Due to a multitude of complex factors and challenges the design and delivery of health services require change in rural and remote areas of Australia. In 2008 the Rural Health Alliance wrote “a new health system must be less dependent on health professionals. This will mean keeping people healthy through early intervention, health promotion and promoting healthy environments, enabling people to engage more fully in disease self-management, redesigning professional roles and finding appropriate funding methods for a range of diverse circumstances.” Nowhere is this circumstance more applicable than the Wheatbelt.

In the agricultural boom of the 1930s–50s a fundamental hallmark of each Wheatbelt town was a fully functioning, local, board managed hospital, with a service range spreading from emergency care and medical inpatients, to maternity care and general theatre. Over time both high and low residential aged care beds were added to the mix and as a result the Wheatbelt region currently boasts 24 small hospitals, most of which are located within 50kms of each other. In today’s health environment not only is the ageing infrastructure incredibly expensive to maintain, the service models that were in place no longer meet the health needs of the population. Hence—a time for change.

In 2012/13 the Wheatbelt, a region within the West Australian Country Health Service (WACHS) was provided with an opportunity to explore a partnership with community to ultimately result in a conversion from the provision of traditional hospital based care to an integrated primary health care model, excluding inpatient options. An oft debated subject of health leaders was how to best navigate this considerable shift in thinking for both the staff and community members whose range of reactions moved on a continuum from wary and openly distrustful to willingly embracing new ideas and hopeful of a better future. In the end what proved successful was encouraging a genuine Primary Health Care (PHC) approach to managing change from the “bottom-up”. Without actually naming it as such the “winds of change” were steeped in a philosophy of:

- dominant characteristics: personal, like a family
- leadership style: mentoring, facilitating, nurturing
- management of employees: teamwork, consensus and participation
- project glue: loyalty and mutual trust
- strategic emphasis: human development, openness
- criteria for success: concern for community, teamwork, achieving the goals.

This paper highlights two areas of the service which demonstrate how the idea of using a “no wrong door” mindset gave rise to mushrooming of truly innovative problem solving and community centred care outcomes.

The Cunderdin Shire boundary encompasses three small country agricultural towns, Cunderdin with a population of 1500, Meckering with 600 people and Tammin with approximately 400 residents. The main industry is sheep and wheat farming along with those businesses that provide support for agricultural activities. The majority of the shire population is in the 15-44 year’s age group, closely followed by those in the 45-69 year’s age group. The number of residents aged between 70 and 84 years is expected to increase by 21% by 2056 (ABS, 2012). Approximately 2.4% of the population is
recognised as being Aboriginal. Cunderdin has a higher proportion of young people than many Wheatbelt towns due to the presence of a popular regional agricultural college.

The leading cause of hospitalisation in the Wheatbelt includes respiratory complaints (asthma and chronic obstructive pulmonary conditions), heart disease including heart failure, high blood pressure, diabetes and the complications of diabetes (Southern Inland Health Initiative, 2015). Stakeholder discussions held during the planning phase of the primary health care centre have shown an upward trend in obesity and the rates of cigarette smoking have had a significant impact on the number of people with chronic disease.

The existing health service in the Cunderdin Shire operates from hospital built in 1967 which in earlier times provided birthing and general surgical services as well as emergency and inpatient care. Over time these services have been reduced to emergency response, low acuity inpatients, residential aged care, respite and palliative care. The closest Wheatbelt rural hospital with an higher service capacity is 60kms away at Northam and the nearest secondary hospital is 160kms distant at Midland. The activity in all departments of the hospital is considered to be low and although there are some visiting allied health and other programs, prior to the Southern Inland Health initiative proposal to develop a Primary Health Care Demonstration Site at Cunderdin, the general public only infrequently accessed the available health services.

To coincide with the commencement of capital works planning phase, the metamorphosis from a hospital based inpatient and residential services to a PHC model began in the Wheatbelt town of Cunderdin in early 2013. At that time there were ten aged care residents in the high care wing of the hospital and a further four living relatively independently in a lodge located within the grounds. The idea of delivering more health care in the community and providing locals with the wherewithal to remain living a satisfying life at home for longer was well accepted by both staff and community members. The challenge lay in finding a way to turn a good thought into reality.

