Community Ward: getting ahead of the game

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Alpine Community Ward

This essay provides a description of a small rural health's service adaption and adoption of a workforce/service model aimed at the prevention of unnecessary and otherwise preventable hospitalisation in the elderly, through early intervention health promotion and a process of coordinated transdisciplinary care. The model was based on a 'Virtual Ward' construct which is an award-winning initiative originally created by Dr Geraint Lewis in Croydon Primary Care Trust, UK.

Background

International evidence suggests that we need to prepare a workforce that is not only fit for purpose for the future, but one that is able to drive fundamental service reform through participation in new and innovative models of care delivery. The Grattan Institute report, Controlling costly care: A billion dollar hospital opportunity (Duckett, Breadon, Weidmann, & Nicola, 2014), calls on health services to embrace innovative ways of working differently and performing better. Adopting innovative ways of working is also a key principle embodied in NHS Scotland's approach to its 'Keep Well' strategy.

> "Keep Well was launched in October 2006 as part of the Scottish Government's 2005 health policy *'Delivering for health'*. This policy listed a number of interventions focused specifically at tackling health inequalities. One of the major actions for primary care was the development of an anticipatory care model targeting geographic communities of greatest need. The programme was expanded further through *Better Health Better Care* (2007) and *Equally Well* (2008)." (www.healthscotland.com/keep-well.aspx, 2015).

Importantly however, the Keep Well (2006) initiative recognized that health service models in other localities were able to achieve higher quality care at a lower cost. Kaiser Permanente in California was identified as a key example of a health service achieving better quality and cost outcomes. (Feachem, Sekhri & White., 2002) A key initiative in that effort was the development of a model that saw high risk people in their population identified and managed intensively in the community setting, to prevent otherwise avoidable admissions.

Based on the Keep Well (2008) NHS strategy's broad rationale, and borrowing heavily from international examples such as the Kaiser Permanente anticipatory care model, and Virtual Ward model located in Croydon - London, Alpine Health defined a conjoined workforce and service development framework, which it described as The Community Ward. Through a relationship and grant support with Health Workforce Australia in 2012, Alpine Health launched a pilot Community Ward model in one of its local community areas.

Service locality

Alpine Health is a Multi-Purpose Service. It is one of seven in the state of Victoria and the largest of its type in Australia. Alpine Health services the Alpine Shire population of roughly 13,500 people. Alpine Health is located in north-eastern Victoria and is 270 kilometers from Melbourne. The major towns are Myrtleford, Bright and Mount Beauty. Geography and weather are significant moderators in terms of service delivery for Alpine Health.

The catchment area of the Alpine Shire covers an area of 4,885 square kilometers of which a significant part is forest and national parks (Mount Buffalo and Alpine National Parks). Geography has a major influence on service development in the Alpine Shire. It features a mountainous topography and narrow bands of fertile valley flats, which influences transport routes, population movement and town development.

Myrtleford and Bright are in the Ovens River Valley in the western sector of the Shire and relate naturally to Wangaratta as the regional support center, while Mount Beauty is in the Kiewa River Valley in the eastern sector, annexed by the Tawonga Range, and relates to Wodonga and Albury.

The Alpine Shire has typically high rainfall. Winters are cold with widespread frosts and snow in the ranges (Falls Creek and Mount Hotham alpine resorts). Some roads may be impassable in the snow season. Summers are hot in the main town areas and in the valleys, and mild in the ranges.

Problem

Unfortunately, there is evidence that shows that current workforce models inclusive of doctors, nurses, and case managers do not appear to be able to predict otherwise preventable hospital admissions reliably (Curry, Billings, Darin, Dixon, Williams & Wennberg, 2005). This is not only a product of an ability to access and understand predictive data, but is also representative of the sometimes discourse in workforce coordination that both patients and service providers experience in the management of disease states and illness. This is well defined in the Heath Workforce Australia Service and Skills Pyramid (adopted from the National Priority Health Action Council, 2006) which underscores the configuration of available workforce around the diversity of care needs of the population, and most importantly how the workforce could be reconfigured in the future to better manage health demand. Additionally, in terms of the specific workforce currently configured in Mt Beauty available to deliver aged care service is not well coordinated and is a workforce in which significant redundancy of function exists relative to their scope of license.

