

## Multipurpose Services - Policy and Operational Guidelines

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**Functional Sub group** Clinical/ Patient Services - Aged Care  
Clinical/ Patient Services - Governance and Service Delivery

**Summary** The Multipurpose Service Policy and Operational Guidelines have been developed to support the functioning of a Multipurpose Service (MPS) in NSW.  
The guidelines are not intended to cover all aspects of the service delivery, rather to cover broader concepts and complement current policy and procedure documents. They are not prescriptive but they are there to provide guidance and support in the delivery of services to assist Area Health Services and managers of Multipurpose Service's  
These guidelines have been developed with significant involvement from a range of staff across government departments and Area Health Services.

**Replaces Doc. No.** Multi Purpose Services (Guidelines for NSW) [IB2010\_002]

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**Applies to** Area Health Services/Chief Executive Governed Statutory Health Corporation, Affiliated Health Organisations, Affiliated Health Organisations - Declared, Public Health System Support Division, Public Hospitals

**Audience** All Multipurpose Services (MPS) staff, Finance, Aged Care, Planners, Capital Works

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### Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

# NSW MULTIPURPOSE SERVICES

## POLICY AND OPERATIONAL GUIDELINES

### PURPOSE

The NSW Multipurpose Service policy and operational guidelines have been compiled to assist Area Health Services (AHS) and managers of existing and future Multipurpose Services (MPS) to provide health and aged care for their community in a flexible manner.

The attached document has been developed with significant involvement from a range of staff across government departments and Area Health Services.

It has been developed to support the functioning of an MPS in NSW. It is not intended to cover all aspects of service delivery, rather to cover broader concepts and complement current policy and procedure documents.

### MANDATORY REQUIREMENTS

This policy establishes the standard procedures for the management of Multipurpose Services as described in the attached Multipurpose Service Policy and Operational Guidelines.

Management of Multipurpose Services is the responsibility of Area Health Services and Managers of MPSs, as part of the delivery of integrated health and aged care services providing flexible and sustainable service options for small rural and remote communities

### IMPLEMENTATION

Area Chief Executives are accountable for ensuring the requirements contained within this policy and operational guidelines are adhered to and communicated to all staff with responsibility for establishing or managing Multipurpose Services within the AHS.

### REVISION HISTORY

Version	Approved by	Amendment notes
July 2010 (PD2010_049)	Deputy Director-General Strategic Development	New policy and operational guidelines for the management of Multipurpose Services.
February 2010 (IB2010_002)	Deputy Director-General Strategic Development	Information bulletin advised PD2005_124 was obsolete as it was no longer applicable.
June 1998 (PD2005_124)	Director-General	New Policy establishing operational guidelines for the management of Multipurpose Services.

### ATTACHMENTS

1. NSW Multipurpose Services Policy and Operational Guidelines

# NSW MULTIPURPOSE SERVICES

## Policy and Operational Guidelines



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# Introduction

## About the Multipurpose Service Program

Multipurpose Services (MPS) are integrated health and aged care services that provide flexible and sustainable service options for small rural and remote communities.

The Australian Government provides aged care funding which is combined with State and Territory government funding for health services and infrastructure to bring a flexible mix and range of aged care and health services together under one management structure. This provides small communities who are having difficulty supporting a range of independently run services the opportunity to develop a more coordinated and cost-effective approach to service delivery.

In 1991, Australian and state government representatives came together to look at improved ways of meeting the health and aged care needs of people living in rural Australia. The group supported the development of the MPS Program. In 1993, it was piloted in 11 services around Australia and raised considerable interest among many rural communities. Since then, the MPS Program has expanded.

The MPS Program is a response to a range of health and aged care challenges in rural communities, including:

- isolation from mainstream services;
- cost inefficiency of delivering discrete services to small populations;
- lack of local residential aged care services; and
- duplicative and inconsistent accountability requirements for the multiple funding streams which can be received by small services.

The MPS Program provides Area Health Services and communities with the opportunity to respond to the unique health care needs of the local community including provision of:

- residential aged care services;
- acute hospital beds;
- community health services; and
- emergency department services.

The MPS Program works on a model of health and aged care service delivery that aims to help small rural and remote communities to tackle some of the challenges they face, such as:

- declining or changing populations causing shifts to occur in the community's health and aged care needs
- being isolated, making it difficult to access a wide range of services
- being unable to support financially viable residential aged care facilities, resulting in the elderly having to leave their community
- having difficulty attracting, retaining and training staff for the health and aged care services.

The major objective of the MPS Program is to help overcome some of these challenges and, in doing so, improve:

- MPS receive Commonwealth funding for flexible aged care places and State funding for a range of health services.

The MPS Program has provided the opportunity to 'pool', or combine, Australian and State Government health and aged care funds and applies these funds across all health and aged care programs according to community need. This pooled funding arrangement allows for more flexibility in how managers use funds to meet the needs of the local community.

## **About these Multipurpose Service Operational Guidelines**

The guidelines have been compiled to assist Area Health Services (AHS) and managers of MPS to provide health and aged care for their community in a flexible manner.

As the MPS Program has now been in place for over ten years there is a wealth of experience and expertise within AHS in the development, implementation and day-to-day management of these services. However, as new MPS are established and changes are made to the models of care and operations, AHS staff, including MPS health service managers, have identified the need for Operational Guidelines to assist them in the day-to-day work of managing an MPS.

These guidelines have been developed with significant involvement from a range of staff across government departments and Area Health Services. The Guidelines have been developed to support the functioning of an MPS in NSW. They are not intended to cover all aspects of service delivery, rather to cover broader concepts and complement current policy and procedure documents.

The policies and guidelines for the delivery of emergency and acute care and community health are generally available through AHS channels. It appears that more assistance is required regarding the overall philosophy of the MPS model, particularly the residential aged care components of the MPS model, and therefore much of the content in these Operational Guidelines are aimed at this element of an MPS.

It is anticipated that these guidelines will be reviewed and updated as required to ensure relevance and value to the managers and staff of the MPS. MPS are, by definition, designed to be flexible to meet local needs. In recognition of the diversity in organisation and services included in each MPS, the Operational Guidelines are not prescriptive but provide guidance in the delivery of these services.

# **Philosophy of the MPS Model**

## 1. Philosophy of the MPS Model

MPS are integrated health and aged care services. The MPS Program aims to provide a flexible and integrated approach to health and aged care service delivery to small rural communities.

The MPS brings together a range of health and aged care services in a single location and under a single management structure. An MPS is not solely a hospital, nursing home, hostel or community health service, but a combination of services. Other services such as ambulance and Home and Community Care (HACC) can choose to be part of the MPS.

The MPS model is generally suitable for small rural communities where there is:

- an ageing population
- a lack of, or limited, nursing home and hostel accommodation
- difficulty in sustaining stand-alone health, community and aged care services

The MPS allows for:

- The integration of all or most public health and aged care services provided within a particular community (ranging from acute hospital care to residential aged care, community health, and home and community care services with the opportunity for others to be involved, such as child health and mental health services).
- The cashing out of former separately identified Australian Government and state program funds into a common pool. 'Cashing out' means consolidating the funds from different services into one central pool of funds.
- Flexible planning and resource management to support the provision of services in accordance with community need.
- Capacity to respond to changes in demand for services that would otherwise threaten service viability.

The MPS model allows for flexibility in meeting the needs of the local community. This may involve the provision of acute care services, residential care, respite care, community services including primary care, Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACHD), and HACC and community development programs.

The focus of the aged care service is to support people as long as possible in the community. The flexible care model enables services to be provided in the person's home, as short-term respite in the MPS or as permanent residential care when required.

The NSW experience of the MPS model indicates that a challenge for managers and health professionals involved with an MPS is to recognise the different philosophy that underpins the functioning of an MPS. Orientation, education and training, and change management techniques are all necessary to allow an MPS to become a truly effective approach to meeting local health care needs.

**Examples of the MPS Model in one local community:****PROVISION OF A RANGE OF SERVICES:**

- Emergency services
- Acute care
- Aged care hostel
- High care residential aged care
- Community services including CACP, EACH, EACHD, HACC and community nursing
- Wellness clinic
- Co-located General Practice

**COMMUNITY WELLNESS PROGRAMS PROVIDED INCLUDE:**

- Walking group
- Day care programs
- Play group
- Community meetings held in multi-purpose room
- Wellness clinic for pathology, screening, etc

**MODEL OF CARE**

- A wellness model is established
- A case manager is appointed to every patient and resident
- Team meetings held with ACAT, hostel staff, GPs, mental health, nursing, and community health staff

## **The Development of an MPS**

A number of processes are undertaken within the Department of Health and Area Health Service in order to identify future potential sites for redevelopment under the MPS model.

Following the identification of potentially suitable sites, further investigation and service planning is undertaken by the Commonwealth and State Governments involving extensive community and stakeholder consultation. (This is led by the AHS).

An outcome of the consultative and planning process will be the development of a MPS Service Plan or (Clinical Service Plan). The service plan is developed in consultation with service providers, community members, staff, Australian Government and State Government representatives and other stakeholders. The service plan needs to demonstrate that there has been wide-spread community consultation and support, and that the service will be able to meet the preconditions for an MPS.

The MPS Service Plan identifies the specific services and the manner in which they will be delivered. MPS are a flexible care service, and thus provides a range of services such as, but not limited to: acute care, community health, primary care, residential aged care, residential respite, community care; co located GP clinics and aged day care centres.

Once the MPS Service Plan has been completed it is submitted to the NSW Department of Health for endorsement and then forwarded onto the Commonwealth Department of Health and Ageing for the support and provisional allocation of the proposed aged care places.

For more information regarding the physical development of the MPS please refer to the document entitled The Process of Facility Planning.<sup>1</sup>

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<sup>1</sup> <http://www.health.nsw.gov.au/assets/facility.asp>

# Management

## 2. Management

An MPS, as a health care facility, is part of the NSW AHS structure. AHS are managed in accordance with the Health Services Act 1997<sup>2</sup>.

While the AHS is the primary administrative body for the MPS, collaboration and partnerships between health, residential aged care, community services, other providers and the community in each local area will facilitate the delivery of flexible, responsive services.

A local Health Service Manager, who reports to the Area/Network Manager (or equivalent) of the AHS, is responsible for the day-to-day running of the MPS. Under NSW legislation, the AHS Chief Executive is responsible for delivering health services to the population of their Area, so he or she has the ultimate legal responsibility for the MPS.

Policies and procedures should be established and maintained to allow for the smooth running of the MPS. These documents will be in accordance with relevant policies and legislative requirements of the Australian Government, the NSW Department of Health and the local AHS.

The range of NSW Health Aboriginal Health policies (listed in Section 14 - Resources) impacts at all service delivery levels including admitted patient care, community health, primary health, residential, respite, community support and transport and should be used in the development, planning and management of the MPS.

### 2.1 Partnerships

The MPS model calls for integration of health services. The integration may involve services becoming part of the MPS, services co-locating with the MPS or working with staff to provide care and service to the community.

Partnerships and coordinated efforts between a range of government and non-government agencies within local communities are promoted with the MPS model.

Where services do not integrate with the MPS, collaboration is required to ensure an effective range of services for the community.

Partnerships need to be established and maintained with relevant service providers to meet the needs of the community. This includes partnerships that meet the cultural, spiritual and personal needs of residents and patients served by the facility.

It is important that all legal, financial and operational implications are considered and formalised when entering into partnerships. For example, one MPS in NSW operates on two campuses, with one campus being a hostel where the land and buildings are leased from the local Council. In another town, the MPS is located across the street from the separately owned and managed hostel but has a level of service integration for case management. In both these examples, service agreements have been established to ensure all parties are aware of and meet their responsibilities.

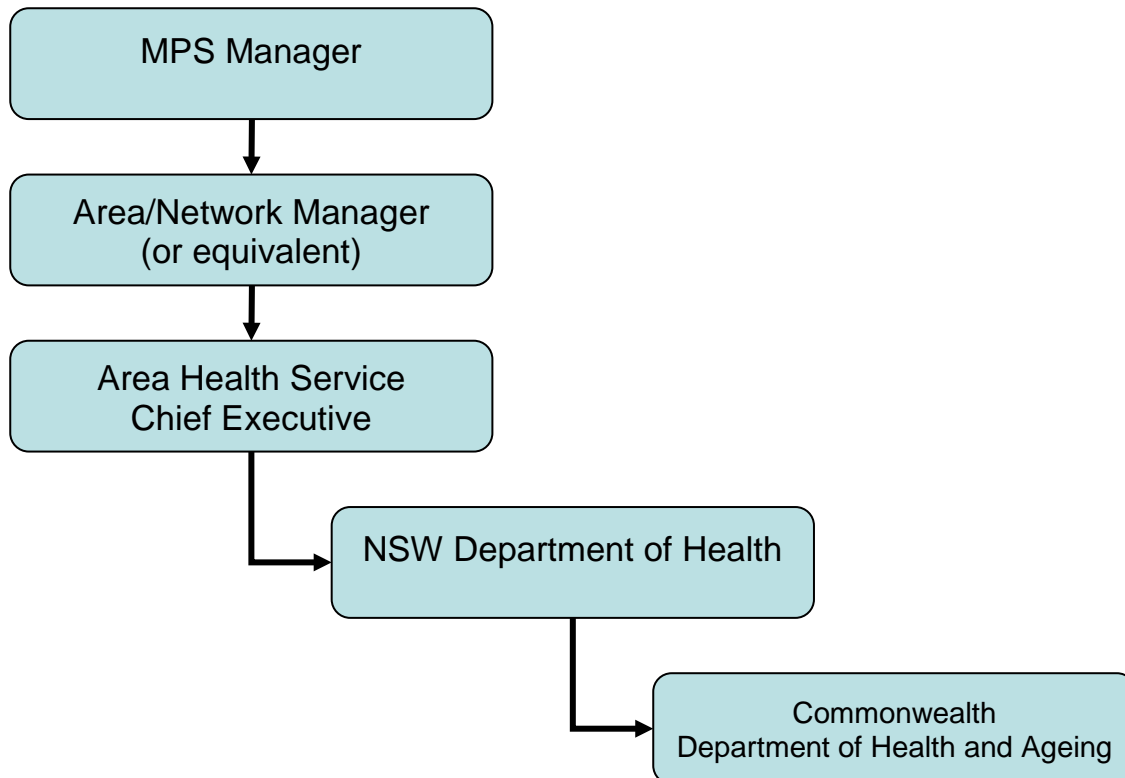
### 2.2 Who to contact for assistance in management issues

Local policies and procedures will be used to lead the day-to-day operation of the services. Where additional issues arise, which are not covered by these guidelines, assistance should be sought first from the AHS. Where further advice is required a representative from the AHS may contact the NSW Department of Health representative.

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<sup>2</sup> [http://www.austlii.edu.au/au/legis/nsw/consol\\_act/hsa1997161/](http://www.austlii.edu.au/au/legis/nsw/consol_act/hsa1997161/)

**A flow chart for managing issues / queries:**



The MPS/AHS should not contact the Commonwealth Department of Health and Ageing directly. The NSW Department of Health will contact the Commonwealth Department of Health and Ageing on behalf of the MPS/AHS when required.

# **Community input into the MPS**

### **3. Community input into the MPS**

Community participation is essential to successful health planning and ongoing service delivery in an MPS.

The AHS is to determine the most effective structure or mechanism to ensure community involvement in the MPS. Local Health Advisory Councils may provide such a structure. Where an existing advisory committee is used, the membership of this committee needs to include any additional stakeholders required to appropriately reflect the community served by the MPS. Structures will incorporate representatives of the local community, recognising the different cultural and ethnic groups.

The local advisory system has an important role in:

- being the liaison between the community and the MPS in helping to identify community needs through a range of planning and research processes in conjunction with the AHS;
- consulting with the community regarding ongoing issues;
- working with the MPS in ongoing service planning;
- representing the community interests in a range of local and AHS projects and initiatives; and
- acting as advocates both for the MPS and the community.

The Manager of the MPS has an important relationship with the local Advisory Committee. This relationship should be transparent and productive to ensure the success of the Committee. The manager should encourage active communication and participation of the Committee in activities pertaining to the MPS.

### **Responding to the needs of the community:**

Community members entering an MPS can expect a service tailored or modified to meet their cultural needs. This expectation of staff and management is reflected in NSW Health policy which recognises that embracing such cultural needs can significantly contribute to the overall health and wellbeing of patients. Where advice or guidance is required, an appropriately qualified or experienced Area Health Service staff member, or alternatively, an appropriate community representative should be consulted.

Aboriginal health is estimated to be three times worse than that of the rest of the community. *Ensuring Progress in Aboriginal Health: A Policy for the NSW Health System* is an important step in meeting the NSW Government's commitment to restoring the health and social, emotional and cultural harmony and wellbeing of Aboriginal people in NSW. It reinforces the NSW Government's commitment to partnership with the Aboriginal community in addressing these issues and was developed in collaboration with the Aboriginal Health and Medical Research Council of NSW (AHMRC).

Access to culturally and socially appropriate services is widely recognised as a major factor in the improvement of the health and wellbeing of Aboriginal people and communities.

The Aboriginal Health Impact Statement is to be used to ensure that the health needs and interests of Aboriginal people are integrated into the policy, program and strategy development process. The impact statement advises that:

*The health status and health service needs of Aboriginal people, and Aboriginal concepts of health and illness, differ from those of the general population in many ways. The development, implementation and evaluation of health policies that affect Aboriginal people must take such differences into account. They must also acknowledge and respond to the history of difficult relationships between governments and Aboriginal people. Efforts to build mutual understanding and greater trust must be continued.*

Every effort should be made to accommodate requests made, for cultural reasons, for particular service attributes.

Ensuring Progress in Aboriginal Health in New South Wales - A Reader Friendly Information Kit (2002)  
[http://www.health.nsw.gov.au/pubs/2002/ensureprogress\\_kit.html](http://www.health.nsw.gov.au/pubs/2002/ensureprogress_kit.html)

# **Providing Care for Patients, Clients and Care Recipients**

## 4. Providing care for patients, clients and care recipients

Policies and procedures should be available covering the referral, intake and assessment procedures in place for all patients, clients and residents of the MPS. Based on experience in NSW, the following information is provided to assist with the residential care component of the care and service.

### Approval of Care Recipients

There are no legislative requirements for an Aged Care Assessment Team (ACAT) approval to access any service delivered by an MPS. This includes permanent residential High or Low care, residential respite or MPS funded Community Care packages (CACP, EACH or EACHD). When an MPS sponsors or provides a CACP, EACH or EACHD like packages of services, they do not do so as aged care providers under the Aged Care Act 1997 as they are block-funded to provide this service. For this reason, ACAT approval to receive the community service is not required.

The NSW Department of Health nonetheless recognises the value of an ACAT assessment for the purposes of determining the most appropriate type and level of care for each person accessing permanent residential care. It is therefore strongly recommended that an ACAT comprehensive assessment is undertaken prior to admission to the MPS.

However, the absence of an ACAT assessment will not prevent a person from being admitted to an MPS for either residential aged care or respite. An alternative is to request a member of the acute aged care team (however titled) to conduct a *comprehensive aged care assessment*<sup>3</sup> of the older person's care and support needs.

### Guidelines for ACAT Assessors

There are some conditions governing the comprehensive assessment process conducted by an ACAT:

- The assessment must be conducted with the consent of the individual and in consultation with their family and carers.
- The referral will be classified as Priority Category 2 which means a response time between 3-14 days unless a level of urgency is identified.
- The assessment should be documented on AHS forms and not on the Aged Care Client Record (ACCR) to avoid any confusion with the Aged Care Assessment Program Minimum Data Set entry.
- A separate record of workload data will be maintained and monitored by the ACAT to ensure the demand for MPS assessments does not affect response times for ACAT eligibility assessments.
- The comprehensive assessment conducted by the ACAT is a generic comprehensive aged care assessment and not an ACAT eligibility assessment required as part of the approval process for accessing Australian Government subsidised aged care services.
- If a client specifically requests an ACAT eligibility assessment because they wish to be able to access permanent residential aged care or respite care at a future date, then the ACAT assessor will complete the ACCR and record their approval in Part 6 as 'MPS' under Flexible Care – Other, as well as the recommended level of permanent residential care and/or residential respite care. These are also the only circumstances when the assessment is to be referred for ACAT Delegation.

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<sup>3</sup> Health Service Managers should note that a comprehensive assessment conducted by the ACAT is a generic aged care assessment and not an ACAT eligibility assessment which would be required to access Australian Government subsidised aged care services.

## **MPS Residents Moving to other Aged Care Services**

If a patient seeks to move from an MPS to an Australian Government subsidised residential aged care service or from an MPS back to their own home with a non-MPS sponsored community package such as a CACP, EACH or EACHD, MPS staff need to refer the patient to their local ACAT for an ACAT eligibility assessment and approval prior to any move from the MPS occurring. The only exception is when the patient has a current ACAT approval for permanent residential high level care (i.e. high or low lever care).

MPS staff should discuss any uncertainties around the need for ACAT approval with their local ACAT. They also need to note that the residential aged care service provider has the ultimate decision about acceptance or non acceptance of the client into their care.

MPS receive annual block funding based on the number of approved residential aged care places. Under these funding arrangements, at any point in time the actual number of residents receiving aged care at the MPS may be more than the number of approved places – this is offset by vacancies at other points in time. Flexible CACPs, EACH, EACHD packages and respite are components of the annual block funding.

### **4.1 Categorising Patients and Residents**

When a public hospital becomes a MPS, nursing home type patients (NHTP) of the public hospital change status to a residential aged care patient of an MPS.

MPS are not able to classify an admitted patient in a general ward bed as a NHTP. The bed must be re-classified to high or low care depending on the status of the patient. Aged care fees apply including entitlement to rental assistance.

The Australian Government provides a level of funding for the approved residential aged care beds. Periods of hospitalisation by people eligible for veteran's affairs subsidies receive Department of Veteran's Affairs (DVA) funding while they remain an acute patient in the MPS<sup>4</sup>. An MPS residential aged care client does not attract the DVA subsidy.

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<sup>4</sup> The MPS and DVA are negotiated under two different agreements with different Australian Government departments.

## 4.2 Information Technology

MPSs should consider the use of telehealth facilities to provide increased access to specialist consultation/liaison services, improved communication and staff development opportunities. This will reduce the need for travel to other centres for both patients and staff.

The range of information systems includes:

- Area Health Service integrated and ongoing data collection
- Intra and internet access for staff and patient education and information
- Centralised ordering of supplies
- Systems to support the progression to integrated, electronic medical records
- Digital imaging and picture archiving systems
- Clinical management systems

Community members either individually or in groups with a common interest should be encouraged to utilise information technology and systems to access information and services not normally available due to their rural location. This concept reinforces the local health service as a gateway to a wider range of services, promotes independence and self-determination for persons with a health need and increases the relevance of the service to the wider community.

# Service Types

## 5. Service Types

Each MPS Clinical Service Plan will identify the specific services and the manner in which they will be delivered. It is important to recognise the importance of the range of health services an MPS provides as a flexible care service. The service types provided by an MPS may include:

- Admitted patient (acute care)
- Community health
- Primary care
- Residential aged care (high and/or low)
- Residential respite
- MPS-sponsored community care

It should be noted that specific issues relating to each of these service types is outlined below.

### 5.1 Admitted Patient (Acute Care)

The Acute Care Service Category for a patient is made where the principal clinical intent or treatment goal is to:

- Cure illness or provide definitive treatment of injury
- Perform surgery
- Relieve symptoms of illness or injury (excluding palliative care)
- Reduce severity of an illness or injury
- Perform diagnostic or therapeutic procedures; and/or
- Protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function

The admitted patient care provided in MPS is generally of a post-acute, sub-acute or ongoing nature. Individuals who require observation, ongoing care or who are at moderate risk can be admitted locally, where they might not be admitted into a large acute facility.

Examples of this type of service include elderly residents with chest infections, individuals with chronic conditions where there may have been a slight exacerbation that requires stabilisation or social admissions. In fact, this could be described as “primary health care in a bed”. This practice ensures that people are accessing safe health care even in an isolated community, where travel by a health provider to an individual’s own home for ongoing care is not practical due to distance and resources.