Under the Multiple Purpose Health Service (MPS) funding arrangements flexible home care packages were available. By combining these with the existing Home and Community Care program some capacity to provide more home based services was achieved, however, not anticipated to be sufficient to meet the level of demand.

The local staff decided a “can do” attitude and a “no wrong door” approach was an essential part of the solution, however they also felt a test of two key community roles aimed at pulling the project together was necessary; the first, a Community Care Coordinator (like a HACC coordinator on steroids) and the second a “super” community nurse. A broad scan community needs analysis was conducted to determine the level and range of resources required to deliver the care. The result clearly demonstrated a gap between demand and capacity and this circumstance with further complicated by an organisational wide staffing establishment cap.

The agreed solution was to seek out accredited private providers with allocations for community care packages, however, it soon became obvious the majority of these companies had the money to provide the service but no local staff to deliver, and conversely WACHS Wheatbelt could source the staff but did not have the budget to expand on the existing staffing establishment. And so a brokered service partnership was born. Cunderdin staff delivered the care and the full cost of the service was invoiced to the private provider and as a result there was an exponential increase in the number of services it was possible to deliver at home.
The role of the Community Care Coordinator is to match the service need and type with a staff member trained to deliver care in the community. The skill base of the home care staff includes the early recognition and reporting of increasing frailty or changes in the care needs. In this way early interventions are possible and in the majority of case with carefully considered adjustments to the level of care provided the person can remain at home with their family. Judicious and effective resource allocation is a key function of the community coordinator role. Local knowledge of travel times, carer capacity, community and social support networks and the assistance of volunteer organisation is a vital element in improving the patient journey through good service integration and reducing or avoiding the need for institutionalised care.

The community nurse provides supportive management for chronic disease clients, wound care, continence clinics, home based contact following up after presentations to the local emergency department and assessment or re-assessment of changing client care needs as required. Low level rehabilitation of post-acute patients is also part of the role. Respite and palliative care in the home has become more doable through the introduction of this position.

The service reform results of the past three years are remarkable. The number of in-hospital residents receiving a high level of personal care reduced from ten to one over an eighteen month period and has remained at just the one patient. The three low care residents are the same group over the three year period and all other potential residential aged care clients have been supported to remain at home.

Community based services have increased from 6 hours on three days a week to 7.5 hours 5 days a week and a shorter shift for essential visits on the weekends have been delivered to a total of over 400 clients. The benefits, including cost savings, realised in preventing hospital admissions for even 10% of these clients is considerable.

One elderly client (92) who was found to be socially isolated, suffering from depression and weight loss due to a reduced swallow reflex was referred to the community nurse by a HACC worker. The nurse organised for the client to be reviewed by a physician who diagnosed Parkinson’s disease and started him on treatment which resulted in a notable improvement in his affect and swallow reflex. The root cause of his low mood was based in his isolation from family members in the United Kingdom. An old laptop was sourced and an internet connection made so that he could “Skype” his sister in Birmingham. Further mood improvements were noted as was his acumen in navigating the internet. He started making internet purchases which gave him a hobby, which got him out and about, which made him happy—perfect outcome!

Another important area of innovation has been the delivery of supportive palliation services in the home using a combination of visiting team members and through maintaining more frequent contact with the client and family using a tele-health platform. Our research into this opportunity for service improvement demonstrated two clear challenges. The first was to get the referral process and therefore the timely involvement of the regional palliative care team right and the second was the capacity of the team to provide support to the family when and how often they needed it.

Australian statistics would show that approximately 70% of people who are in the final phases of their life wish to die in their own home. For a variety of reasons less than 20% people achieve this aim (Swerrison & Duckett, 2014). The Wheatbelt Regional Palliative Care team were keen to find ways to improve this ratio and by working closely with the Cunderdin staff they overcame barriers to providing high quality end of life care at home.
The problem of appropriate referral was easily solved through using a clinical service reform process. The client journey was mapped in order to understand where the trigger points for initiating a multi-disciplinary approach to care planning should occur between the regional palliative and community based care teams.