Service/workforce model

The Community Ward model was designed as both a service *and* a workforce model for delivering multidisciplinary case management to people who are at high predicted risk of unplanned acute care hospitalisation. This model was taken up by Alpine Health as a consequence of a staff secondment initiative between Alpine Health and NHS Tayside in Scotland. Alpine Health facilitated a twelve month placement for a senior member of staff, who subsequently helped lead the roll out of the initial Virtual Ward program in Scotland, most specifically, in the Perth and Kinross Community Health Partnership locality, Perthshire.

The design of the Alpine Health Community Ward model was based on workforce redesign through the lens of a new service model with the dual purposes of (1) using a predictive model to identify people who are at high risk of future emergency hospitalization, and (2) aligning these individuals with a coordinated anticipatory care focused workforce for a period of intensive, multidisciplinary preventive care in home, using the systems, staffing, and daily routines of a hospital ward construct.

This model of preventive, integrated care may have a number of theoretical advantages over ‘‘traditional’’ one-to-one case management. Potential advantages included a reduction in the fragmentation between the primary, community, and social care workforce by bringing together professionals from different organizations to participate in coordinated workforce approaches to service delivery. It also formally, for the first time, included members of the sub-professional and non-professional workforce, including caregivers.

The Community Ward workforce consisted of the Community Ward Clinician (in the Alpine context this was a Registered Nurse) and clerical support. The Community Ward model saw Alpine Health provide project leadership in conjunction with the Mount Beauty Medical Centre, one of the Alpine Shire’s locally based general practices. The role of the Mount Beauty Medical Centre Practice Manager assumed project lead role which proved critical to the operationalisation of the Community Ward model. The Community Ward seconded other care provider (professional and non-professional) participants on an ‘as needs’ basis when necessary within a collaborative primary and secondary care approach.

Preparing the client base

The Community Ward model relied on the development of a ‘virtual’ workforce to empower people, already engaged with any number of social and health support systems and already receiving some form of community support, with new sets of skills, new knowledge, improved attitudes and broadened networks, in order for them and their community based supports to make positive and informed health decisions into the future, much earlier in their care continuum than otherwise would have been possible. The client group identified for this model was over 65 years of age, had two or more long term conditions and some level of social isolation. This was also the ‘typical’ Virtual Ward patient

archetype in the Croydon (London) model, albeit other types of features (e.g. cost of care drivers, capacity of patients to engage) were seen as important in other types of like models in other localities, such as elsewhere in the UK and in the US. The Alpine Health model grew to a capacity of 20 patients at any given time, during its project life of 18 months.

Effectively establishing client goals with clients was important but the establishment of a system of coaching the client to develop a sense of readiness and confidence to achieve those goals was also found to be equally important. This was found to be true even when the client had all of the available condition information i.e. information and education were not enough to produce movement towards goal attainment. Also it was found that the establishment of goals in terms of what mattered to the client was important which made the ability to create links to a range of socio-health outcomes, more possible and subsequently seemed to made more sense to the client.

Preparing the workforce

Engaging a workforce to give this model effect was a key to success. The Community Ward model made explicit connection between patient benefits and the values of the people working in the model and the patient population it serviced, living in the local Shire. This goes to the heart of many healthcare initiatives that have a sound economic rationality but don't always have a sound normative rationality, and therefore don't often deal with social norms of the workforce such as, established 'work arounds', practice habits and peer pressure.

Alpine Health's current Service Plan as well as a recent Workability analysis of Alpine Health's staff base, support the notion that staff shares a vision of high quality healthcare services in the Alpine Shire. For many, the drive to make a difference, such as; caring for, supporting and enabling others is what motivated them to work in the socio-healthcare field in the first place, and is completely aligned with their professional values and aspirations. Alpine Health knows, through the Workability study, about the correlation between staff experience and staff wellness, with the patient experience and patient outcomes. It was important therefore to balance workforce redesign, with the support and development for staff to feel engaged, valued and empowered in leading and driving this change.