The use of MPS to take post-acute patients is a significant benefit to small rural communities, where residents have to travel away for acute and specialist care but can return to their local MPS for post-acute care in an inpatient bed and then in their own home. Anecdotal evidence supports this process, with patients and their carers stating they “get better faster” in their own hometown. This component of MPS care should also assist in reducing bed block in the large regional and tertiary hospitals by allowing post-acute patients to be discharged back to the MPS.

As aged care residents can still be managed as ‘residents’ when they are unwell the decision to reclassify them as ‘acute care’ patients is made in line with NSW Department of Health Classifications. Reclassification of residents to ‘acute care’ would usually occur when, under normal circumstances, the condition would warrant the person’s admission to a hospital if they were being cared for in their home or in a private aged care facility without the support of a public hospital.

Admitted patients within an MPS are treated on the same basis as any admitted patient in a NSW public hospital. Therefore, while a resident has a choice in the General Practitioner (GP) caring for them, all patients categorised in the acute care service type need to be managed by a Visiting Medical Officer (VMO), who may or may not be their GP.

An MPS with admitted veterans will need to assess the appropriate classification of these patients based on the patient's clinical need.

An MPS which has full occupancy of its allocated aged care "places", has the ability to use a hospital bed for a resident if there are hospital beds available. The flexibility of the MPS also means vacant hospital beds can be used to accommodate residents as required.

## **5.2 Community Health Services**

Each MPS will incorporate a range of primary and community health services appropriate to the needs of the local community. The MPS may have a key advocacy role in addressing local issues that impact on the health needs of a community.

## **5.3 Primary Health Care**

MPS are an innovative solution to the primary health care needs of small rural communities. They provide a first point of contact with the health system through their community based services, or through access to the emergency department service.

Working with local GPs provides a link between the private and public primary health care services. Other primary health care services such as those funded through HACC are encouraged to become part of the MPS, either through cashing out or through co-location processes. 'Cashing out' means consolidating the funds from different services into one central pool of funds.

Services that maintain their own funding may choose to be located on the same site as the MPS and hence become co-located. The co-location of partner services can be extended to include any community partners who wish to become part of an integrated primary health care provider. An ideal model would be a facility that co-located all primary health care services, including visiting family support services, playgroups, Centrelink and other visiting Government services.

## **5.4 Residential Aged Care**

The MPS provides residential aged care as a flexible care service rather than as a residential aged care facility. As such, an MPS does not have the legislated requirements of residential aged care facilities. The Responsibilities of Approved Providers - Flexible Care, under the *Commonwealth Aged Care Act 1997* (Section 56-3) are outlined on the next page.

There is no legislative requirement for an ACAT approval to access residential aged care delivered by an MPS.

Services listed in the Section are an indicative rather than an exhaustive list of services provided to aged care residents (refer to pages 59-62). Providing that the MPS model does not disadvantage the resident, local policy will be used to plan and deliver specific services.

The Commonwealth Department of Health and Ageing's Residential Care Manual <sup>5</sup> states, "...Approved Providers of residential aged care services are able to choose the appropriate method and the means by which a resident's individual care needs are met. The inclusion of a resident and/or their representative in the care planning process will ensure they are informed and better understand the range of ways in which care and services are to be provided".

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<sup>5</sup> <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-manuals-rcm-rcmindx1.htm>

It is expected that the care plan for residents will be developed and reviewed in consultation with relevant health care professionals and that there will be a range of strategies to meet resident's needs.

In accordance with the *Quality of Care Principles 1997*, "The rights and dignity of older people must be respected and the care provided must be commensurate with the care needs of older people."

### **Section 56-3 - Responsibilities of Approved Providers - Flexible Care, of the Aged Care Act 1997**

The responsibilities of an approved provider in relation to a care recipient to whom the approved provider provides, or is to provide, flexible care are as follows:

- (a) To comply with the requirements of the User Rights Principles in relation to any accommodation bond charged for the care recipient's entry to the flexible care service through which the care is, or is to be, provided;
- (b) To charge no more than the amount specified in, or worked out in accordance with, the User Rights Principles, for provision of the care and services that it is the approved provider's responsibility under paragraph 54-1 (1) (a) to provide;
- (c) To charge no more for any other care or services than an amount agreed beforehand with the care recipient, and to give the care recipient an itemised account of the other care or services;
- (d) To provide such security of tenure for the care recipient's place in the service as is specified in the User Rights Principles;
- (e) To comply with any requirements of the User Rights Principles relating to:
  - (i) offering to enter into an agreement with the care recipient relating to the provision of care to the care recipient; or
  - (ii) entering into such an agreement if the care recipient wishes;
- (f) To comply with the requirements of Division 62 in relation to personal information relating to the care recipient;
- (g) To comply with the requirements of section 56-4 in relation to resolution of complaints;
- (h) To allow people acting for care recipients to have such access to the service as is specified in the User Rights Principles;
- (i) To allow people acting for bodies that have been paid \*advocacy grants under Part 5.5 to have such access to the service as is specified in the User Rights Principles;
- (j) Not to act in a way which is inconsistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles;
- (k) Such other responsibilities as are specified in the User Rights Principles.

## **5.5 Residential Respite**

The flexibility of the MPS model facilitates a creative use of respite services. The 63 days per year limitation set by the Australian Government that applies to respite care in a Residential Aged Care Facility does not apply in an MPS and a resident can access as many days as required.

It should be noted that the respite recipients must be offered the option to complete a Residential Respite Agreement should they wish to.

Respite can be provided on a planned, regular or emergency basis. Providing short, but frequent respite may enable a person to remain living in the community. The ability to use resources and plan services flexibly is encouraged and supported.

There is no legislative requirement for an ACAT approval to access residential respite delivered by an MPS, but it is recommended that a person should be comprehensively assessed prior to being admitted for respite in an MPS in order to ensure staff understand and provide appropriate care and services tailored to their individual needs.

Where a person receives respite in the MPS on an unplanned basis and has not had a recent comprehensive aged care assessment, they can be admitted to the MPS residential aged care bed and a referral made to either the local acute aged care team or the ACAT for an assessment of the person's current health status and care and support needs.

As respite is primarily provided to support the carer, the care recipient's assessment should be undertaken in consultation with carer and family to ensure carer needs are identified and appropriately addressed. If the potential need for an Australian Government community care or flexible care package is identified, a formal ACAT eligibility assessment should be requested.

The Respite Supplement Equivalent Amount funding is paid as an additional component to the flexible care subsidy from the Australian Government, and is included in the regular quarterly payments for each MPS. The funding is provided as an amount per day per MPS (not per place) on a sliding scale depending on the total number of high and low care residential places funded at the MPS.

The funding is provided on the basis that each MPS will report on the provision of respite services to its community through the Annual Service Activity Report, which forms Annexure B of the MPS Funding Agreement. The information to be provided is:

- (i) whether respite services were provided; and
- (ii) the number of episodes of respite care provided for the reporting period.

For the purposes of the initiative, respite includes services provided to older people and to younger people with disabilities.

## **5.6 Community Care**

### **Community Aged Care Packages (CACPs)**

Community care is provided to meet the needs of the community who are residing in their home environment. A specific component of community care is the flexible care equivalent of CACPs as well as other community services, which have been included in the MPS.

CACPs are planned and managed packages of community care services to help people with complex care needs remain living in their own home. They are designed for each individual and are based on their particular needs.

A person who would be eligible for low-level residential care who would prefer to remain at home may benefit from the CACP. Flexible interpretation of the CACP guidelines is used to take into account the particular circumstances of each person's situation.

The MPS model promotes flexibility in service planning and delivery at a community as well as individual level. Where existing services remain independent of the MPS, strategies are required to facilitate effective working relationships to maximise use of resources and reduce duplication in client assessment and or service delivery.

The types of services that may be provided through a CACP include help with:

- bathing
- meals preparation
- laundry
- dressing
- transport
- housework
- temporary in-home respite
- home maintenance, or
- social activities.

There is no legislative requirement for an ACAT approval for CACPs delivered by an MPS or an MPS sponsored approved provider, but an ACAT assessment may be useful to determine the range of services to be provided to the client.

Clients may be asked to pay a fee for a Community Aged Care Package. For clients receiving the maximum basic rate of pension, the fees must not exceed 17.5% of that pension. The fees should be clearly stated within the client agreement which also clearly sets out the client's rights and responsibilities and those of the MPS.

## **Extended Aged Care at Home (EACH) packages**

EACH packages are individually planned and coordinated packages of care, tailored to help frail older people to remain living at home. They are funded by the Australian Government to provide for the complex care needs of older people.

EACH packages are very flexible and designed to help with individual care needs. Generally a person who requires high level care could be eligible for an EACH package, and the types of services that may be provided as part of an EACH include:

- registered nursing care;
- care by an allied health professional such as a physiotherapist, podiatrist or other type of allied health care;
- personal care;
- transport to appointments;
- social support;
- home help; and
- assistance with oxygen and/or enteral feeding.

There is no legislative requirement for an ACAT approval for EACH packages delivered by an MPS or an MPS sponsored approved provider, but an ACAT assessment may be useful to determine the range of services to be provided to the client.

## **Extended Aged Care at Home Dementia (EACHD)**

EACHD packages are individually customised packages of care tailored to help older people with dementia who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia.

EACHD packages are very flexible and designed to help with individual care needs. The packages provide the same full range of services that EACHD packages provide including:

- registered nursing care;
- care by an allied health professional such as a physiotherapist, podiatrist or other type of allied health care;
- personal care;
- transport to appointments;
- social support;
- home help; and
- assistance with oxygen and/or enteral feeding.

However, EACHD packages offer service approaches and strategies to meet the specific needs of care recipients with dementia who experience behaviours of concern.

There is no legislative requirement for an ACAT approval for EACHD packages delivered by an MPS or an MPS sponsored approved provider, but an ACAT assessment may be useful to determine the range of services to be provided to the client.

# Transport

## 6. Transport

The NSW Health Transport for Health policy<sup>6</sup> provides NSW Area Health Services with a comprehensive policy guide to assist the planning and coordination of non-emergency health related transport in rural and remote NSW. Under the Framework, each Area Health Service is responsible for developing a Transport for Health Implementation Plan, which describes its systems and priorities for meeting the needs of transport disadvantaged health consumers.

MPS staff should ensure that the needs of their consumers and communities are appropriately addressed in these Plans. For non-urgent transport, the MPS may negotiate with the resident's family and friends to assist with meeting transport needs.

### 6.1 DVA Travel for Treatment

Where eligible veterans, their widows/widowers or dependants living in rural or remote locations will not have access to the support of family or friends to attend the nearest suitable provider, then travel may be approved to an alternate location. DVA may also assist with reasonable travel costs for an attendant to accompany an entitled patient when travelling for treatment.<sup>7</sup>

### 6.2 Community Transport

Community Transport is generally provided through the Home and Community Care program (HACC). In accordance with HACC eligibility criteria, community transport is available for people who live in their own home. Where spare capacity exists, service can be accessed on a cost recovery basis.

In areas where HACC services are pooled with other MPS funds, the HACC eligibility criteria remain in place.

### 6.3 Ambulance

Where a resident in the residential aged care section of the MPS requires transportation from the MPS by ambulance to hospital, they are charged the same as if they are being transferred from their home. (Pensioners are not charged). Charges for Inter-hospital transfers for admitted inpatients (i.e. acute/subacute) are raised against the sending hospital.

Guidelines for the use of ambulance services are provided in –  
The Patient Matters Manual Section 25 Travel Assistance/Transport Services<sup>8</sup> and NSW Health Circular PD2008\_031 "Ambulance Service Charges" details of charges and identifies responsibility for payment.<sup>9</sup>

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<sup>6</sup> PD2006\_068 NSW Health Transport for Health - [http://www.health.nsw.gov.au/policies/pd/2006/PD2006\\_068.html](http://www.health.nsw.gov.au/policies/pd/2006/PD2006_068.html)

<sup>7</sup> See DVA Facts Sheet HSV03- Transport Modes Under the Repatriation Transport Scheme <http://www.dva.gov.au/factsheets>

<sup>8</sup> [http://www.health.nsw.gov.au/resources/policies/manuals/pdf/patient\\_matters\\_25.pdf](http://www.health.nsw.gov.au/resources/policies/manuals/pdf/patient_matters_25.pdf)

<sup>9</sup> [http://www.health.nsw.gov.au/policies/pd/2008/PD2008\\_031.html](http://www.health.nsw.gov.au/policies/pd/2008/PD2008_031.html)

Further information is available in the Fees Procedures Manual For Public Health Organisations, Chapter 2 Inpatients Part B Accommodation Charges, 8. Ambulance Transport <sup>10</sup>

Admitted Patients (i.e. <u>non</u> residential aged care)	Charges for Inter-hospital transfers for admitted inpatients (i.e. acute/subacute) are raised against the sending hospital.
Residential Aged Care Clients	If a resident is transferred from the MPS by ambulance (same as if they are being transferred from their home) the NSW Ambulance Service charges the resident accordingly. Pensioners are not charged.

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<sup>10</sup> <http://www.health.nsw.gov.au/resources/policies/manuals/fees.asp>

# Funding and Finance

## 7. Funding and Finance

Australian and State Government funds for health and aged care are pooled to be used flexibly by the MPS. Both the State and Australian governments contribute recurrent funding for ongoing service delivery. The exact nature of the funding will vary based on local needs.

MPS receive recurrent subsidies from the Australian Government to provide flexible aged care services. The Australian Government MPS subsidy is paid on a quarterly basis to the Area Health Service. Unlike the residential or community care subsidy, this is not paid according to the actual level of care provided. It is a “cashed out” rate of subsidy dependant on the number of places approved. This means the MPS can plan services with a known annual allocation.

The MPS model enables the redistribution of pooled funds to provide services based on community needs.

Prior to a hospital converting to an MPS the Area Health Service met the costs of all medical services and prescriptions to public hospital patients. When the facility becomes an MPS, non-acute services provided by GPs to aged care residents in the MPS are paid through Medicare. Routine prescriptions for these residents are paid for through the Pharmaceutical Benefit Scheme. The local Area Health Service continues to pay for all acute medical services delivered through an MPS by GPs.

The Department of Ageing, Disability and Home Care NSW (DADHC) may provide funding for HACC services, and funding may also be provided from other sources such as local government and private organisations.

### 7.1 Recurrent Funding

An MPS receives recurrent funding from both the State and the Australian Governments. A Tripartite Agreement, which is developed and agreed by the three parties being the Area Health Service, the NSW Department of Health and the Australian Government, specifies the level of funding and the services to be provided. Both the NSW Department of Health and the Area Health Service hold a copy of this Agreement.

The MPS Manager should be provided with a copy of the Funding Agreement to become familiar with the funding available for operating the MPS.

#### 7.1.1 State Funding

Each Area Health Service determines the allocation of the State funding component to an MPS. Funding from the State can cover, but is not limited to, the following service areas:

- Acute inpatient
- Emergency Departments
- Outpatients
- Community Health
- Mental Health
- Maternal and Child Health etc.

#### 7.1.2 Australian Government Funding

The residential aged care subsidy for MPS is calculated on the number and type of flexible aged care places originally allocated to an MPS at the time it is established. Unlike Residential Aged

Care Facilities (nursing homes or hostels) the subsidy is paid based on 100% occupancy irrespective of actual occupancy.

The subsidy for high or low care places is made up of three parts:

- 3.1 A basic subsidy;
- 3.2 A Concessional Resident Supplement equivalent amount, paid according to the region in which the MPS is located;
- 3.3 A Viability Supplement equivalent amount determined by the size and remoteness of the service. Further detail on eligibility for this supplement appears below; and
- 3.4 The Respite Supplement Equivalent Amount, described in Section 5.5

Funding for CACPs and EACH packages is also provided on a 'cashed out' rate, which is slightly less than non-MPS providing the same services.

The Australian Government Minister for Ageing sets the rates for Flexible Care subsidies for Multipurpose Services. These rates are adjusted annually to reflect annual indexation.

### **Viability Supplement Eligibility**

The Viability Supplement is funding paid to eligible MPS on top of standard residential care funding. Eligibility is determined by the size of the MPS (i.e., the number of flexible aged care places allocated); the remoteness of the MPS based on the Accessibility/Remoteness Index of Australia (ARIA) score; and the percentage of special needs residents.

Some MPS may be eligible for the Viability Supplement. Additional information regarding the ARIA and Viability is available on the Commonwealth Department of Health and Ageing web site.<sup>11</sup>

### **7.1.3 Home and Community Care Program (HACC)**

The Australian and State Governments jointly fund the HACC Program with DADHC as administrator.

HACC services include Home Care, Meals on Wheels, Home Maintenance and Modification, community transport, community nursing, allied health and respite services.

In the event a HACC service cashes out to an MPS, that service's budget is transferred to the MPS. A HACC service that has cashed out to an MPS continues to receive funding from DADHC via the Area Health Service.

Once agreement has been reached with the relevant organisations regarding cashing out, in the case of HACC services, DADHC will transfer the budget to the NSW Department of Health for allocation to the relevant Area Health Service.

The current position of the NSW Department of Health is for co-location and/or cashing out of HACC services to be assessed on a case-by-case basis. A client who is placed on a CACP is unable to also utilise a CACP.

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<sup>11</sup> <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-rescprov-aria.htm>

# Resident Charges

## 8. Resident Charges

The primary policy source regarding MPS resident charges can be found in the NSW Health Fees Procedures Manual Section 5 Nursing Homes / Multipurpose Services<sup>12</sup>

A summary of the charges has been prepared below.

### Summary of Charges Applicable to MPSs

Charge	Multipurpose Service
Can the MPS charge the income tested component of a residents daily fee?	No
Can the MPS charge accommodation charges?	No
Can the MPS charge accommodation bonds?	No
Can the MPS charge administration fees?	No
Can the MPS charge respite booking fees?	Yes- See Section 8.1.2

Excerpt from the NSW Health Fees Procedure Manual for Public Health Organisations Section 8 Charging Arrangements

### 8.1 Resident Daily Fees

Daily residents fees applicable to an MPS are referred to as the “standard resident contribution” and are outlined in the NSW Health’s - Fee Manual for Public Hospitals (Chapter 5).<sup>13 14</sup>

The “standard resident contribution” for residential aged care services provided in an MPS is applicable regardless of pensioner status and is consistent with the resident contribution recommended by the Australian Government Department of Health and Ageing.

The Commonwealth residential aged care arrangements that commenced on 1 October 1997 apply to veterans and war widows.

With the exception of former Australian prisoners of war receiving high levels of (equivalent to nursing home) care, all veterans and war widows/widowers admitted to residential aged care are required to pay daily resident fees towards the cost of their care. For former Australian prisoners of war receiving high levels of care, the Repatriation Commission pays the standard rate of the daily care fee direct to the facility.

Where a resident is absent from the MPS because the resident has been reclassified as an acute care inpatient or where they have been transferred to another hospital for the purpose of receiving hospital treatment, the resident will pay normal resident fees during all periods of hospitalisation for up to a maximum of 52 days in a financial year.

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<sup>12</sup> <http://www.health.nsw.gov.au/resources/policies/manuals/fees.asp>

<sup>13</sup> <http://www.health.nsw.gov.au/resources/policies/manuals/fees.asp>

<sup>14</sup> NSW Health PD2005\_606 Fees for Hospital and Other Services - Charging Arrangements  
[http://www.health.nsw.gov.au/policies/pd/2005/PD2005\\_606.html](http://www.health.nsw.gov.au/policies/pd/2005/PD2005_606.html)

### **8.1.1 Acceptance of a Residential Aged Care Place in an MPS**

Once a person has agreed to accept a place in the MPS, they are considered to be a resident of the MPS. The resident has up to seven (7) days social leave that may be used as Pre-Entry Leave immediately before the resident enters the MPS. This will allow the resident time to make arrangements to enter and the MPS will keep the place available for up to seven (7) days after the resident is informed of the vacancy. The resident will be required to pay the standard resident contribution during any period of Pre-Entry Leave.

The NSW Department of Health has developed a model Residential Agreement and model Respite Agreement which is to be offered to all residents and respite recipients before they take up a place in the MPS. (Residents are not bound to sign the agreement) Templates for these agreements are provided at Attachments X and Y. See Section 12.1 for further information regarding Residential Agreements

### **8.1.2 Residential Respite Charges**

People who are using respite beds are also charged the resident contribution rate per day from date of entry, less rental assistance. The MPS may charge a booking fee to secure a respite place. The booking fee is a pre payment of respite care fees and not an extra payment. This fee cannot be more than a full week's fee or 25% of the fee for the entire stay, whichever is the lower.

### **8.1.3 Compensable/ Ineligible Residents**

Compensable patients are those patients who are eligible to claim compensation/ damages for hospital charges under workers compensation, third party (no charges raised for accommodation and diagnostics), Public Liabilities Insurance or such other compensation that may apply. Ineligible patients are those not eligible for Medicare benefits or free hospital treatment

Residents who have a right to compensation for charges associated with their stay in the aged care part of an MPS or are ineligible are to be charged accommodation at the rate of "Hospital Other" (See IB2009\_031 – hospital Classification "Other" for the current daily rate- noting that the Information Bulletin will be updated periodically)

### **8.1.4 Income Tested Daily Resident Fees**

The Commonwealth's income tested fee arrangements do not apply to MPS, and therefore cannot be charged.

## **8.2 Accommodation Bonds - Low Care**

An MPS operated by a Health Service may not charge an Accommodation Bond to residents entering the MPS as low care residents as at June 1998.

For Health Services operating MPS that incorporated an existing hostel which previously charged an Accommodation Bond to residents, these MPS may continue to charge an Accommodation Bond in accordance with the *Commonwealth Aged Care Act 1997*.

However, this arrangement only applies to hostels that had joined an MPS or were in planning as at June 1998.

### **8.3 Patient/Client Charges for Services**

An MPS provides services to acute, high and low aged care residents and to people within the community. Whether a patient/client pays for the provision of services is dependent on how the person's situation is categorised and the nature of the service.

#### **8.3.1 Admitted patients**

Inpatients within an MPS are charged on the same basis as any admitted patient in a NSW public hospital. Where the MPS has the facility to provide for private patients this option should be available.

#### **8.3.2 High Care Residents**

Services are provided within an MPS on a similar basis to those of an Australian Government subsidised high care facility. For example, if a client requires (as determined by a health practitioner) allied health services, the MPS will provide these services at no cost to the client. However, if a client privately organises podiatry or other allied health services, the payment of privately arranged services is the responsibility of the resident.

#### **8.3.3 Low Care Residents**

Services are provided within an MPS on a similar basis to those of an Australian Government subsidised low care facility. The MPS is to assist, if required, low care clients' access to GPs, allied health and other services. Any cost incurred in seeking such services (for instance for private practice allied health professionals) is to be met by the client.

Keeping in mind the philosophy behind the MPS (emphasising coordination of care and a seamless approach to health service delivery), services required by low care clients should be provided on site where practical, either through outreach or arrangements with local private practitioners.

Refer to pages 60-63 for a schedule of included services.

#### **8.3.5 Diagnostic Services**

Refer to Section 4 with regards to billing and client charge arrangements for MPS patients and residents.

Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient has elected to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms. Where a patient has elected to be a private patient the patient is to be charged for all services provided by staff specialists (exercising rights of private practice) and VMOs. A GP visiting a resident in an MPS requires VMO status.

High care and low care residential aged care clients are billed directly by VMOs. For salaried clinicians, the MPS will bill the patient on behalf of the clinician at the Medicare Benefits Schedule rate. A GP treats residents as aged care residents unless there is clinical need for them to be treated as acute care patients.

## GPs/Medicare and Multi-disciplinary Care Plans

If a resident of an MPS is receiving residential care within the meaning of section 41-3 of the *Aged Care Act 1997*, they are eligible for Medicare item 731. Item 731 is available for the contribution by a GP to a multi-disciplinary care plan for a patient in a residential aged care facility or to a review of such a plan prepared by such a facility. This contribution to a care plan for an aged care resident must be at the request of the aged care facility (or discharging hospital where the resident is being discharged from a hospital).