In a region with geographical characteristics of the Wheatbelt (155,000sq/km) it is more difficult for a small team, however committed, to provide effective home visiting services given the travel distances required. Additionally the client’s needs are often high and the family and carers find their stressors are reduced by readily available advice and emotional support. The group decided to use a combination a visiting service and virtual support using technology to keep connected with the patient and family. A project was developed to cover the clinical governance elements of the service delivery plan such as Schedule 8 medication checking via tele-health and funds were sourced to purchase the equipment required such as laptops and smart phones. The cost of setting up the services (around $6000) was clearly offset by clinical time saved in travel and the increased reach of the service.

The plan worked well for an Aboriginal family living on the outskirt of the Cunderdin Shire. The patient had entered the terminal stages of cancer and wished to spend his final days at home with his family. A comprehensive care plan to support this request was developed. As a heavy set patient he required additional personal support as time went on. Aids to mobility were introduced into the home and a visiting roster using a combination of staff classifications was commenced. The regional palliative care team, which included the services of a palliative care consultant, was on hand to provide the needed assistance by video-conference (Scopia) giving expert advice on pain management, checking medications and drug administration equipment and generally supporting the family through what is always a testing time.

This was a complex case and on several occasions circumstances were such that it was difficult to see how care could continue in the home environment. What was notable was the willing attitude of the team involved to look objectively at the situation and find a solution to whatever the blocker happened to be. The family were demonstratively appreciative of the care and support they received during this period.

Successfully managing end of life care at home has given the team the confidence and opportunity to use the same approach to care planning and delivery in subsequent cases. The virtual model works using Scopia and can be accessed through smart phone, tablet or PC devices in any location with internet access. The project has to date provided in home support to 30 families and in the last month has facilitated in home palliation for four families. In a more recent example a video conference between the palliative care specialist, using a hotspot connection for his laptop in his car, was able to problem solve a patient and a palliative care staff member in Lake Grace some 400kms away. There have been infrequent occasions when the internet service has dropped out during the contact or the screen has frozen, however, the overriding successes achieved far outweigh the minor technical problems that have been experienced.

Practicing Primary Health Care is at once an aptitude, an attitude and a way of being. In some sense the challenges of providing effective, holistic health care services in an environment where often the community are either reluctant to, don’t or can’t engage or access appropriate health care services becomes almost addictive. The WACHS staff working in the Cunderdin Health Service have demonstrated superior resilience and an enthusiasm for experimenting with new ways to provide the highest quality of health service possible in an environment of unpredictable change, whilst the capital reform program is completed.

The obvious counter question would be: should a state organisation be involved in delivering community based care when commonwealth funds are awarded to private organisation to provide this
type of service? And the answer to that question is no, if of course, the company has a business footprint in, and the capacity to, deliver the quality and type of services required in rural and remote areas. The recent changes in aged care funding are designed to offer the patient more choice and it as yet unknown the number of providers who will be available to provide the level and type of service to keep people living independently at home in country areas.

References

Australian Bureau of Statistics (2012), Cunderdin, Meckering Data


Presenter

Beverley Hamerton spent the early part of her career in emergency and critical care nursing. In 2002 she left the relative safety of those practice areas to start working in remote locations. As a sole nurse practitioner on Murray Island in the Torres Strait, Beverley had some of the best clinical practice experiences of her career. It was the time in which she came to understand the importance of primary health care and ponder on the impact of the social determinants of health. Recently she has worked in various roles as a health executive and has been heavily involved in establishing robust primary health care services or programs. She is currently engaged in transitioning two small rural hospitals from inpatient services to an integrated primary health care model, complemented by an aged appropriate accommodation project that focuses on maintaining the independent quality of life of both individuals and groups. This journey has had many challenges but also many rewards. Community members are awakening to other possibilities in health care and how those expanded services will work to keep their families and friends living longer and living well in a locality they know and love.