Although the broader workforce necessary to deliver on the remit of the Community Ward was otherwise in place in the form of the existing suit of GP, primary care, Shire, regional community health services, and volunteers, Alpine Health's clinical staff establishment in Mount Beauty, some level of repositioning within the model was required in order to promote practice at the top of license. This was codified and measured through the development of a single competency framework supported by tools that made the task of clinical handoff (especially between the non-professional and professional workforce) much more possible and structured, e.g. an early warning of deterioration tool. This framework now informs all of Alpine Health's roles, right throughout its services.

A recent NHS review of staff working on long term conditions highlighted a complex pattern of overlapping and interconnected learning needs, and the importance of support for practitioners to develop the desired approaches and behaviours. These formed a basis for staff training support for the Community Ward project.

The preparation of people necessary for building a workforce capable of delivering on broad anticipatory care models are not new, but include skills that equip people to:

- target and engage with individuals and populations
- better understand individual motivations for health behaviour change
- provide continuous support through health coaching
- support people to self-manage and to be the lead partner in their care
- develop the skills needed to work effectively with people from other sectors to enhance appropriate support.

Also important to workforce practice, was the formalization of intake paperwork, which not only created a common use of health promotion language but also collected valuable performance data in the one place, allowing evaluation of process efficiencies to occur in real time, and from a teams based perspective.

Evaluation

The evaluation of the Community Ward model was based on a range of key performance indicators inclusive of goal attainment score outcomes (GAS scores), linked to key project objectives and project deliverables, as follows:

- level of awareness and understanding of the new workforce model
- level of skills developed in the new model for workers
- level of confidence in exercising the new competency profile for workers
- extent of changes in scope of practice
- impact of model on worker experience and satisfaction we have this from nurse workplace satisfaction
- the impact of the model on workers productivity
- the impact of the model on organisational culture
- the impact of the new model on improving client outcomes targeted through the model and key change metrics.

Notably, the largest increases in capacity development occurred in productivity, organisational culture and client outcomes. Other, broader outcome aims of the Community Ward project related to pursuing an answer to the following;

Did the project:

- Engage and empower clients so that they achieve their self-expressed goals?
- Ensure coordinated anticipatory care and support to reduce avoidable service inputs?
- Develop workforce confidence and understanding of the new anticipatory care model?
- Develop competencies underpinning workforce redesign based on anticipatory care principles?
- Extend the scope of practice of the workforce to operate at upper education/training levels where judgements/skills are best placed and consistent with the model?
- Enhance individual satisfaction and organisational culture of the workforce?
- Improve workers' productivity through the application of a new workforce model based on lean principles?

One key outcome of Health Workforce Australia sponsored community Ward project was the articulation of five pillars for successful workforce reform, and these included 1) competency-based role redesign, 2) focus on a better balanced skills mix, 3) partnering across the continuum of care, 4) building leadership for change, and 5) systems enablers. However additional system enablers were identified by Alpine Health as an outcome of the project. These included;

- Tools for Community ward staff that exemplified anticipatory ways of working, focused on client outcome goals in ways that enabled the client to articulate what 'mattered' to them, and facilitated data collection from point of care.

- The development of a trusting, almost transformational (as opposed to transactional) relationship before all else between the client and the care team and between the care team.
- Integration of the Community Ward model with existing service examples of conjoined organisational effort. In the Alpine Health case, this conjoined effort was represented by an alliance between the local health service and the local shire, called Alpine@Home.
- Building very personalised scripts for case intake interviews helped create a focus on what mattered to the patient, especially in the context of assessments by highly technically trained and skilled nurses. A more personalized and holistic assessment occurred through meetings with a nurse changing the focus from 'what do you think you need?', to 'what matters to you?'
- Health coaching was perceived as an enabler for defining shared practice principles between the Community Ward staff, the medical centre, practice nurses, district nurses and adjunct services such as allied health. Some specialist coaching was provided to locality based staff by Health Change Australia in methods of health coaching. This was also supported and sponsored by Health Workforce Australia, within the Community Ward project.
- Existing funding mechanisms also enabled recruitment to the patients to the Community Ward. The Community Ward was seen by some locality based clinicians to have systematised the coordination of care through utilization of the funding for 75+ health assessment rather than through more random referrals. Yet issues remained regarding the identification of at risk people in the population applying a predictive model. As a Community Ward staff member commented, 'There are still plenty of people with diabetes in the population, and more people per head need dialysis. We are trying to catch people at the start of their conditions before they deteriorate'.