For a GP to be able to contribute to the resident's care plan and the service is eligible for a Medicare rebate, the plan needs to be multi-disciplinary in nature. This means, consistent with the other Chronic Disease Management Medicare items, that the resident has a chronic medical condition and complex care needs requiring care from a multi-disciplinary team. Not all care plans prepared for residents of aged care facilities will necessarily be multi-disciplinary, as plans reflect the particular needs of each resident. The recommended frequency for this service is six monthly, but a GP can claim for a contribution to a care plan on a three monthly basis, where required.

### 8.3.6 Pharmaceuticals

To ensure consistency across MPS the following guidelines are used in determining the supply and costing of pharmaceuticals.

In principle an admitted patient to the hospital has their pharmaceuticals provided at no charge through the hospital. The National Healthcare Agreement covers patients who elect to be treated as private or public patients.

Aged Care Residents must obtain their pharmaceuticals through the Pharmaceutical Benefits Scheme (PBS).

As an MPS has a combination of inpatients and residents, timely categorisation is required to ensure appropriate costing of pharmaceuticals. A resident whose classification changes to admitted patient status has their pharmaceuticals provided free of charge from the MPS. When they revert to resident status their pharmaceuticals again are provided through the PBS. Each MPS is to have local arrangements in place to determine the most appropriate process to implement this policy.

Patient status also influences which particular Departmental policy should be followed when developing local policies and procedures on medication management.<sup>15</sup>

### 8.3.7 Laundry

MPS are required to provide a general laundry service to residents at no additional cost. This means any washing suitable for a washing machine, and includes ironing as appropriate. Local arrangements will determine the process by which this is managed. The resident will meet any additional costs incurred through laundering garments that would not be washed as a general laundry item, such as doonas.

Laundry services provided on site at the MPS must comply with the Laundry and Linen Services Standards as outlined in the Infection Control Policy Directive PD2007\_036<sup>16</sup>.

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<sup>15</sup> Acute care inpatients – NSW Health PD2007\_077 Medication Handling in New South Wales Public Hospitals.  
[http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007\\_077.pdf](http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_077.pdf)

<sup>16</sup> Infection Control Policy Directive – PD2007\_036 (page 27). [http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007\\_036.pdf](http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_036.pdf)

### **8.3.8 Telephone Related Charges**

If a resident requests a private phone line, then rental and call charges are to be paid by the resident. Where a resident does not choose to pay for a phone line they will be charged for calls made using the services line.

## **8.4 Private Clinic Arrangements**

Where an MPS includes a private clinic or facilities used by private practitioners, the relevant Area Health Service policy on the use of and fees payable applies.

Subject to these policies being in place, the NSW Department of Health favours co-location service models.

# Reporting

## **9. Reporting**

### **9.1 Australian Government Reporting Requirements**

Under the terms and conditions of MPS funding agreements, all AHS are required to provide activity and financial reports within three months of the end of each financial year. Reports are required for each operational MPS. The format for the Statement of Financial Compliance has been agreed between the Australian Government and the NSW Department of Health for use in respect of the MPS Program.

The financial report includes a statement of compliance and a statement of receipts and payments in respect of the recurrent funding received from the Australian Government. Activity reports detail service activities and achievement of outcomes.

#### **9.1.1 Funding agreements with the Australian Government**

MPS funding agreements are for a period of three years. During the third year of the agreement, a review of the range of services provided by the MPS and the funding provided by the Australian Government is conducted.

Eight months before the expiry of the funding agreement for an MPS, the Australian Government requests a Service Statement from the NSW Department of Health. In turn, the Department then asks the AHS to develop a Service Statement in consultation with the local Health Advisory Committee. (See Attachment 1 Service Statement Template as at October 2009- for an example of a Service Statement see NSW Health intranet site:

<http://www.health.nsw.gov.au/rural/rhhsp/planning.asp>

The aim of the Service Statement is to outline changes in community needs that have been identified over the period of the agreement, and to propose any changes to services to be provided for the next three-year period. This may include changes to the range of health services provided as well as increases in the number of flexible residential or community aged care places provided, or a change in the mix of places (for example the mix of high and low care).

Where additional funding is requested for aged care places, it is important that supporting evidence of need is provided. This includes annual average occupancy data for residential and community care places, information on the number of people who have had to move outside the town to access a residential aged care place, waiting lists, and data on demographic changes in the MPS catchment area.

Service Statements are submitted to the NSW Department of Health for approval and submission to the Australian Government.

The Commonwealth Department of Health and Ageing assesses the Service Statement and advises the NSW Department of Health as to whether the additional funding has been approved. A new three-year funding agreement is then developed, reflecting the new services outlined in the Service Statement.

Once the Service Statement has been supported by the Australian Government, a 3 year Funding Agreement will be drafted which requires information that can be found in the Service Statement, such a Role Delineation, access to services and budget details.

Under the terms and conditions of MPS funding agreements, all AHS are required to provide Annual Activity and Progress Reports and Financial reports for each operational MPS on the following schedule:

<b><i>Date Due</i></b>	<b><i>Reports Required</i></b>	<b><i>Reporting Periods</i></b>
30 September	Annual Statement of Financial Compliance	Each financial year
	<i>Annual Income and Expenditure Report</i>	1 July to 30 June each year
	<i>Annual Activity Report</i>	

The reporting requirements, including templates for each report are included at Schedule E of the funding agreement. The Commonwealth Department of Health and Ageing sends a reminder and a copy of the template to each Area Health Service approximately six weeks before the due date for each report.

Finance report template: Attachment 3

## **9.2 NSW Health Reporting Requirements**

State reporting requirements are informed by the relevant NSW Health Policy Directive.<sup>17</sup>

### **9.2.1 Staff Details**

Staffing details required for the Department of Health Reporting System (DOHRS) relate to the Award under which they are employed.

For “Personal Care Assistants” (PCAs) who have become Area Health Service employees through hostels integrating into an MPS, the Area determines the Award under which they are classified based on their statement of duties.

When employees from a hostel transfer to an Area MPS the statement of duties from the previous employer needs to be reviewed and realigned to a public sector award.

For “Staffing Category” in the Unaudited Annual Return (UAR), the PCAs are classified as “Nursing” if the employee is under the Nurses’ Award and “Domestic and Other Personal Care Staff” if under a different Award (e.g. Residential Care Assistant).

<sup>17</sup> NSW Health PD2005\_357 Information Management Requirements for Residential Aged Care Clients Accommodated in Federal Funded Beds - Public Facilities - [http://www.health.nsw.gov.au/policies/PD/2005/PD2005\\_357.html](http://www.health.nsw.gov.au/policies/PD/2005/PD2005_357.html)

# Human Resources

## **10. Human Resources**

Human Resources are managed in accordance with Area Health Service policies and procedures.

The MPS model facilitates a flexible approach to staffing and human resource management with an opportunity for multi-skilling and up-skilling of existing staff and also reviewing the staff mix. The staffing levels and skills should meet the needs of the patients, clients and residents. The staffing profile includes provision for clinical care as well as services, such as meals and cleaning.

When a hostel chooses to join an MPS, all staff of the hostel are given the opportunity to transfer to the MPS as Area Health Service employees. This is a voluntary arrangement. Staff transferring will be offered employment on terms and conditions no less favourable than those under which they are currently employed.

All levels of Area Health Service management need to recognise the changes involved in moving to an MPS model. Appropriate change management strategies, commencing at the planning stage, which include consultation with all stakeholders, (community and staff), training, education and support, are essential to the success of the MPS.

### **10.1 Education and Training**

The provision of training in issues and aspects of aged care will need to be included in learning and development plans. Experience has shown the need to plan and implement education and change management strategies early in the planning and development stage of an MPS.

The challenge of providing a range of services and the intrinsic differences in the services provided means a range of staff are required who have the skills and knowledge necessary to provide a quality service through the continuum of the MPS model. Recruitment and support strategies will reflect these needs.

A New Direction for NSW: State Health Plan towards 2020 emphasises an intention to “Continue to build the capacity of health services to deliver appropriate health care to individuals and communities from culturally and linguistically diverse backgrounds”<sup>18</sup>

Local demographics will determine the extent to which cultural awareness training for working with Aboriginal people is required and the nature of delivery. However there is an expectation that all staff will undertake cultural awareness training.

The Aged Care Channel is a useful way of providing education for staff on issues relating to aged care.

### **10.2 Criminal Record Checks**

The Australian Government requires all aged care staff and volunteers to have National Police Certificates. The requirements apply to all staff members and volunteers working in aged care services that are subsidised and regulated by the Australian Government under the provisions of the Aged Care Act 1997 (the Act).

The Australian Government’s Department of Health and Ageing Police Certificate Guidelines for Aged Care Providers, together with the Accountability Amendment Principles 2006, Records Amendment Principles 2006 and Community Visitors Grant Amendment Principles 2006 relating to the Act, provide comprehensive information regarding the new requirements. These documents can be obtained via the Australian Government’s Department of Health and Ageing website: [www.health.gov.au](http://www.health.gov.au).

## **Orienting staff to the MPS model**

Prior to implementing the MPS model many public health facilities provided long term care for nursing home type patients. The care was provided within a health framework rather than an aged care context.

By adopting an aged care model for the residential aged care places there will be changes to the way staff conduct many of their activities. For instance additional staff time may be required to provide a supportive and facilitating role with the residents' activities of daily living, including with personal care and meals. This may mean a resident takes longer to eat their meal with a nurse supervising. Encouraging continuation of activities of daily living contributes to the maintenance of a resident's functioning and to their quality of life. Changes to the skill mix of staff may be a way of meeting the needs of residents and patients and managing the budget.

It is important therefore to recognise and implement strategies to inform and involve stakeholders in the new process. Existing "residents" of the MPS who have been long term patients, and their families and carers will also need to be supported and involved in this process.

## **Orienting Managers to the MPS Model**

New managers of an MPS need to be oriented to the philosophy and model of an MPS to ensure the MPS operates in a manner which effectively meets the needs of the local community.

It is important that managers understand the difference between an MPS model and that of the traditional small hospital.

# Quality Improvement

## 11. Quality Improvement

The quality program of an MPS should span the range of services provided and should include evaluating the effectiveness of the service's health care and wellness programs. In recognising the importance of community development in some of the programs, quality activities will reflect partnerships with both the community and other service providers.

The National Quality Framework for Multipurpose Services<sup>19</sup> has been endorsed and is recognised as a useful resource for MPS. An excerpt from the Framework is included on the next page.

The NSW Department of Health has developed a number of resources to assist in the planning, delivery and evaluation of its services, including the Framework for Managing the Quality of Health Services in NSW (1999) and the Clinician's Toolkit for Improving Patient Care (2001)<sup>20 21</sup>

### 11.1 Certification and Accreditation

Certification by the Aged Care Standards Association of Australia (ACSAA) is not a requirement for MPS under the Aged Care Act 1997. This is because some of the standards may not be appropriate when applied to the MPS environment. The MPS however, needs to provide services in a way that demonstrates a commitment to the intent of the Act. The NSW Department of Health encourages the use of the Aged Care Standards to inform the development of appropriate and relevant Quality Improvement strategies.

MPS must however comply with relevant State legislation for accommodation/ health care facilities, including fire and safety certification.

All redeveloped health and aged care facilities are required to comply with the Australian Building Codes Standards.

### 11.2 Food services and quality

A number of issues have been raised by MPS Managers regarding matters such as donations of food, using eggs from a chicken run, growing vegetables and fruit on the MPS campus. Two relevant documents to assist in determining local policy and procedures are:

- PD2007\_047 - Foodborne Listeriosis - Control in Health Care Institutions  
[http://www.health.nsw.gov.au/policies/pd/2007/PD2007\\_047.html](http://www.health.nsw.gov.au/policies/pd/2007/PD2007_047.html)
- Industry Guide to Developing a Food Safety Program (Hospitals and Aged Care) -  
[http://www.foodauthority.nsw.gov.au/Documents/industry\\_vp\\_pdf/vulnerable\\_persons\\_food\\_safety\\_scheme\\_manual\\_compl.pdf](http://www.foodauthority.nsw.gov.au/Documents/industry_vp_pdf/vulnerable_persons_food_safety_scheme_manual_compl.pdf)

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<sup>19</sup> <http://www.health.gov.au/internet/main/publishing.nsf/Content/national-quality-improvement-mps.htm>

<sup>20</sup> NSW PD 2005\_585 Framework for Managing the Quality of Health Services in NSW  
[http://www.health.nsw.gov.au/policies/pd/2005/PD2005\\_585.htm](http://www.health.nsw.gov.au/policies/pd/2005/PD2005_585.htm)

<sup>21</sup> <http://www.health.nsw.gov.au/pubs/2001/clintoolkit.html>

## **Excerpt from The National Quality Improvement Framework for Multipurpose Services.**

### **Introduction**

The joint Australian Government / State Multipurpose Services (MPS) Program aims to provide a flexible approach to health and aged care service delivery to small rural communities. An MPS typically involves the amalgamation of services ranging from hospital care to residential aged care, community health, home and community care and other health related services.

The Rural Health Policy Sub-committee of the Australian Health Ministers Advisory Council has agreed on the need for a broad framework for quality improvement in MPS nationally that addresses the diverse nature of these services.

The framework has been developed by a Steering Group comprising State and Australian Government stakeholders, and has involved consultation with MPS providers, quality and accreditation agencies, and technical assistance from the Australasian Association for Quality in Health Care.

The framework covers only those MPS services receiving Australian Government funding for *flexible aged care places* – although it may have application to other *small, integrated rural health service models*.

### **Statement of Intent**

This framework sets out at a broad national level, agreed principles and strategies for sustaining and improving quality of care in Multipurpose Services.

In developing the framework State and Australian Governments have recognised that MPS are often expected to demonstrate performance and assure quality against an array of standards and accreditation models, which may or may not suit their circumstance.

The framework aims to assist MPS by:

- Providing a broad national structure for promoting *continuous quality improvement*;
- Facilitating more appropriate standards and accreditation approaches for MPS; and
- Encouraging quality processes that meet the needs of individual MPS providers.

The framework is not designed to establish *additional* standards and/or accreditation requirements for MPS providers.

### **Roles and Responsibilities**

The framework recognises that State/Territory Governments have a primary interest and responsibility for ensuring quality of care in MPS. Each State/Territory will operationalise the national principles for quality improvement in MPS (outlined below) in a way that takes into account local and regional factors and is consistent with existing quality approaches in that State/Territory. Each jurisdiction will be responsible for ensuring that MPS pursue a recognised, robust continuous improvement process.

At the same time, the Australian Government has a national role in promoting quality in MPS, with a particular emphasis on ensuring that the flexible aged care services it funds are delivered in a context that assures quality and safety. While there is no requirement for MPS to meet Aged Care accreditation, the Australian Government seeks an assurance that MPS provide a level of quality care consistent with community expectations, and in a manner consistent with the spirit and intent of the aged care standards where appropriate.

This framework reinforces this objective.

Both State and Australian Governments have a role in monitoring performance through regular reporting to ensure quality of care obligations under the relevant funding agreement are being met and improved upon.

The framework also sets out an approach for working with existing accreditation agencies at the national level to encourage them to adapt their assessment tools and their training of assessors to better suit the MPS setting and their needs.

### **Quality Improvement - National Principles**

The following national principles have been endorsed by the Australian Government, and State and Northern Territory Health Authorities to provide a focus for continuous quality improvement in MPS. The principles embody allegiance to primary health care principles including an emphasis on community involvement in planning, implementation and evaluation of services.

MPS should demonstrate a commitment to continuous quality improvement through participation in an externally recognised quality improvement cycle for the full range of services covered.

1. The active participation of rural communities including local consumers, community representatives, GPs and other health professionals, and health and aged care service staff, is integral to the process of continuous quality improvement in an MPS.
2. The consumer is central to the planning, operation and review processes of an MPS.
3. MPS will be quality focused and adequately address safety and security issues including where appropriate the identification of risk management strategies in areas such as staffing, physical facilities and equipment, and safe work practices.
4. The MPS will be designed and managed to promote *seamless care* to consumers at the local level and to enable smooth transition of consumers across health service boundaries.
5. As a minimum, MPS will evaluate their performance using an assessment approach that incorporates:
  - Corporate governance;
  - Management, leadership & staffing policies (including staff participation);
  - Clinical governance;
  - Continuous quality improvement;
  - Integration and continuity of care;
  - Statutory compliance and administration;
  - Risk management/safety;
  - Complaints management;
  - Consumer participation; and
  - Specific standards covering the provision of a range of key health and aged care services appropriate to the service mix.

### **Working with Accreditation Agencies**

The national framework is supported by a strategy to work closely with the accreditation agencies that currently provide performance measurement and assessment services to MPS.

The strategy involves negotiation with these agencies to:

- Develop (or modify) assessment tools for MPS that are:
- Based on a detailed understanding of the MPS model;
- Appropriate for the diverse range of services and the integrated delivery approach used

by MPS;

- In a modular format that can be packaged to suit individual MPS; and
- Appropriate to the small infrastructure of an MPS in terms of compliance and reporting.

AND

- Improve training/preparation of MPS assessors through:
- Familiarisation with the MPS model; and
- Emphasis on flexible assessment and meeting the needs of the MPS.

### **Cooperative Recognition**

Under *cooperative recognition* arrangements an MPS' performance against a number of standards/accreditation requirements can be assessed through a single process. Accreditation agencies can assist greatly in this regard by developing robust assessment modules (as noted above) that detail any **additional** performance requirements an MPS will need to address for specific services it offers – e.g. a specific module for HACC type services, Mental Health, Aged Care etc.

### **References**

The following references provided useful background for the development of the framework:

The Hoult/Forwood report on A Quality Improvement Framework for Small Integrated Rural Health and Aged Care Services;

The Final report of the National Expert Advisory Group on Safety and Quality in Australian Health Care; and

A Review of Quality Improvement Approaches in Health and Community Services – QIC, June 2001

## Ideas for quality improvement activities

The Australian Government has identified ways in which an MPS could demonstrate its effectiveness in meeting the needs of the community. These indicators are a useful starting point for MPS managers to evaluate the quality and effectiveness of their care and service.

As a guide, an effective MPS should be able to achieve:

### For the consumer

- A single point of contact for families and carers;
- Improved consumer education;
- Increased consumer/ carer satisfaction;
- Increased consumer choice (e.g. older people may be given the choice of home based or residential care)

### For the community

- Early intervention and greater consumer/ community awareness of what health care is available in the local community;
- Active community participation in service planning and consumer participation in care;
- A demonstrated sense of community ownership;
- Direction of resources to areas of identified local community need;
- Greater focus on prevention and community outreach programs;
- A wider range of viable, sustainable services

### For the service

- A coordinated and timely approach to care delivery;
- Streamlined assessment processes;
- Improved discharge planning;
- Improved communication between health professionals/ care givers;
- Improved retention, multi-skilling and up-skilling of staff;
- Better linkages and partnerships between health specific and non health services (e.g. local government)

Source: Australian Government, MPS Model

# **Patient / Client / Resident Rights and Responsibilities**

## **12. Patient / Client / Resident Rights and Responsibilities**

A key component of the MPS model is the implementation and monitoring of the Rights and Responsibilities of patients, clients and residents.

All Area Health Services should have a Rights and Responsibilities brochure available. This information should be in a culturally appropriate format for the community, patients/clients and residents and their carers/families. All patients/clients and residents should also be provided with information on how to make a complaint.

A model Charter of Resident's Rights and Responsibilities is included below.

For communities with Aboriginal populations, appropriate Aboriginal liaison is required to ensure that Aboriginal people accessing services are fully aware of these rights and responsibilities and complaints process and services are delivered in a culturally appropriate way.

Aboriginal and Torres Strait Islander peoples can access Centrelink support which includes a network of Indigenous servicing staff and Remote Visiting Teams who provide a range of information and support services.

## CHARTER OF RESIDENT'S RIGHTS AND RESPONSIBILITIES

- Each resident of a Multipurpose Service has the right to:
- full and effective use of his or her personal, civil, legal and consumer rights;
- quality care appropriate to his or her needs;
- full information about his or her own state of health and about available treatments;
- be treated with dignity and respect, and to live without exploitation, abuse or neglect;
- live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation;
- personal privacy;
- live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction;
- be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect;
- continue his or her cultural and religious practices and to keep the language of his or her choice without discrimination;
- select and maintain social and personal relationships with anyone else without fear, criticism and restriction;
- freedom of speech;
- maintain his or her personal independence, including a recognition of personal responsibility for his or her own actions and choices, even though some actions may involve an element of risk that the resident has the right to accept, and that should then not be used to prevent or restrict the resident's actions;
- maintain control over, and to continue making decisions about the personal aspects of his or her daily life, financial affairs and possessions;
- be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service;
- have access to services and activities available generally in the community;
- be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service;
- have access to information about his or her rights, care, accommodation and any other information that relates to him or her personally;
- complain and to take action to resolve disputes;
- have access to advocates and other avenues of redress;
- Be free from reprisal, or a well-founded fear of reprisal, in any form, for taking action to enforce his or her rights.
- Each resident of a Multipurpose Service has the responsibility to:
- respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole;
- respect the rights of staff and the proprietor to work in an environment free from harassment;
- care for his or her own health and well being, as far as he or she is capable;
- Inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and his or her current state of health.

Some particular issues have been identified in relation to meeting resident's rights and responsibilities within an MPS environment which are described further below.

## **12.1 Residential Agreements**

In accordance with the *Commonwealth Aged Care Act 1997* a formal agreement between the resident and the approved provider must be offered to all new residents before they enter an aged care facility, which includes all health service operated MPS. This applies to a resident receiving high or low care and recipients of community aged care packages. The agreement must be consistent and comply with the *Aged Care Act 1997*, User Rights Principles 1997 and associated legislation.

In the event that a signed residential Agreement is already in place that does not comply with the *Aged Care Act 1997*, User Rights Principles 1997 and associated legislation, the Agreement should be amended based on these principles and fully explained and agreed to by the resident.

The MPS will develop its own agreement, with support from the Area Health Service. Specific information on agreements can be found within the Department of Health and Ageing User Rights Principles. Some information from the User Rights Principles is provided on the next page to assist MPS managers.

Information on "Default in Payment of Money" as it relates to services provided through a Multipurpose Service under either a Residential Service Agreement or an Agreement for the Provision of Respite Care can be found under the NURSING HOMES/MULTIPURPOSE SERVICES section of the NSW Department of Health's Fees Procedures Manual for Area Health Services and Public Hospital<sup>22</sup>.

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<sup>22</sup> <http://www.health.nsw.gov.au/resources/policies/manuals/fees.asp>

## **Excerpt from the Aged Care Act 1997, User Rights Principles 1997**

### **Section 10.4.1 - Resident Agreements**

A formal agreement between the resident and the Approved Provider must be offered to all new residents **before** they enter the service and may be entered into at any future time during the resident's stay. The requirements for resident agreements are set out in section 59-1 of the Act. Residents have the right to choose whether or not they wish to enter into a written agreement with the Approved Provider.

The agreement between the resident and the Approved Provider must treat the resident and provider as equals, be written in plain language, be easy to understand and must specify:

- The name of the aged care home;
- The levels of care and service that the provider has the capacity to provide to the resident, and any limitations to these levels of care;
- The policies and practices that the provider will follow in setting fees to the resident for the provision of care and services;
- The circumstances in which the resident may be asked to depart from the aged care home;
- The assistance that the provider will provide to the resident to obtain alternative and appropriate accommodation if the resident is asked to depart the aged care home;
- The complaints resolution mechanism provided to address complaints made by or on behalf of a resident;
- The resident's responsibilities as a resident in the aged care home;
- The period of the agreement; and
- Any other matters relevant to the agreement, and/or matters negotiated between the Approved Provider and the resident.

Provisions by the Approved Provider should also be made for:

- Varying, by mutual consent, the terms of the contract;
- Terminating the contract upon seven days written notice from the resident or their representative;
- Voiding the contract should the resident or their representative within 14 days after signing the contract; tell the provider in writing, that they wish to withdraw from the agreement. In these circumstances, the resident is still liable for any fees and charges accrued under the agreement during their time in the aged care home. Providers must refund any other amount paid by the resident under the agreement; and
- Explaining and helping the resident or their representatives to understand all terms of the agreement.

The rights given to the resident by the agreement are in addition to any other rights that the resident has in law or equity. The agreement must not contain any provision that would allow the resident to be treated less favourably than they would otherwise be under any law of the Commonwealth. When a resident does not want to have a formal agreement with the aged care home, the home must still abide by the legislative requirements, including the User Rights Principles 1997, to continue to receive Australian Government funding.

