowly focused and task oriented. Some multidisciplinary co-operation occurred but not comprehensively. Barriers to communication were found, referral information was inadequate and case conferences were irregular.

The 'Unplanned Admission Survey' identified issues relating to unplanned admissions namely bed management, planning of elective surgery, human resource management, and financial management. The survey found more than two thirds of unplanned admissions required non-acute medical or nursing assistance.

Changes in resources

At the same time, changes in resources created a need to provide palliative care services by an alternate means. The general philosophy or separate care providers were then questioned The previous provider of the palliative care service resigned but leaving insufficient funds to maintain a similar service. As an alternative, pooling of those resources with a vacancy in PHN would allow the initiation of a continuous service not only providing palliative care but also expanding into other areas.

The PHN and palliative care service expanded to provide a 24-hour service, 7 days a week. The service developed a plan to provide additional acute service provision in the home environment and which was additional to core business. 'Ambulatory Care' and 'Hospital in the Home' programs were gaining interest and momentum statewide. The SWSAHS considered area based service plans that provided outreach type services. WHS was supported in its application to expand TCP into nursing. In its initial phase the project was a nursing based programme catering to patients who had the required supports to enable them to be cared for at home rather than an admission to hospital. After commencement of the program, it became clear that many of the reasons for "unnecessary" or extended admissions were not acute medical problems. Specialised help in social problems, mobility issues, malnutrition and postnatal care was needed. It was also identified for a continuum of care in a so called seamless manner to be provided, a change in philosophy at WHS would be needed. In recognition WHS committed resources to expand into these areas.

It would require an organisational change with aligning all service providers to deliver integrated comprehensive care along the continuum of health. This would involve building relationships between service providers where traditionally none existed. Effective linkages would need to be developed between various components of the health service especially focussing on the working relationship with GP's and other service providers to be an integral component of the program.

The implementation committee, consisted of a wide range of interested parties, was set up initially to establish guidelines and develop ways of introducing the program so that it was generally accepted. Patient health care worker safety statements were also planned.

To facilitate the program expansion and the additional changes necessary for an integrated service, an implementation committee (TCP Working Party) was formed and an evaluation officer employed. The evaluation officer role was to evaluate the program and mentor services through the development and implementation phases of project management. The evaluation officer developed an organisational wide TCP program plan detailing goals, objectives, strategies and measurable indicators. In response to the program plan an evaluation plan was developed outlining evaluation methodology and data collection tools. The evaluation officer then assisted service managers in their development of service plans detailing their strategies to achieve the overall program plan and also conducted a literature review and demographics profile of the shire.

Expansion of service provision required recruitment of PHN and allied health positions. Integration was bridged between community nursing and traditional nursing by PHN TCP staff sharing shifts with emergency department (ED) staff.

There was a co-management structure between the PHN Nurse Unit Manager (NUM) and Director of Nursing (DON) for the implementation of the nursing component of the program into both the acute and community health environments and to break the traditional barriers between them. In addition, a policy development group formed to review and develop polices in recognition of the impact of TCP on nursing and health-based practice. Subsequently, TCP team meetings were held monthly to discuss administration and other implementation issues arising at the ground level.

A wide range of possible difficulties was anticipated with strategies developed to allow the program to be introduced with as few difficulties as possible. To combat these aspects education, marketing, health care worker responsibilities, patient and worker safety, protocol development, sources of referral and contact arrangements as well as management structures were all planned.

During program implementation training and education sessions for management and staff took place. Marketing of the program to GP's, Specialist, consumers and other health services involved providing education and training sessions, distribution of information and reports and attendance at management meetings and case conferencing. The orientation package originally developed for PHN staff expanded to include allied health components. An information flier outlining the services involved in the delivery of TCP was developed and disseminated to all health services within the local government area.

Allied Health services were instrumental in revising policies and became involved in in-service training of staff. Specific selection criteria for clients were developed. How their services could be integrated across sectors more effectively was discussed.

Two main sources of referral were considered and their management planned, as follows.

- From acute care facilities such as the emergency department or as a hospital inpatient
- From the local GP or community.

