Hepburn Integrated Aged Care Project

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BACKGROUND

The Hepburn Health Service was formally incorporated on April 1 1998, following the amalgamation of Trentham Bush Nursing Hospital and Clunes Health Service with the Western Highlands Health Service.

The newly amalgamated Hepburn Health Service incorporates Daylesford Hospital, Daylesford Community Health Centre, Lumeah Lodge Hostel, Creswick Hospital, Lindsay Support Centre, Clunes Health Service and Trentham Hospital.

The Health Service provides 30 acute beds, 92 aged care beds and a diverse range of community health, allied health, home and community care, dental and health promotion services.

The Hepburn Health Service is located within the rural Shire of Hepburn, approximately 120 kms North West of Melbourne. The Health Service spans the entire Shire with facilities and services delivered from four campuses in the townships of Daylesford, Creswick, Trentham and Clunes.

Close working relationships have been fostered with the Shire's health agencies. They include local general practitioners, Hepburn Shire Council, Daylesford Family Services and John Curtin Hostel.

Prior to the most recent amalgamations the Health Service sought to concentrate its efforts on developing an integrated aged care system as a more effective way of providing health care. This required the health service to develop a stronger aged care and community support services sector in order to develop a sustainable health system within the Hepburn Shire. This was achieved firstly by participation in a Ballarat and District Discharge Planning Project 1996 and a Hepburn Shire Home and Community Care Best Practice Project 1994.

Through its involvement in these two projects the Health Service made substantial progress in developing a basic integrated aged care planning framework. However, with the Health Service expanding to encapsulate a whole rural Shire area there was a need to develop a Shire wide integrated aged care model as a matter of priority.

Funding was then sought and obtained from the Victorian Government Department of Human Services Aged Care Division to initiate a pilot project to develop a Shire wide integrated aged care model. It should also be noted that the Hepburn Health Service had significant agency support for the integrated
care project from all of the other Hepburn Shire based aged care and health agencies. Their support was considered to be an essential element necessary for the successful development of such a program.

The pilot project was initiated in 1998 with Melbourne based Consultants, B-Con, engaged to undertake the project work. A steering committee was formulated consisting of a diverse range of health and human service organisations including general practitioners, Hepburn Shire Council, John Curtin Hostel, Daylesford Family Services and members of the Hepburn Health Service multidisciplinary health team.

PARTNERSHIPS

Throughout the duration of the Integrated Care Project a partnership approach with the Shire's health agencies was adopted. The partnership approach included partnerships with external and internal practitioners.

Internal partnerships were developed between acute, aged residential and community health sectors. External partnerships were developed with private and public health and community service providers involved. This included general practitioners, Hepburn Shire Council, aged residential agencies, family support organisations, government and community members.

The implementation of a partnership approach where each agency's contribution is valued was considered to be a significant factor in developing a successful and effective Integrated Aged Care System. The Integrated Aged Care System is heavily dependent upon the willingness of all its members to participate. A high level of consultation and joint planning was therefore required to help break down the barriers to further integration of services.

Briefly, these barriers were perceived to be:

- existing traditional and non-cohesive health care system;
- separate service systems resulting in lack of communication between private and public health care providers;
- an increased sense of threat associated with recent amalgamations and competitive tendering; and
- an existing traditional, separatist and somewhat narrow view of health professionals roles and responsibilities within the health service particularly within the hospital setting and a resistance to change.

These barriers were addressed and their impact gradually decreased over a period of time largely due to the maximising of opportunities to jointly plan, implement and evaluate aged care service provision with the Shire with all of the key players. Joint involvement in a Ballarat Discharge Planning Project and a Home and Community Care Best Practice Project helped the Shire's agencies to network and formulate service linkages, analyse the disadvantages/advantages of integrated care for each of these services and to develop, implement and document protocols for assessment, referral and evaluation of client care.
To assist with the Integrated Care planning process a Coordinated Care Planning Committee was established. The Coordinated Care Planning Committee included membership from all of the Shire’s health and aged care agencies. In addition, there were multidisciplinary representatives from all of the Health Service’s departments. These included both medical and nursing representation and allied health and welfare representation. The overall aim of the Coordinated Care Planning Committee was to promote a culture and practices conducive to integrated care. This was achieved through the development of a range of clinical care mechanisms and the identification of integrated care champions from within the Hepburn Health Service.

In addition to overall responsibility for the Integrated Care Planning Project the Coordinated Care Planning Committee provided a regular forum where the Shire’s aged care providers could work collaboratively to initiate new integrated care activities. Some of its more recent projects include clinical pathways development and implementation of an innovative patient discharge planning booklet.

A Shire wide Health and Human Services practitioners forum has also been initiated. The aim of the Health and Human Services practitioners forum is to provide members of the wider inter-agency multidisciplinary team with a forum where they can network and share information, and develop joint projects. The availability of the Health and Human Services forum has helped to reduce agency barriers even further, thereby making client assessment, referral and information flow more congruently between the practitioners.

One of the key features of the Integrated Aged Care Model is the high level of general practitioner integration, support and participation in team planning processes. It should be noted, however, that rural general practitioners working in small rural hospitals are usually not employees of the hospital. Furthermore, client fees and the Medicare system do not provide any financial incentives for general practitioners to involve themselves in team planning and evaluatory processes. Thus, a valuable and integral part of the health service system was not utilised as much as it could have been.