#### **Section 10.4.4 - Signing Agreements**

An agreement must be signed by both the provider and the resident. Where the resident is physically unable to sign the agreement, that resident may request another person to sign on his or her behalf and the agreement should be annotated to this effect.

Where cognitive impairment makes it impossible for the resident to understand and sign the agreement in person, a legally authorised representative should sign in the resident's place.

Where a resident is not able to sign an agreement and does not have a legally authorised alternative decision maker, assistance can be obtained by contacting the relevant State or Territory government guardianship authority or public advocate or public trustee. See **Section 10.12 List of Guardianship Authorities / Public Advocates / Trustees Offices** for addresses and contact telephone numbers.

## Care and Accommodation Services Provided by the MPS

When describing, in the Agreement, the levels of care and service to be provided, the following headings may be a useful guide and further details can be provided from the health service.

Residential Care		
Item	Care or Service	Content
1	Assistance in the activities of daily living	Personal assistance, including individual attention, individual supervision and physical assistance with
		i. Bathing, showering personal hygiene and grooming;
		ii. Maintaining continence or managing incontinence, and the use of aids and appliances designed to assist continence management;
		iii. Eating, use of eating utensils and eating aids (including actual feeding where necessary) and the provision of eating aids;
		iv. Dressing, undressing, and the use and provision of dressing aids;
		v. Moving, walking, wheelchair use and the use of devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids;
		vi. Communication, including addressing difficulties arising from impaired hearing, sight or speech, or lack of common language (including the fitting of sensory communication aids) and checking hearing aid batteries and cleaning spectacles.
		Excludes hairdressing.
2	Meals and refreshments	Special diet provided.
3	Provisional of emotional support to, and supervision of, residents	Provision of an empathetic and supportive approach to the resident. Recognition in all interactions with the resident of his or her special needs and individuality.
4	Treatments or procedures	Carried out according to the instructions of a health professional or a person responsible for assessing a resident's personal care needs, including supervision and physical assistance with taking medications, and ordering and reordering medications, as necessary, subject to requirements of State or Territory legislation.

Residential Care		
Item	Care or Service	Content
5	Provision of recreational therapy	Recreational activities suited to residents, assistance with participation in those activities and the provision of communal recreational equipment.
6	Rehabilitation support	The provision of, and assistance with, individual therapy programs designed by health professionals, aimed at maintaining or restoring a resident's ability to perform daily tasks for him or herself, or assistance to obtain access to such support.
7	Provision of assistance in obtaining health practitioner services	Arrangements for aural, community health, dental, medical, psychiatric and other health practitioners to visit residents, whether the arrangements are made with the relatives of the resident, or other persons representing the resident's interests, or are made direct with the practitioner.
8	Assistance in obtaining access to specialised therapy services	Arrangements for speech therapy, podiatry, occupational or physiotherapy practitioners to visit residents whether the arrangements are made by the resident, relatives or other person representing the resident's interests.
9	Support for people with cognitive impairment	Individual attention and support because of recurrent confusion, including dementia, and other cognitive impairments and behavioural disorders. This would include individual therapy activities and specific programs designed and undertaken to prevent or manage a particular condition or behaviour and to enhance the quality of life and care for such residents and ongoing support, including specific encouragement, to motivate or enable such a resident to participate in general facility activities.

High Level Care Services		
Item	Care or Service	Content
1	Furnishings	Over-bed tables.
2	Bedding materials appropriate to each resident's condition	Bed rails, incontinence sheets, restrainers, ripple mattresses, sheepskins, tri-pillows, water and air mattresses.
3	Toiletry goods	Sanitary pads, tissues, toothpaste, denture cleaning preparations, shampoo and conditioner, and talcum powder.
4	Goods to assist residents to move themselves	Crutches, quadruped walkers, walking frames, walking sticks, wheelchairs. Exclude: Motorised wheelchairs and custom made aids.
5	Goods to assist staff to move residents	Mechanical devices for lifting residents, stretchers, trolleys.
6	Goods to assist with toileting and incontinence management	Absorbent pads, commode chairs, disposable bedpan and urinal covers, disposable pads, over toilet chairs, shower chairs and urodomes, catheter and urinary drainage appliances, disposable enemas.
7	Basic Medical/pharmaceutical supplies and equipment	<p>Analgesia, anti-nausea agents, bandages, creams, dressings, laxatives and aperients, mouthwashes, ointments, saline, skin emollients, swabs, and urinary alkalising agents.</p> <p>Excludes: Any goods prescribed by a health practitioner for a particular resident and used only by the resident.</p>
8	Administration of medications	The administration and dispensing of medications subject to requirements of State or Territory legislation.
9	Provision of therapy services, such as recreational, speech therapy, podiatry, occupational physiotherapy.	<p>(a) Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain resident's levels of independence in activities of daily living.</p> <p>(b) More intensive therapy delivered by health professionals, on a temporary basis designed to allow residents to attain a level of independence at which maintenance therapy will meet their needs.</p> <p>Excludes: Intensive, long term rehabilitation services require following, for example, serious illness or injury, surgery or trauma.</p>
10	Provision of oxygen and oxygen equipment	Oxygen therapy and oxygen equipment is provided to residents as required following clinical assessment and reviewed in accordance with clinical guidelines.

## Accommodation Services provided by the mps

Item	Care or Service	Content
1	Administration	General operation of the facility including maintenance of resident documentation.
2	Maintenance of all buildings and grounds	Maintenance of all buildings and grounds
3	Accommodation.	Utilities such as electricity and water.
4	Furnishings	Except where a resident chooses to provide them: Bedside lockers, chairs with arms, containers for personal laundry, dining, lounge and recreational furnishings, draw-screens (for shared rooms), resident wardrobe space, towel rails.
5	Bedding	Beds and mattresses, bed linen, blankets and absorbent or waterproof sheeting.
6	Cleaning of services, goods and facilities	Maintain cleanliness and tidiness of entire facility.
7	Waste disposal	Safe disposal of organic and inorganic waste material.
8	General laundry	Provision of heavy laundry facilities and services, the provision of personal laundry services, including laundering of clothing that can be machine-washed.  Excludes:  Cleaning of clothing that requires dry cleaning or other special cleaning process and personal laundry where a resident chooses and is able to do this his or herself.
9	Toiletry goods	Bath towels, face washers, soap, and toilet paper.
10	Meals and refreshments	+
11	The provision of activities	Programs to encourage residents to participate in social activities that promote and protect their dignity and to participate in community life outside the facility.
12	The provision of emergency assistance	At least one responsible person who is continuously on call and in reasonable proximity to render emergency assistance.

## 12.2 Smoking

NSW Health policy precludes smoking within NSW Health facilities and aims to<sup>23</sup>:

- reduce the harm associated with tobacco use amongst staff, patients, visitors and the community, especially exposure to passive smoking;
- provide a clear and consistent message to staff, patients, visitors and the community about the hazards of smoking;
- provide a clear and consistent message to staff, patients, visitors and the community that smoking is not a healthy activity; and
- provide leadership in the community about reducing the harm associated with smoking

### **How does the Smoke Free Workplace Policy affect residential aged care patients in MPS facilities?**

There has been much debate in MPS about the rights of residents to smoke. All common areas such as living rooms, hallways, foyers are considered to be enclosed public places under the *NSW Smoke-free Environment Act, 2000* and therefore smoking is not permitted in these areas.

The decision about whether or not to permit smoking in a MPS should be made by the manager. Increasingly, managers have determined that a smoke-free environment is the most appropriate for an MPS.

It is acknowledged that residential care facilities on public health organisation properties may retain outdoor designated smoking areas for use by the residents and their guests only.

The MPS will need to be aware of the occupational health and safety issues concerning smoking and the duty of care that public health organisations have to all persons who enter its premises and to promoting and protecting public health in general.

## 12.3 Pets

While it is inappropriate for a resident to have a pet at an MPS, some MPS sites have chosen to have a 'facility pet'. This may be a bird, cat or other small pet. The staff report that residents enjoy going outside to be with the pet and that the pet encourages social interaction and promotes a home-like environment.

The decision about whether or not to allow pets should be made by the Manager. A NSW Health guideline may assist local deliberations.<sup>24</sup>

## 12.4 Complaints Management

A process must be in place for the management of resident, client and patient complaints. Complaints management is governed by NSW Health Policy Directive PD2006\_073 Complaints Management Policy<sup>25</sup>. The MPS should have a process for the local handling of complaints and for dispute resolution which is consistent with the NSW Health Complaints Management Policy. A matter may be referred to the Health Care Complaints Commission if the party is not satisfied with the actions taken by the health service.

It should be noted that normally complaints around residential aged care e.g. Private providers or State Government Residential Aged Care Facilities would go through the Department of Health

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<sup>23</sup> NSW Health PD2005\_375 The Progression of the NSW Health Smoke Free Workplace Policy  
[http://www.health.nsw.gov.au/policies/PD/2005/PD2005\\_375.html](http://www.health.nsw.gov.au/policies/PD/2005/PD2005_375.html)

<sup>24</sup> GL2006\_012 - Animals - Therapy Companion in Public and Private Hospital;  
[http://www.health.nsw.gov.au/policies/gl/2006/GL2006\\_012.html](http://www.health.nsw.gov.au/policies/gl/2006/GL2006_012.html)

<sup>25</sup> [http://www.health.nsw.gov.au/policies/pd/2006/PD2006\\_073.html](http://www.health.nsw.gov.au/policies/pd/2006/PD2006_073.html)

and Ageing, Aged Care Complaints Investigation Scheme. However, complaints regarding residential aged care in an MPS should be directed through the Area Health Service complaints procedures.

To assist in determining local policy and procedures in complaints management, the NSW Health GL2006\_023 Complaints Management Guidelines should also be consulted<sup>26</sup>.

The complaint mechanism for residents needs to be articulated as part of the Resident Agreement.

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<sup>26</sup> [http://www.health.nsw.gov.au/policies/gl/2006/GL2006\\_023.html](http://www.health.nsw.gov.au/policies/gl/2006/GL2006_023.html)

# **Legislative Requirements**

## 13. Legislative requirements

MPS operate within a number of legislative instruments including the Australian Government's *Aged Care Act 1997* and the *Aged Care Principles 1999*.

The following information is provided to assist managers with meeting their legislative requirements.

### 13.1 The Aged Care Act 1997

The Aged Care Act 1997 can be found on the Australian Government's Attorney General's website <http://scaletext.law.gov.au/html/comact/9/5674/top.htm>

The following sections of the Aged Care Act 1997 apply to Multipurpose Services.

- Responsibilities of approved providers-flexible care  
<http://scaletext.law.gov.au/html/comact/9/5674/0/CM003390.htm>
- Section 54-5 Flexible Care Standards  
<http://scaletext.law.gov.au/html/comact/9/5674/0/CM003310.htm>
- Flexible Care Subsidy Principles  
<http://scaletext.law.gov.au/html/instruments/0/2/0/2002112103.htm>
- Flexible Care Standards  
<http://scaletext.law.gov.au/html/comact/9/5674/0/CM003310.htm>
- User Rights principles  
<http://scaletext.law.gov.au/html/comact/9/5674/0/CM003350.htm>
- Complaints resolution mechanisms  
<http://scaletext.law.gov.au/html/comact/9/5674/0/CM003400.htm>

# Evaluating the MPS Model

## 14. Evaluating the MPS model

### Introduction

A comprehensive strategic review<sup>27</sup> of NSW MPSs, completed in 2008, identified significant benefits arising from the implementation of the MPS model but pointed to the disparity in the implementation of the model statewide. Significantly, the NSW MPS Program lacks a formal evaluation framework. However, one of the key aspects of the program is that there is an opportunity to garner information about the outcomes and achievements of the service model every three years as part of the current triennial reporting process that underpins the tripartite Funding Agreement between the MPS, State and Commonwealth Governments.

A literature review undertaken as part of the Strategic Review and to inform this evaluation framework confirms that while some service elements have been measured in the past, a real gap exists in respect to the ongoing evaluation of the MPS model and supports the need for a tailored evaluation framework for this model of care.

The recurrent themes identified through the literature review as critical success factors for the MPS Program include:

- Service planning based on population health needs, integrated and innovative service models that accounts for local health needs
- Strong local relationships and in particular, engaging local communities and local health workforce in planning and health and aged care issue decision-making, and evaluation
- Strong local management and leadership through the creation of a strong local health service entity the community can identify
- Commitment from the Commonwealth, states and territories to continued funding of a range of basic acute, aged care, community care and community health services
- Accountability mechanisms that include prescribed reporting of financial, service and quality outcomes as well as accreditation (Sach, 2000; NSW Health, 1999).

### The Evaluation Approach

The service components of an MPS model include community based, acute health services and residential aged care. There is no single model for the composition of services as this depends on the size of the population and the location from larger centres. The underlying service initiative is to integrate and flexibly and efficiently deliver health and aged care in small rural areas. The level of integration and flexibility is where some of the broader variances in implementation have occurred.

Effective program evaluation provides stakeholders the capacity to gather and use information, and to continually learn about and improve programs delivered. What is important is that the framework designed promotes continual evaluation of a program and not just a snap shot view. The evaluation outputs should also assist NSW MPS sites to develop better services and set up a method of recording information about their services ensuring ongoing improvements in delivery. It can also be used to establish the evidence for the critical success factors of a program and build these into the program for greater consistency.

Any suitable evaluation framework needs to be logical, understandable and easily integrated into existing reporting processes. The evaluation framework chosen for MPSs in NSW is known as a Logic Model<sup>28</sup>.

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<sup>27</sup> NSW Department of Health (2008)

<sup>28</sup> "A logic model is a systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan, and the changes or results you hope to achieve". W.K. Kellogg Foundation (2004:1)

The Logic Model reflects the major resources (inputs – capital and recurrent funding) invested in the MPS. These inputs support a number of activities (determined as part of service planning for the establishment of the MPS) which can be measured both quantitatively and qualitatively (outputs), and will be the specific success indicators used to measure changes (outcomes) which are linked to the overall planned objectives (impact) of the MPS program. The success indicators identified in the logic model will be embedded into all service and capital planning documents associated with the MPS program in NSW. This framework aligns with the Results and Services Plan (RSP)<sup>29</sup>, which is a service delivery and funding plan currently used by NSW agencies reporting to Government.

This evaluation framework should contribute to reducing the diversity in the implementation of the model and support the ongoing success of an adaptable and innovative healthcare model in rural and remote communities. The success indicators within the framework have been linked to service outputs, some of which are already reported and some new indicators that capture the current deficits in reporting of accreditation, community involvement in decisions making, workforce retention initiatives and service innovation. However, the inputs of 'capital investment' and 'networked to rural health service hub' and the identified associated activities are currently not reported through that mechanism. Their inclusion should enhance both the reporting and future evaluation process.

A logic model template has been developed for the MPS evaluation framework, and populated to specifically reflect the relationships between specific MPS program inputs and activities that contribute to MPS program objectives planned impacts. This template is provided below:

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<sup>29</sup> NSW Treasury Circular: TC 07/12, 1 August 2007

**MPS Program Aim:** To integrate health and aged care in small rural communities to improve access to sustainable and responsive health services for the local community.

Inputs	Activities	Outputs	Outcomes	Impact
<ul style="list-style-type: none"> <li>Capital investment</li> </ul>	<ul style="list-style-type: none"> <li>MPS Committee establishment</li> <li>Establishment of Local Health Advisory Council (LHAC)</li> <li>Routinely undertake health service accreditation</li> </ul>	<ul style="list-style-type: none"> <li>Existence of endorsed Terms of Reference for MPS Committee</li> <li>Meeting frequency and participation</li> <li>MPS update included on LHAC meeting agenda</li> <li>MPS current accreditation status</li> </ul>	<ul style="list-style-type: none"> <li>Clear defined role of MPS committee members.</li> <li>Community and resident engagement in planning for MPS</li> <li>Residential aged care delivered in an appropriate physical environment.</li> <li>Awarded accreditation</li> </ul>	<ul style="list-style-type: none"> <li>Improved community participation in the planning of local health and aged care services</li> </ul>
<ul style="list-style-type: none"> <li>State revenue for acute, sub acute, emergency, outpatient and community care</li> </ul>	<ul style="list-style-type: none"> <li>Admission and access to hospital services and emergency care</li> <li>Minimal utilization of acute beds by NHTPs</li> <li>Provision of outpatient and community health services</li> </ul>	<ul style="list-style-type: none"> <li>Numbers of separations</li> <li>Number of ED presentations</li> <li>Proportion of acute beds with NHTPs</li> <li>Number of non admitted patient occasions of service</li> </ul>	<ul style="list-style-type: none"> <li>Less acute beds used by nursing home type patients</li> <li>Flexible use of nursing staff for acute and aged care</li> <li>Coordinated care teams for primary &amp; community care</li> </ul>	<ul style="list-style-type: none"> <li>Improved delivery of services through integration, coordination, and flexibility</li> </ul>
<ul style="list-style-type: none"> <li>Networked to rural health service hub</li> </ul>	<ul style="list-style-type: none"> <li>Provision of outpatient and community health services</li> <li>Provision of staff accommodation for visiting staff and students</li> <li>Joint training (nursing &amp; ambulance)</li> </ul>	<ul style="list-style-type: none"> <li>Number of outreach services</li> <li>Number of Telehealth services</li> <li>Residency levels of accommodation by type</li> <li>Number of courses and types</li> </ul>	<ul style="list-style-type: none"> <li>Appropriate referral for higher levels of care</li> <li>Reduce patient travel</li> <li>Reduce the number of avoidable hospital admissions</li> <li>Improved workforce recruitment and retention</li> </ul>	<ul style="list-style-type: none"> <li>Improved economic viability and cost effectiveness of service delivery</li> </ul>
<ul style="list-style-type: none"> <li>Commonwealth flexible funding for residential aged care</li> <li>Community aged care packages</li> </ul>	<ul style="list-style-type: none"> <li>Provision of residential aged High and Low care</li> <li>Care and support provided in the home</li> </ul>	<ul style="list-style-type: none"> <li>ACAT waitlist numbers</li> <li>Number of local residential placements and location</li> <li>Residential occupancy levels</li> <li>Proportion of home care packages used</li> </ul>	<ul style="list-style-type: none"> <li>Increased number of aged community members accessing care close to home</li> <li>Aged residents remaining independent in their homes longer</li> </ul>	<ul style="list-style-type: none"> <li>Improved access to health and aged care services available in the local community</li> </ul>

The template represents a generalized framework developed for the evaluation of MPSs in NSW. The outputs, or performance indicators not only reflect the planned outcomes of the MPS program but are linked to the critical success factors identified in earlier MPS evaluations and comprise elements of robust services planning, strong relationship with staff, management and the community and includes accountability mechanisms through the reporting component.

There is an opportunity to incorporate the evaluation framework linked to the Service Statement required to be completed at the end of the three year MPS funding agreements. This comprises of a review of the range of services provided by the MPS and the funding provided by the Commonwealth and State governments. This process enables changes in community needs over the funding agreement period to be captured and to propose any changes to services to be provided for the next three-year period. The NSW Health Department's Service Statement template (**Appendix 1**) has been amended and expanded to reflect the planned outcomes of the program as identified in past evaluations and the NSW strategic review, to incorporate the performance indicators.

# Resource Documents

## 15. Resource Documents

A range of resource material is available which can assist with MPS services. Where available, a web address has been provided to assist with accessing the material.

The supply of the following web addresses is for information only and does not imply endorsement of the sites.

NSW Health	
Fees Procedures Manual	<a href="http://www.health.nsw.gov.au/resources/policies/manuals/fees.asp">http://www.health.nsw.gov.au/resources/policies/manuals/fees.asp</a>
State Health Plan – A new direction for NSW	<a href="http://www.health.nsw.gov.au/pubs/2007/state_health_plan.html">http://www.health.nsw.gov.au/pubs/2007/state_health_plan.html</a>
Aged Care- Information Management/ Requirements/ Residential Aged Care Clients Accommodated/ Federal Funded Beds	<a href="http://www.health.nsw.gov.au/policies/PD/2005/PD2005_357.html">http://www.health.nsw.gov.au/policies/PD/2005/PD2005_357.html</a>
Fire Safety in Health Care Facilities – Guidelines	<a href="http://www.health.nsw.gov.au/policies/pd/2010/PD2010_024.html">http://www.health.nsw.gov.au/policies/pd/2010/PD2010_024.html</a>
VMOs in Rural Doctor's Settlement Package Hospitals Indexation of Fees from 1 August 2009	<a href="http://www.health.nsw.gov.au/policies/pd/2009/PD2009_079.html">http://www.health.nsw.gov.au/policies/pd/2009/PD2009_079.html</a>
Protecting people and Property: NSW Health Policy & Guidelines for Security Risk Management in Health Facilities December 2003	<a href="http://www.health.nsw.gov.au/resources/policies/manuals/protecting_people_property.asp">http://www.health.nsw.gov.au/resources/policies/manuals/protecting_people_property.asp</a>
NSW Dementia Action Plan 2007 - 2009	<a href="http://www.health.nsw.gov.au/policies/gl/2007/GL2007_025.html">http://www.health.nsw.gov.au/policies/gl/2007/GL2007_025.html</a>

<b>Aboriginal Health</b>	
NSW Aboriginal Employment Strategy	<a href="http://www.health.nsw.gov.au/policies/PD/2005/PD2005_120.html">http://www.health.nsw.gov.au/policies/PD/2005/PD2005_120.html</a>
NSW Aboriginal Mental Health Policy	<a href="http://www.health.nsw.gov.au/policies/pd/2007/PD2007_059.html">http://www.health.nsw.gov.au/policies/pd/2007/PD2007_059.html</a>
NSW Rural and Remote Aboriginal Nursing & Midwifery Strategy	<a href="http://www.health.nsw.gov.au/nursing/projects/aboriginal_nam.asp">http://www.health.nsw.gov.au/nursing/projects/aboriginal_nam.asp</a>
NSW Aboriginal Safety Promotion Strategy	<a href="http://www.health.nsw.gov.au/pubs/2003/ab_safety.html">http://www.health.nsw.gov.au/pubs/2003/ab_safety.html</a>
Aboriginal Health Impact Statement , 2007	<a href="http://www.health.nsw.gov.au/policies/pd/2007/PD2007_082.html">http://www.health.nsw.gov.au/policies/pd/2007/PD2007_082.html</a>
Communicating Positively, A guide to appropriate Aboriginal terminology, 2004	<a href="http://www.health.nsw.gov.au/pubs/2004/aboriginal_terms.html">http://www.health.nsw.gov.au/pubs/2004/aboriginal_terms.html</a>
NSW Aboriginal Health Strategic Plan	<a href="http://www.health.nsw.gov.au/pubs/1999/ahealthstrategic.html">http://www.health.nsw.gov.au/pubs/1999/ahealthstrategic.html</a>

<b>Mental Health</b>	
Caring for Mental Health. Better Mental health for the people of NSW	<a href="http://www.health.nsw.gov.au/policy/cmh/publications/caring_mh.pdf">www.health.nsw.gov.au/policy/cmh/publications/caring_mh.pdf</a>
Framework for Rehabilitation for Mental Health	<a href="http://www.health.nsw.gov.au/pubs/2002/rehabilitation.html">http://www.health.nsw.gov.au/pubs/2002/rehabilitation.html</a>
Sustainable Communities Network	<a href="http://www.sustainable.org">http://www.sustainable.org</a>
<b>Quality</b>	
Quality and Safety in Health Care Website	<a href="http://www.health.nsw.gov.au/quality/">www.health.nsw.gov.au/quality/</a>
Framework for Managing the Quality of Health Care Services in NSW	<a href="http://www.health.nsw.gov.au/policies/pd/2005/PD2005_585.html">http://www.health.nsw.gov.au/policies/pd/2005/PD2005_585.html</a>
The Clinicians Toolkit for Improving Patient Care	<a href="http://www.health.nsw.gov.au/policies/gl/2005/GL2005_062.html">http://www.health.nsw.gov.au/policies/gl/2005/GL2005_062.html</a>
Australian Resource centre for Healthcare Innovations (ARCHI)	<a href="http://www.archi.net.au">http://www.archi.net.au</a>
<b>Community and Consumer Consultation</b>	
Guidelines on consumer and community participation	<a href="http://www.health.nsw.gov.au/resources/gmct/guidelines_consumer_pdf.asp">http://www.health.nsw.gov.au/resources/gmct/guidelines_consumer_pdf.asp</a>
<b>Human Resources</b>	
Workforce Learning and Development Strategy for NSW Health	<a href="http://www.health.nsw.gov.au/policies/PD/2005/PD2005_113.html">http://www.health.nsw.gov.au/policies/PD/2005/PD2005_113.html</a>