From the programmes initial conception means to overcome traditional barriers between hospital and community care were considered a crucial factor to the successful implementation of the programme. The following strategies were considered to have helped break down these barriers to the required cultural and organisational changes:

a) GP's remain responsible for the medical care of clients;

b) Emergency department nursing staff were encouraged to participate in home visits to gain experience on limitations and advantages of home based care;

c) Allied health services such as Physiotherapy, Occupational Therapy, Social Work and Nutrition were given direct responsibility to provide TCP services; and

d) A proactive review of all patients and incidents was undertaken.

Resources were provided to directly engage appropriate specialist staff and also strengthen the existing network between acute and community settings. The extension of hospital based carers into the community and likewise the extension of community based carers back into the hospital, helped drive the significant cultural change needed to move towards better integrated care in WHS.

Conclusion

Community health, allied health and acute care services were connected through the health setting, however, the services provided were informally linked. The TCP goal was to facilitate the organisation to become a formal network of services, with an integrated and comprehensive service delivery system. This integrated network facilitated the use of existing services and resources more efficiently and provided better care to clients.

The transitional care program is about the development of an integrated consumer focused organisation directed at two levels:

a) Service delivery level: aimed at facilitating patient discharge, decreasing length of stay and preventing unnecessary admissions by ensuring appropriate community support services; and

b) Organisational level: which is about an organisational change process directed towards integrated care not only at a service level but more broadly in terms of the structures, processes and culture of the organisation.

TCP service providers include primary health nursing, physiotherapy, occupational therapy, social work, nutrition, and a maternity early discharge program. Each service caters for different needs of the client group with the overall focus being to reduce admissions and decrease length of stay in the hospital environment. Various needs are met including: following discharge from hospital and/or after an acute medical/surgical episode; palliative care; aged care facility patients; patients referred from GPs and other community health services and clients who present at ED and would normally be admitted. These patients/clients require more intensive or frequent interventions than the normal PHN or Allied Health service could traditionally provide.

Each client is assessed individually on their diagnosis, treatment, support requirements and service provider needs. The appropriate service to deliver the care is identified and contacted and the consumer is visited in the home or appropriate setting within 24 hours. Where more than 1 service is required to help care for the client this is co-ordinated at the service provision level. TCP is generally a short sharp intervention. Once the episode is over the client would be referred to an existing community service or appropriate other.

To encourage referral and especially early on in the development to advertise the existence of the service, a proactive approach was taken. Service providers of TCP made daily rounds of each ward, attended hand-over and case management meetings, received referrals by fax, phone or mail in order to identify possible clients. Clients were assessed for their suitability to the program by checking client details with TCP referral criteria. Where the client matched the criteria, the client then became a consumer of TCP. One requirement for patients remaining in their own home or being discharged home early from hospital is that the clients local GP supports the care plan.

Integration between acute and community services and General Practitioners/specialists has been improved. WHS now utilise a collaborative client management model. Networking pathways have been established and there are now identified communication channels and multiple access points. There is a seamless transition of clients between services from admission to discharge and all services involved in delivering care are mapped.

Evaluation for TCP in the future involves formalising the referral and discharge process between TCP service providers, GP's and other care providers; reviewing and enhancing integration process's between TCP service providers; and identifying and addressing resource and staffing issues impacting on the implementation and expansion of TCP. New outreach services are being developed for the Paediatric department and Mental Health. A coaching/buddy system is in place to assist with this development.

Membership of the Wingecarribee Health Service Transitional Care Working Party consisted of the following:
Amanda Larkin: General Manager
Joan Lowe: Director of Nursing Bowral Hospital
Noelle Orchard: Nurse Unit Manager Bowral Community Health
Kathie Bowie: Nurse Unit Manager Emergency Department
Carolyn McMahon: Nurse Unit Manager Milton Park
Marian Ison: Director of Allied and Community Health
Julie Marks: Acting Nurse Unit Manager Maternity
Claire Hewat: Manager Nutrition Service
Frances McCormack: Occupational Therapist
Terry Flynn: General Practitioner
Catherine Weaver: Nurse Unit Manager Children's Ward
Margaret Mogg: Manager Aged Care
Maria De Domenico: Health Promotion and Safety Officer
Gail Atkins: Division of GP
Jennie Cox: Manager Social Work
Jackie Siren: Manager Physiotherapy services
Robert Jackson: Manager Mental Health
Annette Jarvis: Evaluation Officer

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