How then did we secure the medical staff’s participation and commitment to integrated care? Firstly, through a partnership approach, a regular forum was established with the general practitioners where common areas of healthcare interest were identified. Some of these areas included men’s health, maternal and child health, drug and alcohol support amongst many other issues. The Health Service then undertook to provide project and funding support for some of these interest areas. This was both acknowledged and appreciated.

In exchange, general practitioners made a substantial commitment towards integrated team processes, for example, participation in the Co-ordinated Care Planning Committee, Health and Human Services Committee, case management forums and special projects. This relationship has developed over time with both doctors and Health Service enjoying a large amount of success.
and national recognition for some of their joint projects. The success of the men's health project in particular, for example, has helped to strengthen the linkages with general practitioners.

INTEGRATED CARE CLINICAL MECHANISMS

In an atmosphere of trust, with strong linkages in place between the Shire's health practitioners, a range of integrated care clinical mechanisms were able to be developed with the full support of the Shire's health and aged care agencies. Integrated Care clinical mechanisms included streamlined assessment procedures, fast track referral systems, community needs analysis, aged care services packaging, clinical care pathways, continuity of care mechanisms, structured case management forums and continuous quality improvement systems.

Streamlined Assessments

Streamlined assessment procedures have been developed in partnership with the Hepburn Shire Council Home and Community Care Division. The assessment procedures involve a written agreement outlining a working framework for integrated assessment of all of the Shire's Home and Community Care clients.

This Assessment Protocols Agreement recognises the efficacy of each agency's assessment procedures and provides an opportunity for the respective agencies to utilise one another's assessment information. In this way, unnecessary duplication of assessment is avoided thereby minimising potential stress for frail aged and disabled clients. To assist in this process integrated assessment forms are utilised.

Further advances in the streamlining and integration of the assessment process for community based clients are currently being discussed. This includes the potential for a single point of entry for all Home and Community Care and post discharge clients.

Program Statements

Detailed Program Statements have been developed for all Shire based aged care programs. Program Statements include program aims, objectives and roles, assessment criteria, risk assessment, key referral pathways, service provider linkages and key performance indicators.

The Program Statements are used as an information tool for other service providers within the service system and for prospective and actual clients of the service.
Case Management

Weekly multidisciplinary case management forums have been initiated where clients' cases are reviewed and managed within a team context. Case management criteria have been developed to govern who and under what circumstances clients are case managed.

A sub-regional case management forum has also been developed which includes the ACAS team and sub-regional wide aged care practitioners from Ballarat, the nearest major referral centre to the Hepburn Health Service. In this way, sub-regional aged care services are both oriented and integrated into the Hepburn Integrated Care Network. The benefits of such integration include:

- a more comprehensive, focused and informed client management process which then lead to improved client outcomes; and
- maximises opportunities to both network and share information with all agencies providing services within the sub-region.

Aged Care Services Packaging/Clinical Pathways

The Health Service has endeavoured to ensure all relevant services are provided to clients in an efficient and timely manner. Mechanisms adopted to ensure maximum support is provided include case management, case review, creation of an emphasis on service development and community needs analysis.

This approach is currently being trialled through the development, implementation and evaluation of clinical pathways in the acute hospital setting. These are currently being introduced by trialling pathways specific to both Angina and Chronic Obstructive Airway Disease (COAD). A third generic pathway is also being trialled specifically for clients with co-morbidities. Similar pathways will also be developed for community based clients.

The development of facilities for the co-location of aged care services including Hepburn Shire, housing, transport, family support and allied health services has provided a 'one-stop shop' approach to care provision. This has increased the accessibility and availability of a range of community based services for aged care clients.

Fast Track Referrals

The formulation of Program Statements has enabled the Shire's aged care practitioners to work collaboratively in order to clarify and identify referral procedures, priorities and review documentation. Referral and assessment systems are thus promoted to the wider aged care team and thereby effectively reduce unnecessary and inappropriate referrals.

INTEGRATED INFORMATION TECHNOLOGY PROJECT

With funding from the Department of Human Services, Rural Health Division, the Hepburn Health Service has initiated a Hepburn Shire wide integrated information technology project. The aim of the information technology project is
to develop the hardware and specialised software systems to enable improved and efficient communication between the Shire's aged care promoters for client's assessment and referral information.

The information technology project will help to integrate aged care services further by increasing local services capacity to communicate service information via a common network and utilising a common language. Information and documentation developed as part of the Integrated Care Project will be installed onto the computer network thereby creating a Shire wide computerised system of client data.

The computerised system will include the Shire's aged population health service information regardless of where they have entered the service system. This will include both private and public health agencies including general practitioners, pharmacists, acute health, aged residential, community health and Hepburn Shire Council home and community care personnel.

CONCLUSION

The development of an effective Integrated Aged Care Service System has been dependent upon the development of partnerships in health care within a small rural Shire context.

Partnerships and a spirit of cooperation have been fostered through joint work on a range of integrated care projects. The partnership approach has broken down traditional boundaries and includes partnerships with private and public health providers, transport operators, housing and welfare agencies. In developing partnerships an integrated service system has been developed which spans the continuum of care between acute, aged residential and primary care.

Common assessment, referral and client information forms have been developed and are in the process of being developed even further. A range of integrated care mechanisms have been initiated which provide significant benefits to the Shire's aged care clients. They include Co-ordinated Care Planning Forums, Clinical Pathways, Community Needs Analysis, Aged Care Services Packaging and Case Management. Furthermore, a Shire wide Integrated Care Information Technology Project will help to develop the Integrated Care Network further by providing a common client data information technology system for the Shire’s aged care practitioners.