<b>Australian Department of Health and Ageing</b>	
Multipurpose Services	<a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-services-mps-introduction.htm">http://www.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-services-mps-introduction.htm</a>
Residential Aged Care Manual	<a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-manuals-rcm-rcmindx1.htm">http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-manuals-rcm-rcmindx1.htm</a>
Aged Care Assessment Program - Operational Guidelines	<a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-acapopgu.htm">http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-acapopgu.htm</a>
Aged Care Assessment and Approval Guidelines	<a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-acapaag.htm">http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-acapaag.htm</a>
<b>Community Care Packages</b>	
What are CACPS?	<a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-brochure-ccp.htm-copy3">http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-brochure-ccp.htm-copy3</a>
What are EACH packages	<a href="http://www.health.gov.au/internet/main/Publishing.nsf/Content/ageing-commcare-comcprov-eachdex.htm">http://www.health.gov.au/internet/main/Publishing.nsf/Content/ageing-commcare-comcprov-eachdex.htm</a>
What are EACH Dementia packages?	<a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-eachd.htm">http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-eachd.htm</a>
National Program Guidelines for the Home and Community Care Program	<a href="http://www.health.gov.au/internet/main/Publishing.nsf/Content/hacc-pub_pg_npg.htm">http://www.health.gov.au/internet/main/Publishing.nsf/Content/hacc-pub_pg_npg.htm</a>
Viability Supplement Eligibility	<a href="http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-cacp-ruralremote.htm">http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-cacp-ruralremote.htm</a>

<b>Department of Ageing Disability and Home Care</b>	
DADHC Home Page	<a href="http://www.dadhc.nsw.gov.au/DADHC.htm">http://www.dadhc.nsw.gov.au/DADHC.htm</a>
Home Care	<a href="http://www.dadhc.nsw.gov.au/dadhc/homecare.htm">http://www.dadhc.nsw.gov.au/dadhc/homecare.htm</a>

<b>Department of Veterans Affairs</b>	
DVA Determining charges of CACP	<a href="http://www.health.gov.au/">http://www.health.gov.au/</a>
DVA Info on community support	<a href="http://www.dva.gov.au/benefitsAndServices/health/Pages/index.aspx">http://www.dva.gov.au/benefitsAndServices/health/Pages/index.aspx</a>
Veterans Home Care	<a href="http://www.dva.gov.au/benefitsAndServices/home_services/ve_tshomecare/Pages/index.aspx">http://www.dva.gov.au/benefitsAndServices/home_services/ve_tshomecare/Pages/index.aspx</a>
Veterans' Home Care Guidelines	<a href="http://factsheets.dva.gov.au/factsheets/documents/HCS01%20About%20Veterans%60%20Home%20Care.pdf">http://factsheets.dva.gov.au/factsheets/documents/HCS01%20About%20Veterans%60%20Home%20Care.pdf</a>
DVA Veterans Home Care	<a href="http://www.dva.gov.au/benefitsAndServices/home_services/Pages/index.aspx">http://www.dva.gov.au/benefitsAndServices/home_services/Pages/index.aspx</a>
DVA Home Modifications	<a href="http://www.dva.gov.au/BENEFITSANDSERVICES/HOME_SERVICES/Pages/home%20modifications.aspx">http://www.dva.gov.au/BENEFITSANDSERVICES/HOME_SERVICES/Pages/home%20modifications.aspx</a>
DVA Info for Health Providers	<a href="http://www.dva.gov.au/service_providers/Pages/factsheets.aspx">http://www.dva.gov.au/service_providers/Pages/factsheets.aspx</a>
DVA - Veteran Co-payment Arrangements	<a href="http://www.dva.gov.au/Pages/home.aspx">http://www.dva.gov.au/Pages/home.aspx</a>
DVA - Community Support Home Care and Support	<a href="http://www.dva.gov.au/benefitsAndServices/health/Pages/index.aspx">http://www.dva.gov.au/benefitsAndServices/health/Pages/index.aspx</a>

## 16. Glossary

**Aged Care Act** means the Commonwealth Aged Care Act, 1997 as amended from time to time and including all regulations and Principles there under.

**Aged Care Assessment Teams (ACATs)** help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance. ACATs provide information on suitable care options and can help arrange access or referral to appropriate residential or community care services such as Home and Community Care (HACC).

An ACAT assessment and approval is required before people can access Australian Government subsidised residential aged care (high or low), Community Aged Care Packages (CACPs) or Extended Aged Care at Home (EACH) packages delivered by an aged care provider recognised under the Aged Care Act 1997. As MPS providers are not aged care providers under the Aged Care Act 1997, there is no legislative requirement for an Aged Care Assessment Team (ACAT) approval to access any service delivered by an MPS.

**Aged care residents** are people who have been assessed by an ACAT as requiring Residential Aged Care and who have been admitted to the facility for residential care or respite.

**Authorised Body** means an authorised body for the purposes of the Aged Care Act 1997.

**Community Aged Care Packages (CACP)** are a planned and coordinated package of community care services to assist a person who requires management of services because of their complex care needs. A Community Aged Care Package is targeted at frail older people living in the community. These people would otherwise be eligible for at least low residential care. A CACP provides for home help, toileting, dressing or undressing, transfer, the provision and consumption of meals and refreshments, sensory communication or the fitting of sensory aids, gardening, laundry and short term illness.

**Entry Date** is the latest of the following dates:

- i. The date on which the Resident begins living and receiving Residential Care (not being respite care) in the MPS under this Agreement; or
- ii. If the Resident transfers from respite care to permanent accommodation in the MPS, the date of the transfer.

**Extended Aged Care At Home (EACH)** packages are individually planned and coordinated packages of high level care, tailored to help frail older Australians to remain living at home. They are funded by the Australian Government to provide for the complex care needs of older people.

**Extended Aged Care at Home Dementia (EACHD)** packages are individually customised packages of high level care tailored to help older Australians with dementia who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia.

**Flexible Care** is care that is provided outside the usual residential and community care settings in a flexible manner.

**HACC services** provide community care services such as: community nursing; allied health services; meals on wheels and day centre-based meals; home help; personal care; home modification and maintenance; transport; community-based respite care (mostly day care); education and/or training for service providers and consumers; assessment and/or referral services; information and advocacy services; social (including neighbour aid) support; and carer support.

**High level care services** are nursing type services and additional personal care services. They include: specialised furnishings and equipment items, such as those used to assist mobility, e.g. walking frames, wheelchairs, lifting devices basic medical and pharmaceutical supplies and equipment and aids to assist with toileting and continence management, nursing procedures, administration of medication, provision of therapy services, oxygen and oxygen equipment on a short term or episodic basis.

**Low level care services** are personal care type services. They include: assistance with the activities of daily living such as bathing, toileting, eating, dressing, mobility and communication certain treatments and procedures, including assistance with medication recreational therapy and rehabilitation support assistance in accessing health and therapy services and support for people who have difficulty understanding.

**MPS** (Multipurpose Service) means a service, which has a tripartite agreement between the Australian Government, NSW Health and the Area health Service for the provision of both health services and flexible care.

**Personal Information** means information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.

**Respite Care** means residential care or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangement. It does not include residential care provided through a residential care service while the care recipient in question is on leave from another residential care service.

**Service Plan or (Clinical Service Plan)** identifies the specific services and the manner in which they will be delivered. MPS are a flexible care service, and provide a range of services such as but not limited to: Acute care, Community health, Primary care, Residential aged care, Residential respite, Community care, Co located GP and Aged Day Care.

**Service Statements** outline changes in community needs that have been identified over the period of the 3 yr funding agreement, and proposes any changes to services to be provided for the next three-year period. This may include changes to the range of health services provided as well as increases in the number of flexible residential or community aged care places provided, or a change in the mix of places (for example the mix of high and low care).

**MPS Service Statement Template – Revised October 2009****New items included are underlined****1. Description of the Facility****1.1 Paragraphs including:**

Location (including location from other health service), including LGA etc, size and structure, management structure, partnerships with the community (e.g. Memorandum of Understandings (MOUs) with aged care hostels; partnerships with HACC providers). Is the facility used by other organisations within the community?

**2. Current service profile**

- 2.1 Acute Care Services –overview of activity and average occupancy (summary only)
- 2.2 GP and VMO services – frequency of visits and indicate whether co-located clinic
- 2.3 Aged Care Services - high/low care – average occupancy for each of the three years, flexible high/low community places average occupancy for each of the three years, level of palliative care and respite
- 2.4 Community Health Services (description only – frequency not required)
- 2.5 Outpatient services (if Telehealth available indicate numbers of occasions used)
- 2.6 New services introduced since last Funding Agreement
- 2.7 Staff accommodation – if available describe type and estimated level of occupancy/utilisation

**3. Changing community needs**

- 3.5 Population projections including age profile, indigenous status and numbers
- 3.6 Overview of Trends and Emerging Health Needs of the Population (e.g. Aboriginal health needs, ageing population, chronic illness) – summary only
- 3.7 Trends and Emerging Aged Care Needs of the population (e.g. ageing population, increasing care needs). Apply aged care benchmarks to projected aged population
- 3.8 ACAT data and Waiting List Information -trends in levels of care required by residents - any local information e.g. number of people having to leave community to access care & reason for relocation
- 3.9 Needs and priorities identified by the community- include description of local advisory processes and any community consultations and their recommendations and outcomes

**4. Proposed new services and configuration**

- 4.1 Role Delineation
- 4.2 Proposed Service Configuration- including acute services, flexible high care/low care residential places. Where additional residential places are proposed, evidence of availability of suitable facilities, such as conversion of existing acute care beds with low occupancy (this should be considered for occupancy levels less than 50%) or capital funding required to modify existing facilities. [It should be noted that increasing the number of aged care beds may increase the proportion of annual respite funding received from the AG]
- 4.3 How many flexible high/low Community Aged Care Services (CACPs and EACH) are required and description of how these will be provided (by the MPS or brokerage) with evidence of the MPSs capacity and readiness to deliver community care, and any brokerage arrangements in place
- 4.4 New community health services or outpatient services; new service providers; 'walk-in, walk-out' capacity
- 4.5 Proposed operating budget

**5. Summary**

Paragraphs providing a description and justification for any proposed change to MPS configuration based on population projections and changes in local health needs.

## **Certificate of Compliance**

Multipurpose Service (MPS): **[insert name of MPS]**

### **Statement of Compliance:**

"I certify for the above mentioned MPS that for the financial year ending [insert date]:

- (i) the Funds and Other Contributions received were spent for the purpose of the Project and in accordance with the Funding Agreement;
- (j) salaries and allowances paid to persons involved in the MPS were in accordance with any applicable award or agreement in force under any relevant Law on industrial or workplace relations; and
- (k) at the time the Annual Financial Report is provided to the Commonwealth, the [insert name of Approved Provider] is able to pay all debts as and when they fall due.

I acknowledge that under section 137.1 of the schedule to the *Criminal Code Act 1995* it is an offence to provide false or misleading information to the Commonwealth.

**\*Signed for and on behalf of [insert name of Approved Provider] by**

Full name

Position

Date

Signature

\*

The template must be completed and signed by the **Participant's Chief Executive Officer or Chief Financial Officer**, or a person authorized by the Participant to execute documents and legally bind the Participant by their execution.

## Annual Statement of Income and Expenditure

**Multipurpose Service (MPS): [insert name of MPS]**

Income and Expenditure Statement	Budget*	Actual*
<b>INCOME</b>		
State contribution (a)	\$	\$
Commonwealth contribution (b)	\$	\$
HACC contribution (if any) (c)	\$	\$
Other (d) Revenue from patient/client fees, aged care resident's fees etc	\$	\$
<b>TOTAL INCOME</b> (a + b + c + d) (e)	\$	\$
<b>EXPENDITURE</b> (for all MPS health and aged care services, excluding capital works)		
Total Salaries/Oncosts Expenditure (g)	\$	\$
Total Non Salary Expenditure (h)	\$	\$
<b>TOTAL EXPENDITURE</b> (g + h) (i)	\$	\$
<b>REMAINING FUNDS</b> (from b) (b)	\$	\$
Please provide comments about any changes in MPS income or MPS expenditure. (e.g. the MPS has only been operational for part of the year, changes in income from resident's fees; increased staff pay rates, a change in sub-contractor.)		
<b>Budget*</b> This refers to the agreed figure in your payment agreement (or contract). Each MPS manager and the AHS CEO have a copy. The "Budget" figure is intended to be a fixed reference point only. The term "Budget" is defined in the contract.		
<b>Actual*</b> The Commonwealth provides each AHS CEO with quarterly MPS payment advice letters containing details of the Commonwealth's funding contribution for each MPS in your Area. Copies are also mailed to each AHS's finance department.		



## **‘A WORKING MODEL FOR INTEGRATION’**

LINKING SILOS IN RURAL HEALTH

**Model Produced By:** Robin Haberecht  
Greater Southern Area Health Service

October, 2005

## ACKNOWLEDGMENTS

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The Australian and NSW State Governments for their accessibility, support and resource material provided to support this project;

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## EXECUTIVE SUMMARY

This project specifically targeted the Multipurpose Service (MPS) program. It recognised (from experience) that the program has generally been very successful, providing a broader range of services than the typical small hospital. The program's success has shown particular benefits for the provision of aged care services to local communities. However, the level of service provision, integration and flexibility varies between the multipurpose services. This can limit effective service delivery, access to services, continuity of care and coordination of services across the dimensions of care.

This variance to integration and flexible service provision has meant that some Multipurpose Services have not outgrown the traditional hospital concept and embraced the objectives of the MPS program. This affects sustainability of services and services being provided that are appropriate to the needs of the community. This Project explores the MPS program because this is currently the only formal program that supports integration for small rural health services.

By developing this model the project aims to support service integration at an operational level within small rural health services and, in doing so, provide more appropriate and sustainable services to meet community needs.

A Project Management Group guided project planning and progress. This Group included representation from the Greater Southern Area Health Service, Australian and State Governments, consumers, Charles Sturt University and the NSW Department of Ageing Disability and Home Care (DADHC).

It became apparent in the project's early stages that integration at an operational level should not apply to the MPS program alone – it could apply to *any* small rural health service that wished to pursue integration. This was because small rural health services were likely to have similar issues of sustainability and changing community needs as do other agencies servicing those communities.

### The Process of Developing the Model

Because this model is applicable at a national level, it was essential to research the structure of each state's health and human services sector, research current reviews of these services within the states, research material relevant to integrating health and non health services all with particular emphasis on rural health.

The project involved a combination of interviews, some site visits and surveys of 30 multipurpose services across Australia, each State health/human services department, consultation with the Australian Government and key stakeholders including the Department of Ageing Disability and Home Care (DADHC), community representatives, local government agencies, tertiary institutions and Divisions of General Practice.

The purpose of this research and consultation was to in the first instance identify the challenges or variances that affect a small rural health service's ability to integrate services. Then it was to identify those multipurpose services that were well integrated or had systems that would certainly support them integrating services more

effectively than others. Identifying the challenges to integration was essential when developing a model that could work nationally for a range of small rural health services across differing jurisdictional structures.

Two levels of integration were considered, the management and operational. Integration at a management level melds a range of services and resources (including financial allocation) under the one management structure. At an operational level, it involves:

- the actual service delivery components;
- how the services are provided; and
- co-ordination and planning between service providers so clients receive appropriate services in a co-ordinated and seamless manner which could also include the sharing of resources.

Ideally a service would be integrated at both a management and operational level which is the case with many multipurpose services. But from a practical sense due to many and varied reasons this is not always possible. As identified in the project research an organisation can be integrated at a management level but this will not guarantee that successful integration at an operational level where the outcome of that integration benefits the client will occur. Fragmentation, duplication and services operating in silos can continue.

Therefore, given the complexities that often exist in achieving a process of integration at both management and operational level, this project focuses on integration at an operational or functional level. Integration at an operational level between agencies is a practical approach that supports client centred care. It focuses on a coordinated, continuum of care and providing services based on the needs of the client.

## **Project Research Findings**

In developing the model there were essential features identified that would support effective integration. These were identified by project research and each has been applied in a practical sense. The essential features are chapters within the resource and form the process followed to achieve effective integration. These features are all common within multipurpose services researched that have been effective in facilitating integration and better practice within the MPS program.

What is interesting about these features is that they have all been applied regardless of the area health/regional or state structure. The features are explained in detail in their relevant chapters but their relationship to the integration process is explained broadly below:

### ***Primary Health Care***

Primary health care forms the basis of the model, the services that have progressed integration and continue to move forward have a strong primary health care foundation. Primary health care encompasses their services at all levels of the continuum. A primary health care focus has supported improved access for clients, expanded service profiles and supported the development of interagency partnerships.

### ***Setting health priorities***

Setting health priorities is about understanding the community receiving services, the development of a community profile developing a profile of the community including its strengths and weaknesses. Services that support integration undertake regular and continuing community assessments in different forms and engage relevant agencies and key players in local service planning processes based around the identified community needs.

### ***Leadership and Management***

Key players consistently identified that good leadership and management was essential to drive the process of integration, support change and to build productive and positive relationships with the community and other agencies.

### ***Service Delivery Models***

Service delivery models relate to the processes that support the range of care for clients and help them access different services. Service delivery models focus on client needs and a client-centred care approach. Service delivery models effectively adapt to local circumstances, help link services in a coordinated way and enhance communication processes for the benefit of the client and agencies.

### ***Community Participation and Partnerships***

All key players identified the importance of developing positive relationships with the community. Active community participation was seen in community profile assessment and continuing service planning. Community members themselves acknowledged that they were very willing to work with health and other agencies and believed that integration between agencies had only positive outcomes for all involved.

### ***Developing the Interagency Partnerships***

This chapter builds on the others discussed and gives some practical insight into identifying potential partnerships, and what to consider when attempting to develop partnerships. It also discusses the necessary components which ensure the partnership is productive and sustainable.

The foundation of this entire process is education. All who contributed to the information in this project identified education as the main driver underlying the successful implementation of each of the features in the model. When consulting with managers, it was very apparent and they were confident in acknowledging that they actively supported education processes for key players involved in their integration process.

Those who supported the concept of integration and wanted to work towards this process also acknowledged that education was needed across all components. This included community education as well as educating the workforce within agencies.

Consulting other stakeholders also contributed to the collection of information that validates these features and supports what is being achieved in health services that are successfully achieving an integration process.

An important consideration that needs to be acknowledged at the outset is that integration and changing how health does business is an evolving process. It must be well planned and takes time to implement. Integration is about moving forward and challenging the traditional boundaries that have developed across and between health services, other agencies and the community that impact on access and quality of care and create inefficiencies within the services.

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## INTRODUCTION

*'A Working Model for Integration'* is a practical resource designed to support the integration of health and related services within small rural communities. It provides information to support the process, details examples of successful initiatives and discusses the advantages of integration in the context of rural health in Australia. Anyone pursuing the integration of health services in rural communities can use this resource – clients, community representatives, agencies and health service providers including staff and management.

Rural health services are not unique in facing viability issues today. All rural communities are confronting challenges of economic and social sustainability. Challenges of providing and maintaining essential services to people within these communities so people can access services they need.

Rural communities have always been challenged by historical social, political and economic factors which affect services in these communities. The profile of the rural community is changing rapidly and as Dade Smith (2004) outlines, the population living in rural and remote Australia is as diverse as the country itself. This diversity is a result of government policy, post war trends and geographic isolation. Dade Smith also notes that the stereotypical 'wealthy farmer', often depicted in rural images is becoming extinct. Economic and environmental forces affecting the agricultural industry are having a major impact on the viability of many small rural communities.

The type and range of health services that have traditionally been provided within rural communities has also changed over time. Historically there were small hospitals built in nearly every town. Early funding of those services had a charitable focus, so hospitals became the centre of rural community fundraising efforts and volunteer support. This has led to a strong sense of ownership within rural communities.

Increasing complexity of health care, attention to patient safety, reduced length of stay for hospital inpatients, increased and changing technology, more specialist medical and nursing care and changes in the professional workforce have led to a shift in the role of small rural health services with many services facing issues of viability and some health services at their current service level, no longer adequately meeting the needs of their local communities.

The Multipurpose Service Program (MPS) was introduced in 1993 by the Commonwealth Government in partnership with State Governments to help address the problems of sustainability and access to health services in small rural communities.

The Commonwealth Government (2002) in its Multipurpose Services Model document outlines that the MPS program was a response to a range of issues affecting health service provision in small rural communities such as:

- decreasing populations and changing demographic needs in rural communities;
- difficulties in maintaining economic viability of country hospitals and the ability of those hospitals to deliver discrete and cost effective services to small populations;

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- isolation of services from mainstream services;
- inability of small rural communities to provide viable nursing home facilities resulting in the elderly leaving their community or entering into the local hospital;
- duplication of limited infrastructure and resources;
- rigid program guidelines and accountability restricting flexibility and coordination opportunities within rural communities;
- difficulty in attracting and retaining staff.

The program has provided the opportunity to pool Commonwealth, State health and aged care funds and apply these funds across all health and aged care programs according to community need. The Commonwealth Government objectives of the MPS program are:

- to improve access to a mix of health and aged care services that meet community needs;
- to provide more innovative, flexible and integrated service delivery;
- flexible use of funding and/or resource infrastructure;
- integrated service planning;
- improved quality of care for clients; and
- improved cost effectiveness and long term viability of services.

The MPS program now operates in all states of Australia but not yet in the Northern Territory. To date there are 86 approved multipurpose services operating and there are a number of communities in varying stages of developing MPS models.

Service integration and flexibility of service provision are the main features of the MPS model. The fact that various rural agencies have similar sustainability issues aids integration between these agencies and improves services access – a cornerstone of the MPS model.

In 2000 Chapman and Neumayer completed a review of a range of Multipurpose Services in NSW to compare their effectiveness against the traditional small rural hospital in providing appropriate and effective health services. The review found that generally Multipurpose Services provided more effective health services to rural communities than did traditional hospitals.

The results identified that an MPS was more flexible in service delivery and generally provided a greater range of appropriate services. The review also identified that one of the constraints to effective service delivery was when other agencies did not integrate or co-locate with the MPS.

The NSW Ministerial Advisory Committee completed a report on health services in smaller towns in 2000 for the NSW Minister for Health. This report highlighted that to improve access and provision of quality health, aged care and human services in small rural communities there needed to be a collaborative approach between government and non government providers. Many rural towns have difficulty supporting stand-alone services due to their small and dispersed populations therefore, integrated and flexible service delivery models adapted to meet the needs of individual communities was required.

Widely known as the Sinclair Report, it identified five obstacles to providing effective health and related services to small rural communities:

- inappropriate service models that no longer meet community needs;
- absence of public transport and limited community transport;
- lack of co-ordination and planning between different service providers across health, aged and human service sectors;
- difficulty attracting and retaining health professionals;
- the need for improved communication between levels of government, management, health professionals and the community.

The Sinclair Report also identified that integration of health and other human services could not only provide a more effective and comprehensive range of services but would also improve use of existing resources.

The NSW Department of Health (p. 2, 2004) in its document entitled *In All Fairness*, acknowledges that partnerships are essential for effective action to address health inequities within the health system itself, within local communities and other government and non government agencies. The Department of Health suggest that integration supports an equity approach which recognises that:

- not everyone shares the same level of health or level of resources to improve their health;
- in working towards more equitable health, it is important to respond to people with differing need in different ways.

### **The Health of Rural People**

Some 34% of Australians live in regional and remote areas in a range of diverse environments but all live some distance from major population centres. These people have higher levels of health risk factors and higher mortality rates than people in urban areas (Australian Institute of Health and Welfare 2004).