Barriers and limitations

- Anticipatory frameworks may require further explanation including risk management aspects from service providers' perspectives.
- Variations existed in individuals' (patients') readiness to adopt self-management principles.
- Slowness to adopt innovation in the service system was another barrier. As a CW member commented, 'Changing the way people do things is not easy to do quickly'. The industrial relations framework affecting nursing tasks and scope of practice was also a barrier in reconfiguring nursing competencies.
- Rudimentary capacity to identify and quantify 'potential for future admission' as a risk profile, particularly with data on the same locally based patient not shared at an operational level by service providers, especially general practice and hospital based data.
- Measurement challenges became obvious early in the project. Avoided hospitalization was neither an immediate outcome or easily quantifiable, particularly with statistically low numbers of patients through the model over its lifespan.

Moving forward

Alpine Health has committed to the principles of the Community Ward service model in its current Service Plan and as such a commitment to the development of its workforce moving forward in terms of developing anticipatory health coaching skills. Role descriptions have been developed that bring primary and secondary care clinicians together in action and performance measurement and these are being extended to the non-professional and semi-professional workforce. Measurement frameworks including Alpine Health's 'Matters Framework' has been developed to encourage and frame organizational behavior in that direction. Ongoing relationship management with local general practice has seen the beginnings of a move to a construct of 'values based' service provision and away from 'volume based' service delivery. These actions continue to have their foundations in the five pillars of change necessary to support the combined service and workforce reform described

above. Finally, Alpine Health is committed to the secondment of Specialist Geriatrician support to continue to enable a focus on workforce reform in the elderly population by training senior clinicians locally in terms of up skilling, discharging care as appropriate, engaging other parts of the workforce in care provision and participating in collecting the evidence to support the validity and veracity of the intervention – workforce and service reform for the elderly in the local population. Alpine Health formally engages its aged population in service planning and will continue to test the strengths of this intervention directly with them.

Sustainability and transferability

The Community Ward model acted as a disruptive strategy, linking the acute, primary and community care systems.

Alpine Health believes that it has been able to demonstrate that conjoined effort across the primary and secondary care domains creates vital links in terms of the available patient intelligence at a local level. This creates opportunities for decision efficiencies, particularly in an anticipatory context. International evidence in like models supports the notion that the richer the data, the more informed the intervention decision can be. Local knowledge and existing local service delivery relationships have also been proven to be enablers of the Community Ward model. Significant levels of trust and professional respect have been shown to inform best ways of engaging and working in a virtual team.

As discussed earlier, Alpine Health is committed to the ongoing development of the Community ward model and the development of the workforce necessary to support it. This is also consistent with thinking at both levels of Government with respect to getting ahead of the demand for supply driven care. The opportunity to transfer and replicate this model to the other two localities in the Alpine Health catchment is now being explored.

Considerations for policy and system development

Key enablers of this model should be considered in the context of the wider aged care system moving forward including but not limited to;

- Joined up primary and secondary care data sets
- Influencing the MBS to recognise the value of and encourage system behaviour in the direction of early, predictive intervention
- The establishment of a set of ‘organisational readiness’ metrics for those organisations that are planning workforce and service reform, to act as a checklist so managers commissioning this type of change can reliably perform an organisational gap analysis and apportion resources in the direction of best spend
- Recognition of the MPS model as a flexibly appropriate model in the small rural setting within which the re-apportionment of workforce resource from secondary to primary care can follow service development across the same divide, much more easily than mainstream funded agencies.
- Underscoring the importance of recognising the value that focusing on the five pillars of change will be important. Primarily these pillars ask for the establishment of the defined needs of the clients / patients in the very first instance. This makes sense of any investment in workforce reform moving forward, underscores the importance of leadership and the necessity to embed the change with organisational systems support
- Organisational systems support, as identified in the literature related to performance excellence in healthcare, is found to most reliably prosper where the commitment to a broader approach to organisational improvement exists i.e. an approach to a framework of total quality management that pervades all systems and programs. Importantly, in the context of this project, workforce reform is not something that sits alongside whatever else the organisation is aiming to achieve, it is simply a key part of its performance improvement.

Key references

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Presenter

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