Rural people are more likely to be smokers, drink alcohol in hazardous quantities, to be overweight, less physically active, have lower levels of education, poorer access to skilled employment and less access to a range of health and medical services. Rural occupations also present higher risks and travelling on rural roads can be more dangerous (Australian Institute of Health and Welfare 2004).

The health of rural people is a necessary consideration at a national level and for rural service providers and their communities in the context of not only health service planning but planning of other services and allocating resources across those communities. This emphasises that a focus on primary health care underpinned by the social, economic and environmental influences of health and quality of life reflecting the changing environments of rural communities is required.

Neumayer & Chapman (2003) comment that one of the major issues for rural health providers is how to best meet the needs of older adults and support access to and provide quality aged care for older people. Another is the complexity of chronic disease management and associated aspects of health and wellbeing influenced by social, cultural and environmental factors. These issues require a range of agencies and services providing care in a seamless, accessible manner with a focus on the

concept of primary health care to successfully encompass far reaching health and quality of life issues.

## **The Rural Culture**

According to Dade Smith (p. 2004) rural people have a belief in the benefits of hard work and they generally share an attitude of optimism and stoicism. They have a different view of health than their urban counterparts, they see health as the absence of disease, wellbeing is linked to productivity and being able to carry out daily tasks. Rural people view health services as curative services and are less likely to access a particular health service until they are unwell rather than as a preventative option.

In contrast to this view of health, Indigenous Australians say that they have no word for health. Dade Smith cites Johnson (1992) as finding that generally, Indigenous groups emphasise the spiritual aspects of a person, physical appearance, their relationship to the land and the absence of alcohol. Indigenous Australians relate health to those issues that influence and control their destiny which supports a more holistic and social approach to health and wellbeing. Again this approach to health lends itself well to the concept of primary health care.

As already outlined, the rural culture is very diverse for many reasons and many characteristics differentiate the rural persona from the urban. There are often distinct divisions between certain groups within rural communities and there are systems of social status characterised by wealth, length of time in the community, reputation, social standing and religion. There is an increasing mix of cultural groups in rural areas so these communities no longer live in an insular world (Dade Smith 2004). Tolerance and respect for other cultures can be challenging.

One of the many generous characteristics of the rural culture is the rural community's self reliance and the ability to take care of people and conditions within the community. Rural communities take good care of each other and do look out for those that may be disadvantaged in some way. However, a crucial factor which affects the level of self reliance and how communities take care of themselves is the poor or ageing infrastructure within communities.

Accounting for rural culture is needed, because the culture of values and beliefs of a community affect its sustainability. Health services and other agencies must consider the cultural aspects when prioritising, planning and allocating resources for services provision.

The management and provision of rural health services is both rewarding and challenging in its broadest sense. The mix of services provided can be many and varied. But access to appropriate services can be difficult for the client due to a range of factors unique to the rural environment. There is often duplication and fragmentation of services which can adversely affect a person's experience with the service, their continuity of care and potential outcome of care.

## THE CONCEPT OF INTEGRATION

The concept of integration is discussed widely and there are a number of theories relating to its different levels, meanings and application. Regardless of the definition applied, service integration is a key theme of government and non government agencies to support more effective provision of services and use of resources.

In the rural health environment it is becoming increasingly difficult for people seeking access to services and/or care, to find their way through the complex array of services provided by a range of agencies all functioning quite independently of each other and possibly located or sourced from a number of locations. It also becomes challenging for service providers to support, refer and guide people through different spheres of care.

Several factors highlight the need for integration. Limited resources due to the social infrastructure, limited numbers of health professionals, the continuing knowledge explosion and the necessity to remove as many burdens from those finding themselves needing health care, make the process of integration the only vision of how health services should be provided (Schneider 2004).

Schneider neatly sums up those issues impacting on the provision of health and related services to people within rural communities and identifies that these issues are also affecting the workforce and how services are provided. One of the biggest burdens impacting on clients requiring health care and on service providers in rural areas is the ability to access appropriate services. This ability will impact on the clients experience with the service, the quality and outcome of care. Health service providers and partner agencies have a responsibility to support clients accessing services by facilitating seamless and coordinated approaches to service delivery and care.

### Integration Defined

***Integration is Agencies working together in collaboration and/or partnerships to enable more effective service delivery for the benefit of service users and carers.***

***(United Kingdom National Health Service 2003)***

This definition does not focus on the management level of integration but recognises that collaboration and partnerships support the best possible outcome for the client. Integration defined in this context supports a functional process between agencies and service providers at an operational level. The key words in this definition are described in the following table:

<b><i>Agencies</i></b>	Agencies are organisations and the people within them who provide care and support to maximise health, wellbeing and consequently quality of life. Agencies may be internal or external to health services but they have a common purpose in providing support and/or care to a client.
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<b><i>Collaboration</i></b>	Collaboration is when two or more people or agencies with skills that complement each other's purpose, work together to achieve a common goal.
<b><i>Partnership</i></b>	A partnership is when agencies or people join together in a shared or mutually beneficial formalised relationship working towards a common goal.
<b><i>Effective</i></b>	To be effective is to accomplish a goal or to produce an intended result.
<b><i>Benefit</i></b>	A benefit is an outcome that aids or promotes wellbeing.

### **The Commitment to Integration**

There are four essential components that agencies must commit to which will support the integration process between them, these components are described below:

<b><i>Interdependence</i></b>	Interdependence recognises that agencies don't individually have the resources and skills to provide all aspects of care and support that is needed by a client. Agencies recognise that they are reliant on each other, they solve problems together and a sharing exists between them.
<b><i>Co-operation</i></b>	Co-operation occurs when agencies have a common purpose and share the same values. Agencies positively assess the work of each other, share expertise and coordination of tasks. Agencies willingly acknowledge that each has an equal level of importance and they continually assess and evaluate the value of their partnership.
<b><i>Co-ordination</i></b>	Co-ordination is the process that guides the relationship between the agencies. It involves a strong will to make the system operate and to organise the behaviour of the agencies involved. Co-ordination is the formal process that supports integration such as policies, formal agreements, guidelines and organisational structures etc.

<b><i>Trust</i></b>	Trust involves the willingness to put behind past differences, share information openly and to move forward sharing the same values. With trust comes the willingness of agencies to respect each other and the contribution that each makes.
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### Factors that Influence the Capacity for Integration

It is important to acknowledge that there are many factors that vary the capacity for integration of both internal health services and those external to health. It is also important to consider the MPS model and its objectives discussed earlier as these objectives focus on integration which can be limited by these factors.

As part of this project research has identified the following factors that influence a health services capacity for integration. These factors are outlined in four categories being ***political, attitudes, knowledge and community***:

<b><i>Political</i></b>	<ul style="list-style-type: none"> <li>▪ Australian and State Government funding and responsibilities;</li> <li>▪ State Government structures;</li> <li>▪ area/regional health service structures;</li> <li>▪ the relationship between health and non health agencies;</li> <li>▪ the relationship between government and non government agencies;</li> <li>▪ industrial relations.</li> </ul>
<b><i>Attitudes</i></b>	<ul style="list-style-type: none"> <li>▪ the focus of health professionals, community and other agencies on an illness or institutional model of health;</li> <li>▪ a focus on provider needs and not those of the client;</li> <li>▪ professional boundaries and remoteness;</li> <li>▪ physical boundaries and environments within organisations that promote silos;</li> <li>▪ differing levels of transparency;</li> <li>▪ a willingness of providers to share power and decision making.</li> </ul>
<b><i>Knowledge</i></b>	<ul style="list-style-type: none"> <li>▪ a well developed understanding of the community and its strengths/needs;</li> <li>▪ differing service roles and responsibilities;</li> <li>▪ the capacity for innovation;</li> <li>▪ the primary health care concept and its relationship to rural health;</li> </ul>

	<ul style="list-style-type: none"> <li>▪ an understanding of the social influences of health and wellbeing;</li> <li>▪ a holistic approach to care and service provision focussing on client/population needs;</li> </ul>
<b>Community</b>	<ul style="list-style-type: none"> <li>▪ the level of community participation in service planning, priority setting and service provision;</li> <li>▪ the level of community capacity;</li> <li>▪ the ability of management to develop productive partnerships with the community, key players and other agencies;</li> <li>▪ provision of information that is relevant to communities to enable them to make informed decisions relating to health service priorities.</li> </ul>

These factors influencing an integration process are real and must be carefully considered. Planned strategies, continuing monitoring and evaluation processes are required to help overcome or address these factors. The process of integration within health services and between health and non health agencies must be a well defined and planned process.

### **The Benefits of Integration for Small Rural Communities**

Long term sustainability of appropriate services and access to services are challenges affecting the health and welfare of small rural communities. The issues that impact on a communities sustainability have already been discussed. Integration of health and non health agencies has many benefits that support sustainable services for communities. These benefits include:

- improved access to services and a wider range of services;
- improved quality of health and wellbeing outcomes;
- improved understanding of services roles and responsibilities;
- joint planning and prioritising;
- increased co-operation between agencies;
- sharing of resources;
- reduced fragmentation and duplication of services;
- innovation;
- cost efficiencies;
- access to different funding options;
- capacity for improved information management infrastructure;
- a sustainable workforce;
- improved community capacity and cohesion;

### **Integration Supporting Aged Care Clients**

The integration process in this resource does not specifically target individual services but services as a whole. In saying this it is important to acknowledge and consider throughout the resource the benefits of integration for aged care clients who

are largely represented across all services and within all agencies in local communities.

Aged care clients whether in residential care, acute care or receiving community based services have much to gain from integration between agencies. Home and Community Care Services (HACC), Community Aged Care Packages (CACPS), low level care/hostel, high level residential care, transitional care services, primary health care services and respite care options all have a crucial role to play in providing quality and continuity of care to aged clients.

The fact that these services can operate quite independently from each other both locally and externally to communities, only compounds the difficulties of access, appropriate care and quality outcomes already experienced by many aged clients and by those who will potentially access services.

Within a health service that has a high level of integration and flexibility of service provision, access to a range of services is enhanced for aged clients. Continuity of care exists for these clients, ageing in place is supported and there is a higher emphasis on multidisciplinary planning with less fragmentation between services. As care needs change there is a more seamless and easier transition through the different levels of care and quality of life is significantly enhanced.

When studying this resource consider carefully the impact that service fragmentation and professional boundaries have on the ageing population within a rural community that in reality is also experiencing economic and social issues that compound service access issues. Consider also the benefits to these people if agencies could form positive partnerships and provide services in a more integrated environment.

### **The Process of Integration**

Working in an integrated way relies on a range of factors and it's acknowledged that there are challenges/variances the influence an organisation's ability to do this. However, integration is necessary to support future sustainability of services for rural communities and it is a process that is achievable at an operational level. Several key factors influence its success: agencies and the community shifting their focus to primary health care, seeking positive community participation, the willingness and ability of management to drive the process in partnership with the community.

Integration is a joint responsibility of health services and agencies that share a common purpose of maximising the health and wellbeing of their communities. These agencies and key players have the capacity to integrate and/or influence the way services are provided. Key players in the process include:

- health services;
- the consumer and wider community;
- primary care providers such as allied health professionals, community health services, general practitioners, health promotion units;
- complimentary medicine providers;
- divisions of General Practice;
- community care and social service agencies;
- local government;
- aged care service providers;

- private sector agencies;
- tertiary institutions;
- schools.

The process not only involves services situated or based within the community itself but also those who provide outreach/visiting services and agencies that provide services to the community from another location.

### **The Features that Support the Integration Process**

The project research has identified essential features that support an integration process, these features are all common in multipurpose services that have progressed integration or are attempting to enhance integration. What is interesting about these features is that they have been applied regardless of the area health/regional structure and have not necessarily been influenced by ‘cashing out’ particular services.

The features of integration outlined in the following chapters will guide the process. They are all interrelated and complement each other. They cannot be implemented individually but must be considered collectively. Each feature has been studied and applied in the context of rural health in Australia.

The chapters provide an overview of the feature, why it’s important, the relevance to integration and how it can be implemented. Many resources have been utilised in the development of this model, some of these are listed at the back of this resource and can be used to access further information. The following chapters comprise the Working Model for Integration and guide the process;

**Chapter 1:** Primary Health Care

**Chapter 2:** Setting Health Priorities

**Chapter 3:** Leadership and Organisational Culture

**Chapter 4:** Service Delivery Models

**Chapter 5:** Consumer/Community Participation and Partnerships

**Chapter 6:** Developing Interagency Partnerships

## CHAPTER 1: PRIMARY HEALTH CARE

Primary health care is commonly known as the front end of the health care system. It can include a range of primary care and community care services and it is generally the first point of contact for people seeking help with their health (Harris & Simpson 2003). The primary health care system is where most people will receive most of their health care most of the time.

Primary health care is an essential component of the health care system and often the least understood by communities and health professionals, in particular those health professionals who are more hospital or treatment oriented. Being at the front end of the health care system primary health care is critical to service access, quality of care and quality outcomes of care.

The National Rural Health Alliance (NRHA) supports rural health services in taking a primary health care approach. Primary health care is one of its six principles in implementing Healthy Horizons 2003 – 2007. This principle is acknowledged by the NRHA because it supports people to keep healthy within the community setting and to intervene at the earliest possible stage to support and maintain good health. Primary health care also equips people with the skills to manage and maintain their own health.

Providing adequate and appropriate services at the ‘front end’ of the health care system affects services and outcomes throughout the system itself. Inadequate provision of primary health care creates a higher burden of care and impacts on resource allocation across all levels of the health care system. Primary health care represents a vital link within rural health services and the wider community. It can strengthen existing rural health services by:

- broadening the range of services available;
- reducing service fragmentation and duplication;
- improving service access;
- supporting continuity of care; and
- information management.

Agencies providing primary health care can include:

- the local health service;
- general practitioners;
- aged care providers;
- divisions of General Practice;
- allied health professionals;
- complementary medicine providers;
- community health services;
- pharmacies;
- local government;
- community care/social service agencies;
- schools;
- sporting organisations;
- health promotion/public health units.

## How Can Primary Health Care Support Integration?

Traditionally, primary health care was not seen as a core role of rural health services or small hospitals. In many regions, primary health care has been managed and provided quite separately from the local hospital/health service. This resulted in fragmentation and duplication between rural health services, primary care services and community care agencies. A focus on primary health care and its integration across the health sector *is* needed, to reduce fragmentation and duplication and create a more client focused, transparent and accessible services (Harris & Simpson 2003).

### ***Upper Murray Health and Community Services (UMHCS)***

*UMHCS in Victoria is a highly integrated Multipurpose Service and demonstrates the far reaching benefits of a focus on primary health care. By focussing on primary health care and having the capacity for flexible use of funding under the MPS program, UMHCS has effectively expanded its range of services to meet identified needs of the community.*

*As a result of recommendations from an evidence based needs assessment, a strong relationship has been built between the MPS and local government to initiate public health programs and support healthy public policy. One particular public health program conducted in partnership by the two agencies has been a cardiovascular disease prevention program. This program aims at increasing the opportunity for community members to participate in a variety of activities including triatholons, identifying smoke free restaurants and the development of a mini gymnasium for staff and community use.*

*The local general practitioners have engaged in a pilot project called Active Script. This involves an activity self-assessment undertaken by the GP and an activity program being prescribed for the client to benefit their health status if required. A community directory of active programs has been developed to assist the GP's in making appropriate referrals.*

*UMHCS has been committed to the primary health care principles of the Healthy Horizons Framework demonstrating a high level of responsiveness to community needs across all service areas.*

Because primary health care involves many different sectors, including the health sector, it encompasses everyone organisations and people within a community and addresses the main issues of health and wellbeing. Appropriate primary health care needs the collaboration and partnership of a range of agencies in any community.

Primary care services and health promotion are components of primary health care. To provide effective primary care and health promotion requires many sectors working in partnership utilising a mix of interventions and capacity building strategies to address priority health and wellbeing issues.

### ***Tasmanian Multipurpose Services***

*The health services of West Tamar, Campbell Town and Tasman are not located in close proximity to each other and have varying structures and funding models. The Tasman health service, for example, is managed and funded under local government.*

*They each have varying types of primary health care services including community care services such as HACC/home care and social services not necessarily under their management structure and many services outsourced from other larger centres. But they all share a commitment to primary health care and actively engage all external and internal primary health care providers in all aspects of planning and service provision.*

### ***Ottway Health – Victoria***

*Ottway Health in Southern Victoria has grown from a small disparate group of separately managed and delivered services to an integrated service with significantly expanded primary health care services provided in a coordinated and client centred manner. A population health philosophy guides the service and demonstrates that an orientation to primary health care can expand the range of services meeting community needs and improve access without the loss of traditional services.*

Understanding what primary health care means and what it intends to achieve takes not only the health professional but the consumer and partner agencies away from an illness model to a focus on wellness, disease prevention and quality of life. It enables service providers to identify the factors collectively within a catchment population that affect its health and wellbeing.

### ***South West Healthy Communities Project***

*This Western Australian project partners the Australian Government Department of Health and Ageing, the Peel Division of General Practice and the South West Area Health Service. Located in rural communities across the South West, it works with communities, helping them to consider how social environments and lifestyle factors influence health.*

*The project works with communities to:*

- *strengthen partnerships between service providers and community members;*
- *achieve shared understanding about the state of health within communities;*
- *consider factors in the social and physical environments that may be promoting ill health and/or disease;*
- *identify and build on assets in the social and physical environments that can promote wellbeing;*
- *develop a plan of action to promote the long term health of the community; and*
- *increase community self reliance.*

*The project emphasises health as more than the absence of disease it is about optimal wellbeing. It includes a sense of both belonging to a community and being in control of your circumstances and life. A healthy community builds and shares a culture that supports healthy life choices and high quality of life.*  
(Healthy Communities Project 2004)

Primary health care supports the coordination of care across the whole health and community environment, particularly in rural areas where access to services can be limited. Such co-ordination strengthens existing services by bridging gaps between services and improving communication between agencies. Health care providers and communities must acknowledge that a primary health care foundation emphasising collaboration and partnerships between agencies is essential for appropriate and sustainable services to rural communities.

### **Australian Health System Reform Influencing Primary Health Care**

The Australian Health Ministers Advisory Council in 2002 as cited by Harris & Simpson (2003) outlined that advances in medical technology, the ageing population and the increasing number of people with chronic and complex illnesses have not only influenced the type of services provided by small rural health services but have created increasing demand for community based services.

These factors combined with the increased knowledge of consumers and political influences are causing pressure on the health care system for expansion and reorient primary health care services to meet these changing and complex needs of the consumer.

Primary health care views the health and wellbeing of individuals and populations as a whole, encompassing a social model of health. Both are affected by the social, economic, political and environmental conditions within communities. In Australia, evidence increasingly indicates a widening gap between advantaged and disadvantaged people which is dramatically affecting the health and wellbeing of those disadvantaged including people within rural and remote areas (Government of South Australia 2004). The challenge for government and non government agencies is how to address this issue.

Another major factor which emerges throughout this resource is access to services and care. The difficulty of access is more apparent in rural and remote areas and for those people who are disadvantaged. It is recognised within Australia that primary health care can support improved access to a range of comprehensive health services. This does not only mean physical access or availability of locally based services but also a broader range of services supported by regional centres, networks and tele-health initiatives.

Access to primary care and primary health care services is crucial to a well functioning health system. It is not only about medical care but also the community care, social services, environmental and other support services which are often very unevenly distributed (Duckett 2004). Poor access and quality of care at this first point of contact will inevitably affect service provision throughout the system.

The Healthy Horizons Outlook 2003-2007 is a framework for improving the health of regional, rural and remote Australia. This framework stresses the necessity for a broader approach to health issues recognising the importance of collaboration with local communities and other services to address underlying causes of ill health rather than simply providing the means of treatment.

The traditional hospital or institutional/illness model does not suit a primary health care approach in rural health. The stand alone hospital model does not seek active partnerships within the community and therefore cannot adequately understand and address the community's needs. No one sector or agency can deal with the social model of health and its influences on health and wellbeing, this requires a collaborative partnership with a range of agencies and stakeholders across a variety of government and non government sectors.

There are major reforms occurring across all states in Australia with an increasing focus on primary health care particularly in rural health. Harris & Simpson (2003) in the University of New South Wales Consultation Report Strengthening Health Care in the Community, outline that international research shows countries with a strong primary health care infrastructure had lower health costs and generally healthier populations.

The above mentioned report also recognises that primary health care in those countries is characterised by:

- fairer distribution of resources;
- fewer barriers to service access;
- increased provider choice;
- long term relationships between clients, families, communities and providers;
- integration of services.

Increasing emphasis is rightly placed on client needs. Recent interstate reviews of rural health have identified the need for services closer to home and expanded, accessible home-based services for clients. An increased primary health care focus facilitates this concept and information technology advances can support it. Health services (such as Upper Murray health, Ottway health, the Tasmanian services and many more), evidence how effective primary health care integration can support more people in their own home environment reducing many inpatient and residential care demands.

Adopting a primary health care approach does not exclude the need for acute inpatient services. It recognises that small rural health services have an essential role and responsibility in providing primary health care throughout the entire episode of care and experience with the health care system. Thinking more laterally about service provision and the role that other non health agencies and the community can play in complimenting health services can pay dividends. Small rural health services are predominately the front end and first point of contact for people with the health care system therefore their role is crucial in this area.

The Council of Australian Governments (COAG) in its 2004 Report on Government Services, outlines its objectives to provide primary and community health services which must be considered when discussing primary health care in the Australian

context. COAG states that primary and community health services aim to promote the health of Australians by:

- acting as the first point of entry to the health care system;
- providing health care that promotes changes in lifestyle behaviour and prevents possible illness;
- coordinating and integrating health care services on behalf of clients;
- providing continuity of care;

This will be achieved in an equitable and efficient manner based on the best available evidence of the effectiveness of health care interventions.

### **Guiding Principles for Reorienting to a Primary Health Care Focus**

Experience shows that reorienting health services to a primary health care focus can be challenging for many rural health services. This requires effective leadership and a cultural change for not only health professionals but also the local community, other agencies and key players.

When considering primary health care and understanding what it involves, it becomes easier to appreciate the essential role that small rural health services play in supporting and providing primary health care and how it becomes a whole of community responsibility.

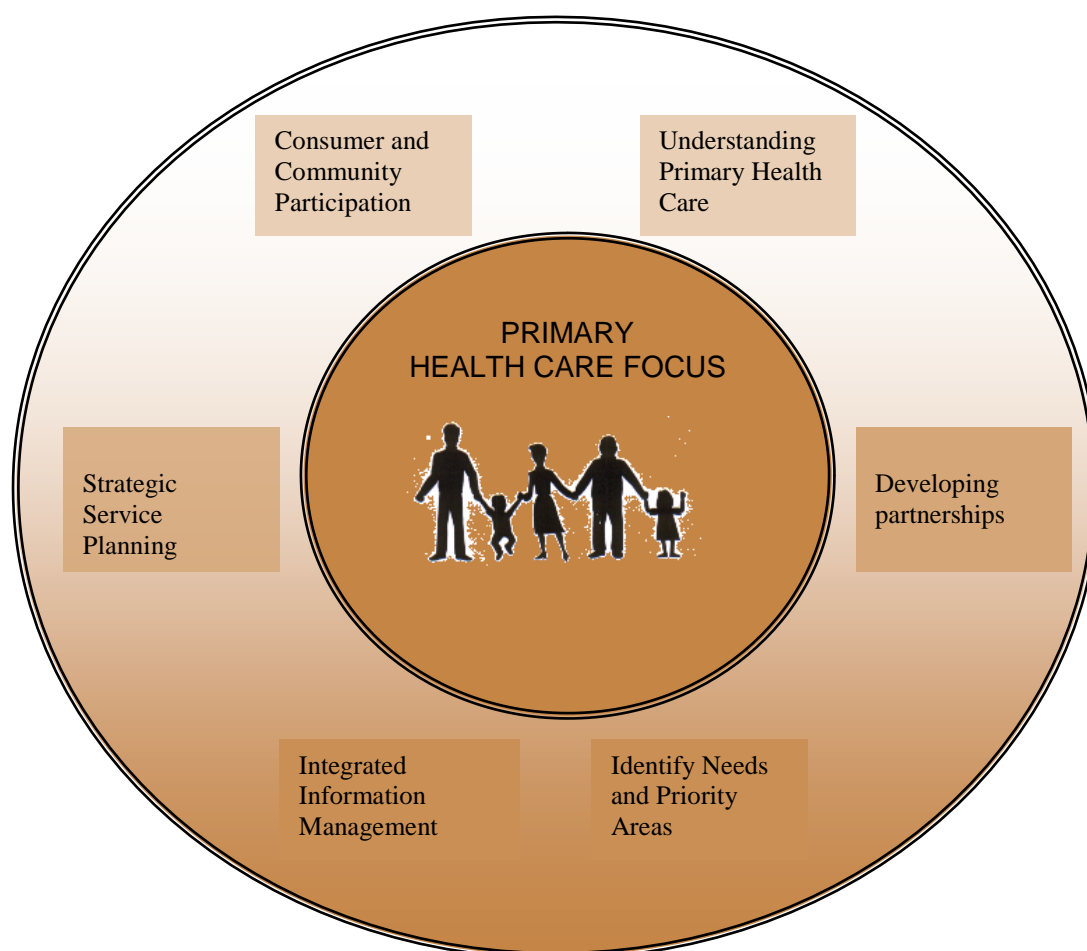
The following guiding principles are designed to support rural health services and their communities to reorient their approach. These principles have been developed from researching resources and initiatives that have been developed in the context of primary health care:

<p><b><i>Understanding the concept of primary health care</i></b></p>	<ul style="list-style-type: none"> <li>▪ educate health service staff, community, key players including other primary health care providers;</li> <li>▪ identify workforce development needs based on the social model of health;</li> <li>▪ understand the social model of health and those factors that influence the health and wellbeing of the community from a national, state and local perspective;</li> <li>▪ recognise joint responsibilities for primary health care between all agencies including hospital and community health staff;</li> <li>▪ emphasise prevention, promotion and management of chronic disease and the transition from hospital to community care;</li> <li>▪ emphasise supporting people in their own home environment, as apposed to the hospital or residential environment;</li> <li>▪ extend the skills and competencies of service providers to promote a more flexible workforce;</li> <li>▪ develop knowledge and understanding of the roles and responsibilities of other agencies within the community.</li> </ul>
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<p><b><i>Developing Partnerships</i></b></p>	<ul style="list-style-type: none"> <li>▪ identify agencies that are key players;</li> <li>▪ educate key players;</li> <li>▪ identify the partnership purpose and how it can improve quality of care;</li> <li>▪ develop formal agreements outlining the roles and responsibilities of the partner agencies;</li> <li>▪ multi-disciplinary teams and established clarity of roles and responsibilities;</li> <li>▪ continuing strategic, service planning and evaluation between all partner agencies;</li> <li>▪ promote the partnership within the community and the benefits of the partnership.</li> </ul>
<p><b><i>Identify needs and priority areas</i></b></p>	<ul style="list-style-type: none"> <li>▪ in conjunction with the area health service/region – determine the core range and level of services that can be provided and expected within the community;</li> <li>▪ look beyond health services to what is happening in the broader community;</li> <li>▪ access data and evidence to support the need for action in particular areas and what is likely to affect sustainable change, local government can play a major role in this area;</li> <li>▪ consider the differences in gender and culture which influence health behaviour and beliefs within the local community;</li> <li>▪ support joint tasks, initiatives and projects between agencies.</li> </ul>
<p><b><i>Integrated Information Management</i></b></p>	<ul style="list-style-type: none"> <li>▪ develop and utilise common practices, processes, protocols and systems to integrate the way in which clients come into contact with services to enhance communication and continuity of care;</li> <li>▪ formalised multi disciplinary care coordination processes and planning between health and non health agencies to reduce duplication and promote a primary health care approach;</li> <li>▪ have a clearly documented discharge policy and process that supports discharge arrangements and referrals between agencies;</li> <li>▪ develop strategies for active, consistent and appropriate communication with the local community including feedback processes. Information can include: <ul style="list-style-type: none"> <li>- service profiles and access</li> <li>- health priority information</li> <li>- the needs and gaps in service provision</li> <li>- services planning and solutions to identified needs and gaps</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>- the roles and responsibilities of all partner agencies</li> <li>- the health and wellbeing profile of the community.</li> </ul>
<b><i>Strategic Service Planning</i></b>	<ul style="list-style-type: none"> <li>▪ integrate planning across sectors involving consumers and key players;</li> <li>▪ ensure primary health care presents a core component of strategic planning within each agency and between agencies. This will enhance the integration process reducing structural and professional boundaries which can jeopardise reorienting to primary health care;</li> <li>▪ planning must be based on evidence of local, state and national health priority areas.</li> </ul>
<b><i>Active consumer and community participation</i></b>	<ul style="list-style-type: none"> <li>▪ enable and encourage people to have input into what influences their health and wellbeing and what could make a difference to them;</li> <li>▪ empower people by providing them with information and skill development to understand what promotes health, wellbeing and illness and to be able to mobilise resources to take control of their own lives;</li> <li>▪ help ensure that every individual, family and community group can benefit from primary health care within the community;</li> <li>▪ active community participation in strategic planning;</li> <li>▪ provide honest, appropriate and adequate information to the community to promote a relationship of trust and respect;</li> <li>▪ community ownership and participation are important success factors in sustaining outcomes.</li> </ul>

**The Guiding Principles Reorienting to a Primary Health Care focus**



Primary health care emphasises a *population health approach*. Which recognises that to achieve improved health and wellbeing, an understanding of the needs and situations of different population groups or communities is required. This can highlight health and wellbeing inequities between and within different groups and strategies can be targeted to these groups (Victorian Department of Human Services 2001).

***The Regional Health Service (RHS) Program***

*The RHS is an Australian Government initiative designed to support small rural communities to expand their primary health care services. The program is based on a number of basic principles:*

- *local solutions for local health problems ensuring that there is still health gain;*
- *flexible, innovative and integrated solutions promoting better health;*
- *governments supporting improved access to health services, particularly in small rural communities;*
- *all levels of government collaborating to provide the best way to improve health in rural communities.*

### **Ceduna District Health Services – South Australia**

*Ceduna District Health Services catchment area is characterised by a number of remote communities with a range of primary health care centres providing services to these communities.*

*The regional health services program has enhanced primary health care and population health services within the communities serviced by Ceduna. This has been achieved by encouraging and supporting community consultation and participation in deciding what services the communities require. The program has facilitated training and education of local staff and community members to enable them to provide particular services in the absence of a health professional.*

*Ceduna has a significant Indigenous population. When regional health services funding expanded community based and health promotion programs in Ceduna, plans also targeted the health needs of this group. The program also delivered a range of primary health care services to low level aged care clients who previously could not access them.*

### **Upper Murray Health and Community Services (UMHCS) – Victoria**

*UMHCS is a highly integrated health service and demonstrates how a focus on primary health care and supporting staff and the community to understand this concept broadens their service profile and strengthens access to services*

*UMHSCS has expanded its service profile to include health promotion, the introduction of a health and fitness centre, cardiac rehabilitation programs, asthma education, youth services, community mental health services, additional allied health services, well women's and men's groups.*

*The health service works in partnership with a range of agencies including local government and actively involves community groups in planning and prioritising services and programs.*

### **Ottway Health – Victoria**

*The Multipurpose Service development at Ottway enabled the flexible funding model to enhance primary health care services and integration of these services. Significant funds have been shifted from acute care to preventative health and supporting people in their own home environment.*

*The health service focuses on keeping people out of inpatient care and this is successful due to the improved access and focus on primary health care services and programs. In response to this shift there has been a reduction in acute care beds required and it is important to note that this has not affected acute care access.*

### **Tasman Multipurpose Service – Tasmania**

*In its first year of operation the Tasman MPS successfully integrated a range of services to support primary health care. A sample needs assessment was undertaken within six months of operation to provide a bench mark for future service provision and evaluation. Primary health care programs supported by the health service have included nutritional programs, strength training, suicide prevention with the establishment of a very active community group and youth programs.*

### **Urana & District Health Services – New South Wales**

*Urana is a multipurpose service in southern NSW. It does not have a range of primary health care services under the one management structure. Urana is a relatively isolated and very small rural community. An extensive needs assessment a number of years ago identified a range of serious social issues impacting on the health and wellbeing of the community. These included increasing drug and alcohol problems, family breakdown, increasing rates of pregnancy in teenagers and increasing mental health issues.*

*The health service partnered with the local shire and identified the issues and their social impact. A local committee was then formed, involving police, recreational groups, health, local government, schools, religious groups, community members, young people and the area health promotion unit.*

*Having brought together the key drivers in mobilising the community, the committee developed a community social plan. It's clear achievable strategies aimed to deal with these issues and recognising that positive, visible outcomes could take a long period of time. This approach mobilised the community, bringing social issues into the open and community backing for the education process to help deal with them.*

*An added benefit was the sustainable partnerships which developed between service providers. This all highlights the positive impact of a primary health care approach.*

### **Texas Multipurpose Health Service – Queensland**

*Redeveloping Texas, on the QLD/NSW border, as an MPHS has enabled more flexible funding use. State funds traditionally allocated for specific purposes, could be redirected to other identified community needs. This redirection focused strongly on primary health care, in particular preventative health strategies. A project officer was appointed to implement these strategies across the health service and between other agencies within the local community.*

*Texas has integrated a range of primary care services. Strong partnerships with local government, schools and other community groups have supported preventative health programs and other initiatives including healthy lifestyle programs targeting local school children.*

## CHAPTER 2: SETTING HEALTH PRIORITIES

Setting health priorities is the fundamental first step in providing appropriate and equitable health services. Identifying health priorities helps to:

- establish the service profile;
- determine appropriate services required;
- recognise *potential* services that could enhance and strengthen existing services;
- determine those agencies and/or community groups with a degree of responsibility in service provision.

Understanding the community receiving the services is the key to setting health priorities, appropriate service planning and provision of services/care. Unless there is understanding of the community, those involved in planning services can't determine what can work, and what works best within that community. Assessing community circumstances is important when both making decisions about resource allocation and deciding whether the service provided support the health and wellbeing of the community.

*“Health providers and communities must be able to develop local solutions and service models that reflect their own needs and circumstances.”*

*(Healthy Horizons 2003 – 2007)*

Community profiles change over time and many influences affect the community and its resilience. The general factors that influence community health and wellbeing have been discussed and a range of government and non government agencies are responsible to support these. Together these agencies must develop an understanding of their community, its strengths and weaknesses.

*“Health services must be focused on the needs of patients/clients and their carers and the needs of Australians wishing to avoid illness.”*

*(Australian Health Care Summit 2003)*

Establishing the community profile when starting a service redevelopment (such as moving to a multipurpose service model) determines the level and mix of services. Often this process is not completed again because:

- there isn't regular, ongoing strategic and service planning at a local level;
- its perceived as 'not necessary';
- local service providers are unsure of how to do this and why its important.

Therefore, service providers and the community are not aware that their community is changing or has changed, and there is limited community involvement and participation in the planning and prioritising of health and related services.

Assessing the community profile in whatever format or model the partner agencies and community find suitable is a necessary part of appropriate and meaningful service planning, priority setting and resource allocation. It also enables service providers to recognise gaps and duplication in service provision.

## **Why is Setting Health Priorities Important in Supporting Integration?**

Assessing the community, and what constitutes ‘appropriate services’, and then setting health priorities and subsequent planning can involve a range of service providers across different sectors (including health, local government, community care organisations, welfare agencies and education to name a few). The process also involves representatives from within the local community including clients.

Community assessment facilitates the integration process by:

- managing improved communication between individual agencies and between agencies and the wider community;
- integrating service planning between agencies;
- focussing service provision on the identified needs of the client/community;
- involving a range of agencies and sectors in the process;
- recognising areas of duplication and fragmentation between services;
- supporting improved understanding of agencies differing roles and responsibilities;
- the open and transparent sharing of knowledge;
- forming the basis for agencies to work in partnership;
- identifying agencies that could benefit from a partnership;
- linking specific population groups to program areas and relevant service providers;
- enhanced information management between agencies and the community.

Integration between agencies provides other sources for more detailed information on issues from different groups and different perspectives (that cannot be accessed from other avenues) it supports the process of identifying and setting health priorities.

## **Developing the Community Profile**

The Victorian Department of Human Services (DHS) has excellent resources for community assessment and service planning. In its Integrated Service Planning document, DHS recommends considering:

- who comprises the community?
- what factors affect community health and wellbeing?
  - demographic and social characteristics;
  - the community’s health and wellbeing status, epidemiological data;
  - the physical environment and its influence;
- are there inequities across different groups in the community and what are they?
- how does the community or catchment area compare with others of a similar size and environment?

The community profile draws out the social and demographic characteristics that characterise the community. These become the basis for analysing community health and wellbeing. The physical environment can also have positive or negative effects. Local government plays a major role in providing this information.

## Developing the Service Profile

Determining the community profile enables the health service and partner agencies to critically analyse the services provided and whether these meet community needs. The outcome of this analysis is the *service profile*. When developing this profile, consider the following:

- what services currently exist for the local community?
- who are the clients of these services?
- do different services have clients in common?
- do current services meet community needs?

OR

- are current services equipped to match current community needs?
- which services are duplicated or fragmented, if any, and why?
- what are service alternatives?
- which community groups are priorities for future action?

*All agencies providing health and related services to a catchment population need to critically analyse and define their role and the level of services they are able to provide that fits with their individual circumstances and community. This will help alleviate service duplication and fragmentation which can only benefit the client and wider community. (Division of General Practice)*

Clarifying which agency is doing what and the level of service they can provide (role delineation) is important. This may need to be reviewed during the service profile development or when assessing community needs. The community and partner agencies need to know and understand what this means and what level of care and service mix can be safely and adequately provided.

It is essential that health service providers review existing services and service delivery that could require change/improvement. The following checklist will help identify significant issues of service delivery and the data or information factors required:

<b><i>The policy and planning environment</i></b>	Policy documents/strategic plans for national, state and area or regional services
<b><i>Service/community environment</i></b>	<ul style="list-style-type: none"> <li>▪ geography;</li> <li>▪ demography;</li> <li>▪ epidemiology.</li> </ul>
<b><i>Current Services</i></b>	<ul style="list-style-type: none"> <li>▪ location, type, level;</li> <li>▪ facilities;</li> <li>▪ activity;</li> <li>▪ budget;</li> <li>▪ staffing;</li> <li>▪ demand and supply/projected demand;</li> <li>▪ external services;</li> </ul>

	<ul style="list-style-type: none"> <li>▪ client inflows and outflows;</li> <li>▪ performance against state targets/benchmarks;</li> <li>▪ comparative data;</li> <li>▪ service quality measures.</li> </ul>
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## Assessing Community Needs

The community need for health care assesses how well health care services meet the problems of individuals recovering from or managing ill health or in maintaining good health. Need can be objectively defined and measured. Health need goes beyond physical wellbeing and encompasses personal independence, community wellbeing and identity. Distinguish ‘need’ from ‘demand’ – the concept of demand is based on an individual’s preference for health care and their willingness to pay for it (Eagar, Garrett & Lin 2001).

A needs assessment is a comprehensive picture of the health of a community/catchment population in a region. This process can then support choices and priority setting for health intervention in that region. A collaborative approach is required engaging all key players and also those whose expertise and resources is needed to support the key players in this process.

The key players who may be involved in assessing community needs can include:

- the community itself;
- consumers of services;
- partner agencies/service providers;
- the researchers and planners who present statistical data.

*“Local government has a key role in this process in partnership with health. Local government can identify environmental and social issues that may impact on the health and wellbeing of the community and provide valuable data to validate aspects of community need.” (Local government agency)*

## The Process of Assessing Community Needs

The process discussed is detailed further by Eagar, Garrett & Lin (2001) in their text *Health Planning Australian Perspectives*. The process involves six essential steps acknowledging that the level of analysis at each step will vary:

<b>Consultation &amp; Collaboration with key players</b>	<ul style="list-style-type: none"> <li>▪ this is an essential and continuing process;</li> <li>▪ necessary to ascertain key players views on major health issues;</li> <li>▪ identifies community strengths and weaknesses;</li> <li>▪ gives the community’s perceptions of health and wellbeing.</li> </ul>
<b>Collect &amp; apply quantitative data</b>	<ul style="list-style-type: none"> <li>▪ includes epidemiological and demographic data;</li> <li>▪ provides supporting evidence of health priorities;</li> </ul>

	<ul style="list-style-type: none"> <li>▪ supports the decision making process;</li> <li>▪ need to identify what data is not collected and why.</li> </ul>
<b><i>Collaboratively collect &amp; apply qualitative data</i></b>	<p>This data may identify:</p> <ul style="list-style-type: none"> <li>▪ perceived risks;</li> <li>▪ unmet needs;</li> <li>▪ reasons for seeking care;</li> <li>▪ satisfaction with services;</li> <li>▪ provider preferences.</li> </ul>
<b><i>Determine strategic issues and priorities</i></b>	<p>Key players should collaboratively prioritise issues arising from data collection and consultation.</p>
<b><i>Review the evidence on the priority issue</i></b>	<ul style="list-style-type: none"> <li>▪ access information on factors which contribute to the problem;</li> <li>▪ source evidence-based interventions;</li> <li>▪ compare local circumstances with like areas.</li> </ul>
<b><i>Analysing the health problem or issue</i></b>	<ul style="list-style-type: none"> <li>▪ a more detailed analysis of the issues identified;</li> <li>▪ prioritising areas for action;</li> <li>▪ determining what resources are required;</li> <li>▪ are current resources appropriate to need?</li> <li>▪ an assessment of key player ownership of issues and their willingness to change;</li> <li>▪ consensus on possible solutions.</li> </ul>

## Community Mapping

Community mapping can also identify community needs. It involves collecting information about a community's assets in the form of services, businesses, organisations and people. These assets indicate a community's resources (its means of support and strengths). By determining ('mapping') a community's strengths, it is possible to build on them to develop positive change and increase community capacity to cope with health challenges (Robertson 2004).

The process of needs assessment, consequent priority setting and strategic service planning should involve the relevant area health service/region's population/public health units. These units have the knowledge and resources needed to support this process.

## The Process of Service Planning

The community profile, service profile, identified needs and community priorities are the basis of service planning which can include:

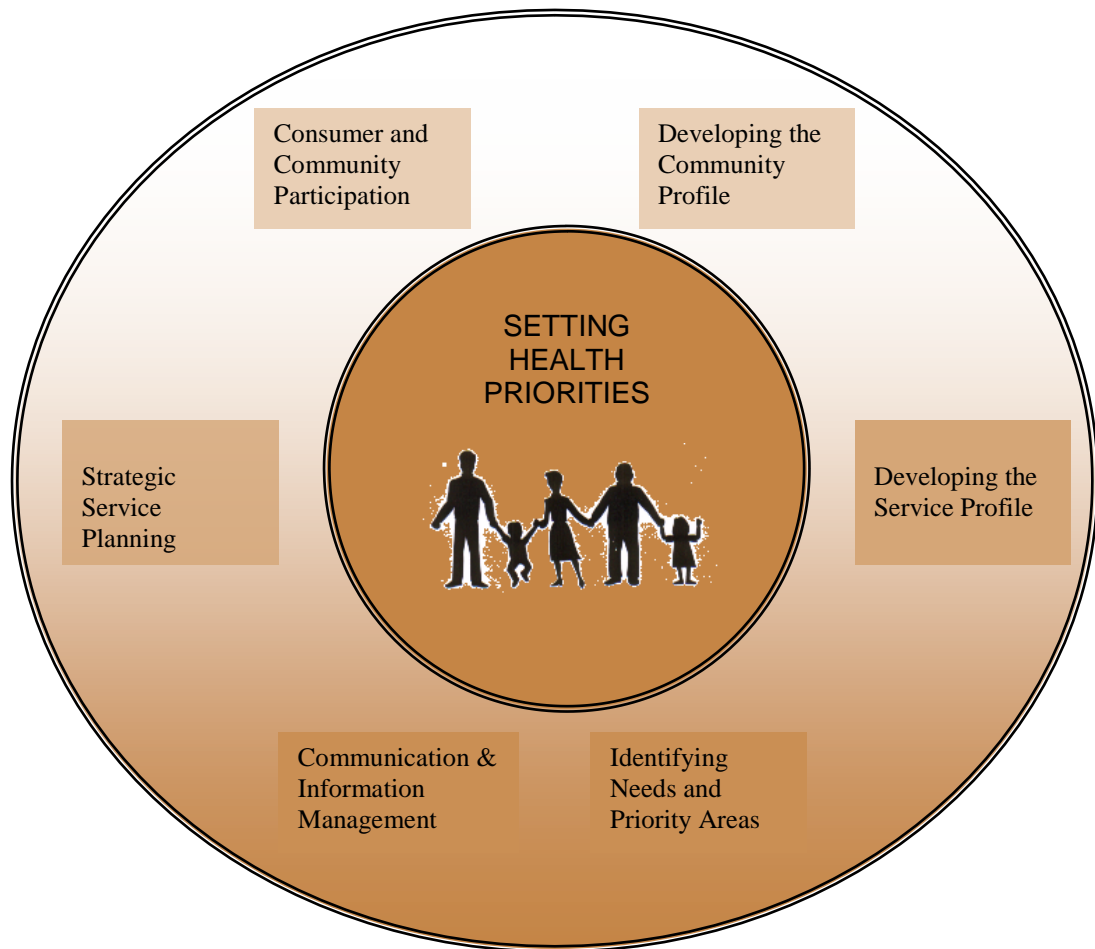
- a description of the community profile;
- updated and detailed descriptions of the services provided including those of the partner agencies;
- the identified health priority areas;
- analysis of current service level matched to identified needs;
- the relationship of national and state priority areas;
- clear and attainable objectives;
- strategies to achieve these objectives;
- timeframes;
- the person or agency responsible for achieving the objective;
- expected outcomes and performance measures.

<b>Objectives</b>	States the specific outcomes that an organisation expects to accomplish within a given time. Objective details should provide an overall sense of what is desired, they are specific and measurable targets.
<b>Strategies</b>	Strategies are organisational methods applied to situations. They are generally specific actions taken to achieve objectives. Because strategies directly target outcomes, they should form the day to day operations of an organisation.
<b>Outcomes</b>	The effect of applying strategies to achieve the objective, the expected or unexpected effect.
<b>Performance measures</b>	Performance measures are real results that show how the organisation is progressing to or has achieved its objectives.

Involving all key players including community representatives and clients in the service planning process is critical. Each agency should undertake a service planning process for their organisation and an integrated service planning process between agencies. Joint planning should build on individual plans, addressing priority areas.

*“The health agencies participation in local government social planning is an essential part of local government strategic planning. Both agencies have valuable information necessary for social planning within communities.” (Local Government agency)*

### Setting Health Priorities



The service planning process within each agency and between agencies must consider resource allocation including workforce planning and funding allocation. Resource allocation should focus on reduced duplication and fragmentation of services and the potential to share resources.

#### ***The Upper Murray Health and Community Services Evidenced Based Needs Assessment***

*The Upper Murray Health and Community Services (UMHCS) is a relatively isolated MPS in Corryong Victoria. The UMHCS undertook an extensive needs assessment process in 1997 and more recently in 2002.*

*The 2002 needs assessment was similar to the previous assessment but also used a community-led consultation process. This needs assessment involved three diverging approaches:*

- 1. developing a demographic and epidemiological profile for the catchment population;*

2. *developing evidence-based case studies relating to the priority areas identified through the demographic and epidemiological profile, community led consultation and the national priority areas;*
3. *continued development of community participation strategies to facilitate community decision making.*

*The third approach is a continuing process and helps the community identify health areas of concern, facilitate outcome measurements and make decisions on funding priorities. The health service has demonstrated significant improvements in a number of areas including national priority areas of cardiovascular disease, injury and cancer.*

*“The process in UMHCS supported a community empowerment model of health service development in a small rural community. It showed that when supported, informed and resourced, communities can build the capacity to engage in decision making and priority setting.” (Evans & Hoodless 2003)*

### **Campbell Town Health and Community Services Health Map Project**

*Campbell Town Health and Community Services (CTHCS) is an MPS situated in Campbell Town Tasmania. The CTHCS Health Map was completed in December 2003 and is expected to have a three year life span.*

*The Health Map was a process to map the health needs and priorities of the residents of the Campbell Town catchment area. The Health Map had three major aims:*

- *to involve the community in discussions regarding the future and present health needs of the area;*
- *to gather information which would assist the Community Services Board (CSB) to determine key issues for the CTHCS; and*
- *promote knowledge of and access to services already provided.*

*The mapping process involved the staff of CTHCS, the CSB and the Tasmanian University Department of Rural Health. Information collection involved a community survey, community forums and health provider survey interviews. Consideration was given to a range of perspectives on which to build a comprehensive view of needs and then begin a process of how best to meet those needs.*

*The process supported an increased awareness of service providers, identified unmet needs and encouraged equal sharing of information that will be ongoing. The process was action based whereby matters that were identified as needing to be changed were acted upon within the capacity of the health service as the project progressed. The community was also informed as to how the information collected would be used.*

*“Community engagement and mapping has opened communication and improved how we deliver services. The process has promoted trust and partnerships within the community by having lots of people working together for a common goal, what happens in the community does not have to be owned by health.”(Health Service Manager)*

### ***How is Your Life in Boyup Brook – Boyup Brook Health Service WA***

*The primary health care team and local health service collaborated to develop a questionnaire to assess health and other needs of this community. Issues had come to the attention of the health service including isolation of particular population groups, limited access to services, limited public transport options and growing divisions between different socio-economic groups.*

*The survey was based on the social, economic and environmental determinates of health and specific issues such as health service delivery. It was a snap shot of views and issues of the community. Those involved in the survey acknowledge that it was not comprehensive but it provided valuable information and perspectives on community life in this area.*

*The responses to the survey provided the opportunity to further identify in more detail, areas of particular concern within the community. Questions focused on the following areas:*

- *the physical environment;*
- *economic viability;*
- *education within the community;*
- *work life;*
- *basic needs including water/food/housing/transport/goods and services affordability and accessibility;*
- *recreation;*
- *participation in community decision making;*
- *social contact;*
- *equity/tolerance of diversity;*
- *safety/trust in the community;*
- *family functioning;*
- *health services.*

*At the time of this research, the surveys were still being undertaken. Following completion results will be presented to the community for discussion and action. Community priorities will be identified and it is anticipated that health services including primary health care services will have a clearer direction in planning service provision and resource allocation.*

### ***“Healthy People in Healthy Communities is Every Body’s Business” South West Area Health Service – WA***

*The South West Area Health Service ran this forum so health service providers, non health agencies and community representatives could collectively make constructive input to regional health service development plans. Representatives learnt how residents could have a voice in such developments in the future.*

*The forum included representation from the South West Development Commission, police, local governments, social welfare agencies, private sector health and non health agencies, clients including many selected randomly from the electoral role and South West Area Health Service providers.*

*Representatives were asked to consider what could be done to build partnerships in their communities, to consider health and wellbeing issues from the perspective of themselves, their family and their community. Extensive information regarding the health and wellbeing profile of the catchment population was presented to forum members. The forum focussed on a population health approach and the recognition of the need for developing partnerships and coordinated links between the area health service and the many agencies that support the communities.*

*The forum was run over two days and included a process of identifying health service priorities involving focus groups and using a nominal group technique. Relevant demographic and epidemiological information was provided and groups were asked to consider priority areas and rank these priorities.*

*Information from the forum will inform further service planning and partnership development between agencies. It was anticipated as the first of several continuing community consultation processes, with forum outcomes presented to the wider community.*

Both the Upper Murray and Campbell Town needs assessment and community mapping projects have progressed to include extensive service planning involving a range of non health agencies including local government, primary health care providers and community representatives. The other examples are very recent but all share a commitment to ongoing partnerships with the community and a shared responsibility between the community, health and non health agencies. All projects were different but included key players and all had valuable outcomes which enhanced the relationship with their communities.

All stakeholders met who were involved in developing and implementing these priority-setting examples acknowledge that the process was just as important as the outcomes in information sharing and developing a stronger partnership and participatory relationship with the local community.

The examples of community needs assessment and setting health priorities broadly outlined in this chapter, demonstrate the importance of good leadership, the ability and willingness of management and the organisation to empower and work with their communities including staff and key players. To be successful and sustainable, the process requires a commitment to sharing information, decision making and transparency.

### 3: LEADERSHIP and ORGANISATIONAL CULTURE

Leadership plays a vital role in achieving acceptance in any program delivered in a rural community. The number of key players, who are often also the community role models, is usually small and their interest and responsibilities often overlap. Gaining the respect and participation of these key players is part of developing self-sustaining change.

Rural communities see their health service, like many organisations, as essential to the social and economic structure of their community. It is a focus of health care and also employs a considerable number of community members. Its network of volunteers and support groups give the community a degree of ownership of the service.

Rural health service management faces many complexities unique to its environment. There are minimal layers between the manager and staff, the manager is very visible to the community. The community often has a strong interest in how the manager undertakes their role and the relationships that form between the health service and the community. Health service issues that directly (are *perceived* to) affect a community will fall squarely on the health service, including its staff and management.

*“Leadership is 80% of the success factor to driving change and supporting innovative and integrated service delivery models.”*  
(Chief Executive Officer, Victorian MPS)

Successfully progressing integration in a rural community is a significant change which affects all key players. The health service manager plays a pivotal role in supporting change by guiding and empowering the key players including the community itself. This will support sustainable community and interagency partnerships which in turn can help build healthy communities. It is therefore essential that managers are leaders.

#### Leadership Challenges for Managers in Rural Health

The research which prompted this resource identified from interviewing health service managers, community representatives and non health agencies, numerous and varied challenges in managing rural health services which can affect change and relationships between agencies and the community:

<p><b><i>The ‘silo’ attitude</i></b></p>	<ul style="list-style-type: none"> <li>▪ characterised by traditional boundaries between professions;</li> <li>▪ the constraints of industrial awards and staff having worked in the same environment for many years constraining flexible roles and work practices;</li> <li>▪ compartmentalised departments;</li> <li>▪ the ‘them and us’ attitudes.</li> </ul>
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<b><i>The health workforce</i></b>	<ul style="list-style-type: none"> <li>▪ an ageing workforce;</li> <li>▪ inequitable distribution and insufficient numbers;</li> <li>▪ differing levels of training and competency within and between the professional groups/departments;</li> <li>▪ disenchantment and cynicism;</li> </ul>
<b><i>Changing community profile</i></b>	<ul style="list-style-type: none"> <li>▪ poorer health status in rural and remote areas;</li> <li>▪ the ageing population;</li> <li>▪ limited access to services;</li> <li>▪ social, economic and environmental issues;</li> <li>▪ poor infrastructure.</li> </ul>
<b><i>Health services</i></b>	<ul style="list-style-type: none"> <li>▪ changing mix and viability of services;</li> <li>▪ increasing need for and use of primary health care services;</li> <li>▪ equity of access;</li> <li>▪ differing levels of integration of aged care, community and primary health care services;</li> <li>▪ increasing complexity of chronic disease;</li> <li>▪ dual funding of services.</li> </ul>

Many people employed in a rural community, including volunteers within agencies and in particular health services, have usually worked for the organisation for many years. They display a high degree of loyalty to the organisation and are held in high regard by the community. These people may be viewed in the community as the 'backbone' of the organisation. In some situations the community and its network of staff and volunteers can present a major challenge to introducing change and innovative ways of working.

A manager coming into this organisation and driving change needs considerable leadership skill. They must strike a balance between sensitivity, motivation and respect for the contribution people make to the organisation.

Service providers all share a common purpose - to maximise the health and wellbeing of their communities. All organisations need to focus on this common purpose and understand how it can be achieved.

### **Why is Leadership Important to Integration**

Leadership and management is an essential component to successful integration. Chapman and Neumayer identified in their research in 2000 that one of the essential characteristics of successful integration in the services they studied was the ability and willingness of the manager to support the process.

Research for this project mirrored these findings. Of the Multipurpose Services researched in this project, the agencies that showed a high level of integration, or

integration progress, had managers who sought opportunities for service enhancement outside the traditional boundaries of health service provision and empowered their staff and community. This research showed the most effective managers must:

- support the concept of integration and its advantages for the consumer, community and agencies involved;
- facilitate a continuing education process for all agencies involved in the partnership and the community;
- work in a collaborative approach with other agencies;
- support and promote different and innovative models of care and service delivery;
- communicate effectively and advocate transparency between the health service, community and partner agencies.

A Victorian MPS program evaluation clearly identified that Upper Murray Health and Community Services senior management was a major contributing factor to the success of this particular MPS. The same could also be said for Ottway Health which was also researched in this project. Both have understood the concept, its potential to benefit the community and they have achieved success in this program.

Integration involving partnerships and collaboration with other agencies and the wider community moves outside the traditional hospital environment. It can present many challenges, not just undertaking the process but guiding the community and key players in the process.

### **How the Leadership Role Can Support Integration**

Integration-supportive leadership needs managers willing to work in partnership with other agencies and the community to create and maintain a shared vision of what is needed to make their community a healthier place to live. This type of manager needs to:

- have a clear, appealing and achievable vision of what the organisational and partner agencies are aiming for;
- be definite and positive about what the organisation and partner agencies want to achieve;
- understand the importance and benefits of integration for their community and services;
- be flexible and open to innovation;
- motivate and empower key players;
- communicate effectively using all available methods;
- be ethical and consistent in practices and decisions;
- be open and receptive to community issues and concerns;
- facilitate the education of key players in aspects of organisational change, roles and responsibilities;
- develop a knowledge and understanding of the community, its needs, strengths and values to support planning and service provision;
- undertake joint service planning in collaboration with key players;
- prioritise and allocate resources in collaboration with key players;
- share responsibility and decision making but make clear and justifiable decisions when required;
- always be open to meaningful community participation and input.

Managers must always keep the big picture in mind and not only assess the community's needs but also consider the future in terms of likely events or changes affecting the community. This is challenging in itself and requires effective collaboration and partnerships.

## Change Management

Doug Stace and Dexter Dunphy (2001) are both well recognised as leading Australian exponents of organisational management and change. Their book entitled *Beyond the Boundaries* is essentially about managing successful organisational change. Stace and Dunphy discuss how to lead change so it becomes an energising force and identify that change has now become a steady state.

Stace and Dunphy recognise three critical elements to progress organisational change strategy into action: the leadership of change; communication strategies and strategies for cultural renewal.

### ***The Leadership of Change***

Throughout this chapter the terms *manager* and *leader* or *leadership* are used interchangeably and the necessity for a manager to also be a leader has been identified.

The following table by John Kotter cited by Stace and Dunphy helps clarify the two roles and the shift from just managing continuing tasks, to leading change and organisation improvement.

### ***Comparing Management and Leadership***

<b>Management</b>	<b>Leadership</b>
<i>Planning and budgeting</i>	<i>Establishing direction</i>
Establishing detailed steps and timeframes for achieving needed results, and then allocating the resources necessary to achieve this.	Developing a vision of the future, often the distant future and strategies for producing the change needed.
<i>Organising and staffing</i>	<i>Aligning people</i>
Establishing structures to accomplish the requirements of the organisation. Staffing the organisation, delegating responsibility and authority for carrying out the tasks/plan, providing policies and procedures to help guide people and putting systems in place to monitor implementation.	Communicating the direction by words and actions to those people whose cooperation may be needed in order to influence the creation of teams and partnerships that understand the vision and strategies and accept their validity.
<i>Controlling and problem solving</i>	<i>Motivating and inspiring</i>
Monitoring results verses planning, identifying deviations, planning and organising to solve those problems.	Energising people to overcome major political, bureaucratic and resource barriers to change by satisfying very

	basic but often unfulfilled needs of these people.
<i>Produces a degree of predictability and order, and has the potential of consistently producing key results expected by various stakeholders.</i>	<i>Produces change, often to a dramatic degree and has the potential of producing extremely useful change.</i>

*“The rural health manager needs to identify the champions within their community and within their services that can support and help drive changes.”*  
(Local government agency)

Managing integration requires identifying and developing people within the agencies and community who can create the energy and momentum to progress a new way of working and providing services. In short, identifying and developing leaders, both individuals and agencies.

### **Communication Strategies**

This resource has emphasised communication and strategic planning. Not strategic service planning process is successful without effective communication at all levels within the organisation and wider community. Communicating is not a one-way process of explaining directions and exhorting action. It is also about listening, and acting on what you hear. It is through two-way communication that strategic planning chooses appropriate directions, because the directions reflect stated community concerns.

An important point that continually emerged in researching this resource is that, in encouraging the community and agencies towards an integrated approach or any change process, there should be no surprises. This again supports the value of trust and transparency in developing relationships with key players.

New directions and ways of working require two way communication and engagement throughout the whole organisation and wider community, involving feedback loops and the ability to flesh out core ideas and strategies. In saying this it is also crucial that leaders set clear direction and also communicates this effectively through all levels of their organisation.

### **Strategies for a Cultural Renewal/Change**

Organisational culture is the values, beliefs and norms shared by those within the organisation. It is influenced by patterns of behaviour, language and other factors that have emotional meaning for members of the organisation. The culture creates the rationale for what people do and their purpose. It sets the boundaries for what is and is not acceptable behaviour (Stace & Dunphy 2001).

Understanding the culture of the organisation and community will help a manager to understand the challenges encountered when facilitating change. Progressing integration by reorienting to a primary health care focus, developing and maintaining interagency partnerships and different service delivery models all challenge the traditional culture within health professions, the culture of the small rural health service and its community.

The health care system has a deep, hierarchical structure with top down management, defined roles and responsibilities. It faces continual challenges of balancing demand, prioritising services, quality of care and resource allocation with finite budgets.

Historically most people have been “passive receivers” in health care and have generally placed blind faith in the system. Health care providers have at times been paternalistic (‘we know best’), resulting in an environment of diagnosis and treatment, based on service needs and not necessarily *client needs*.

The consumer and communities have begun to influence much of the cultural change emerging within the health care system and this is at the fore front in rural health. Clients have increasing knowledge, a demand for information and they want an active part in decision making not for their individual health needs but also those of their community.

Managing cultural change which supports integration requires a leader who:

- identifies and accepts with the community what needs to change;
- empowers others;
- supports all key players with education and training;
- develops a clear understanding and respect for the roles, responsibilities and contribution of key players;
- enables staff at all levels within the agencies to contribute in priority setting processes, planning, implementation and continuing evaluation.

Through effective leadership, a manager can help shape the new culture. Without this ‘paradigm shift’, cultural change or renewal will not support and reinforce the organisation’s vision or that of partner agencies. Cultural renewal is a cumulative process. Debate and conflict between stakeholders may occur, but helps to shape an emerging culture with new values. Good communication strategies, with people sharing ideas, opinions and experiences, help shift the existing culture to its new paradigm. Stace and Dunphy identify three interventional levels that help create cultural change:

<b><i>Structural Interventions</i></b>	These can include organisational restructure, workplace design, new technology and information systems/management, new leaders. These interventions will affect patterns of behaviour.
<b><i>Process Interventions</i></b>	Changing human resources, the mix of staffing, roles and responsibilities, education, changing emphasis on how and what services are provided.
<b><i>Symbolic Interventions</i></b>	The introduction of new values within the organisation, the new relationships and partnerships formed and the emphasis on client centred care and service provision.

## ***The Redevelopment of Urana – NSW***

*Urana (southern central NSW) was one of seven national pilots for the MPS program in late 1994. Urana's redevelopment is an example of using the three intervention levels to bring about a cultural change. This change evolved over a number of years before the staff and community were able to fully accept a better way of working and providing care and services to the community.*

*During early program development there was little if any networking and no comparisons to make, therefore the service (like others in the pilot) was able to develop in its own way, with support from the State and Commonwealth governments during that time. The community were suspicious and negative about the program not knowing how it would evolve and what it would become.*

### ***Structural intervention***

*Occurred with a capital works redevelopment and physical joining of the existing aged care hostel. Staff and community were able to move freely between all areas of the service, the workplace was designed to have a central meeting room/staff area.*

*Management had recently amalgamated to become a combined director of nursing and executive officer position known as health service manager. Services including low level aged care and home and community care services were introduced under a single management structure within the health service.*

*The management board was disbanded and a community advisory committee was established by the NSW Department of Health. This Committee become an advisory and advocacy group who represented the community in service planning and health issues being far removed from the administrative role of the previous board.*

### ***Process Intervention***

*This intervention involved creating new positions and the introduction of flexible staffing and work practices which led to flexible care approaches. Staff helped develop flexible positions and subsequent position descriptions - they were given ownership of the process and their positions continued to evolve.*

*The introduction of Home and Community Care Services HACC services, previously co-ordinated from another town placed more emphasis on primary health care. With a dynamic co-ordinator of the HACC who could see the potential of integration, who was willing to share information and educate staff and community, the services were supported to link in a more co-ordinated way and access to these services was increased.*

### ***Symbolic Intervention***

*This occurred in conjunction with the other interventions, as the service began to change with new roles and responsibilities, the values of the organisation changed and it become more client focused with staff taking a holistic view of health. Management and staff introduced a model of service delivery that supported a more coordinated approach to care and services become blended.*

*Another symbolic intervention was changing the name from hospital to health service. This gave the service a broader focus and started the community thinking outside the*

*square of an institutional model about the services provided. This change also become evident in local fundraising which traditionally had only focused on the hospital and now shifted its focus to other components of the health service.*

*It is important to emphasis that capital works alone is not the focus of a cultural change. In Urana's case like many others it was necessary because of antiquated unsafe buildings but it certainly wasn't the key to a cultural renewal. Structural issues have many other facets that may place physical and organisational boundaries between services and departments.*

*When considering structural interventions, consider what practical applications can be made to promote a more cohesive and team orientated environment. Again, this study highlights the importance of leadership, communication and community participation and ownership.*

### ***The Redevelopment of Jerilderie – NSW***

*Jerilderie's progress to become an MPS was very political to say the least. Jerilderie, in southern central NSW, had a range of difficulties that affected its viability to the point where it was closed over weekends with only minimal outpatient/inpatient and community nursing services provided during the week. This situation lasted for a number of years while its future was debated at many levels. Staff were particularly affected, having little confidence in the system, loss of self confidence and declining clinical competencies and not knowing what their future employment options would be.*

*In 2000, Jerilderie began redevelopment as a Multipurpose Service. Given its history and the politics involved, there was a highly charged community very committed to saving its hospital. Jerilderie's health service closed for capital works to begin. This promoted speculation and community debate that it would not reopen. This unique and highly emotive situation provided the opportunity to in effect start again, applying all three cultural interventions.*

#### ***Structural Intervention***

*Recruiting a manager with experience in MPS development helped guide the process and dispel myths and concerns along the way. The capital works were needed but there was community and staff involvement in the planning process and emphasis was placed on structuring services to remove barriers rather than just a rebuild process.*

*A strong commitment was made to complete transparency and honesty with regard to all aspects of the redevelopment including staffing levels, mix and services and so on. A communication strategy was developed in conjunction with the newly formed Health Service Advisory Committee and local Auxiliary to keep people informed throughout the redevelopment and to provide a feedback loop.*

#### ***Process Intervention***

*This intervention involved an extensive education process and reorientation for all staff, the building of new positions, roles and responsibilities with the direct involvement of those staff. A range of non health agencies and other health services provided valuable support and mentoring for staff.*

*The redevelopment features community aged care packages and residential high and low aged care. Staff have multi-skilled to provide flexible staffing and care across all areas including primary health care services. The Health Service Advisory Committee (with its community representatives) has built a high profile in the community and is actively involved in service planning and a range of health service initiatives and programs.*

### **Symbolic Intervention**

*This occurred while other aspects of the service began to change. The health service's vision is to promote the health and wellbeing of the community and enhance quality of life. It is not just treatment focused and there is an increasing commitment and reorientation to a primary health care approach.*

*Many new initiatives have evolved which focus on health promotion, education and improving the social wellbeing and connectedness of the community. Activities undertaken involve a range of organisations within the community and there is an inclusive and transparent relationship between the health service and wider community.*

Of the Multipurpose Services researched, those that have developed partnerships successfully and an integrated way of providing services have also recognised that it is an evolutionary process that takes time. No 'one size fits all' model fits the process - it is about recognising what needs to change and why. These services have then moved to support the process and planning adapt to their individual environments, organisations and community. Change is often hard work, and as this evolution continues it will require more hard work and commitment to be sustained.

An important consideration in cultural change is looking at what other organisations are doing well and how they have achieved this. There are many different examples of innovation and quality practice that can provide valuable new insights into improved efficiencies and outcomes.

### **Advantages of Flexible Staffing**

Flexible staff use is essentially about horizontal workflows across traditional functions (Stace & Dunphy 2001). The multipurpose service program has facilitated the introduction of flexible staffing across different service areas. This has helped break down many traditional service boundaries. There are advantages to flexible staffing for both the staff and the agencies involved:

<b><i>Employee</i></b>	<b><i>Agency</i></b>
<ul style="list-style-type: none"> <li>▪ broader roles and responsibilities;</li> <li>▪ variety in the work environment;</li> <li>▪ improved opportunity for professional development;</li> <li>▪ a more holistic and broader view of client/community needs.</li> </ul>	<ul style="list-style-type: none"> <li>▪ less parochialism between departments/agencies;</li> <li>▪ flexibility in the work environment;</li> <li>▪ increased recruitment and retention options due to expanded and flexible roles;</li> <li>▪ a more holistic and broader view of client/community needs.</li> </ul>

Flexible staffing uses various service providers across different departments and service areas or disciplines. It also expands various roles and responsibilities across services and covers multi-skilling. This means staff with appropriate training can undertake a combination of roles and activities within the organisation and also between agencies.

The complexity of industrial awards (complicated by differing awards within and between the States and Territories) can prove challenging for managers seeking to adopt flexible staffing.

### Guiding Principles to Support Flexible Staffing

The following guiding principles can be applied when considering flexible staffing options within the small rural health service:

<p><b><i>Identify the industrial awards that can support blended roles and positions, and services that have the potential for flexibility.</i></b></p>	<ul style="list-style-type: none"> <li>▪ research and understand the awards;</li> <li>▪ actively consult with relevant industrial bodies;</li> <li>▪ establish a staffing and service profile;</li> <li>▪ consult staff and partner agencies to identify potential areas of role expansion and movement across departments/sectors;</li> <li>▪ remember, that rostering practices must be compliant with the relevant industrial awards.</li> </ul>
<p><b><i>Develop the Position Description (PD)</i></b></p>	<ul style="list-style-type: none"> <li>▪ actively involve staff in this process;</li> <li>▪ the PD must reflect the broader flexible role and responsibility;</li> <li>▪ the PD must identify the different awards that could fulfil the position;</li> <li>▪ a PD must be developed for <i>all</i> positions including those that have multiple staff providing the service/care;</li> <li>▪ <i>The PD is a 'living' document and process subject to continuing evaluation.</i></li> </ul>
<p><b><i>Education</i></b></p>	<ul style="list-style-type: none"> <li>▪ support all staff with education and on-site training to facilitate and understand this process;</li> <li>▪ education about integration and associated flexible staffing and care must form part of the orientation process;</li> <li>▪ all staff receive education and professional development in relevant areas to support their broader roles;</li> <li>▪ education must be a continuing process.</li> </ul>

<b><i>Monitoring of competencies</i></b>	<ul style="list-style-type: none"> <li>▪ competencies relevant to particular services/care are matched to service improvement standards;</li> <li>▪ competencies are assessed and monitored regularly;</li> <li>▪ performance management processes are in place and support competency training and assessment.</li> </ul>
<b><i>Evaluation</i></b>	<ul style="list-style-type: none"> <li>▪ processes are in place to support monitoring and evaluation of flexible staffing practices;</li> <li>▪ the PD will reflect any changes to positions;</li> <li>▪ all staff are involved in the development, implementation and evaluation processes.</li> </ul>

This flexible approach supports the concept of integration because there is a focus on the team that is interdependent and coordinated, flexible staffing has a range advantages for all the partner agencies and the wider community such as:

<b><i>The Workforce</i></b>	<ul style="list-style-type: none"> <li>▪ a team approach that supports interaction necessary for efficiency and effective work practice;</li> <li>▪ shared goals and values which extends across the partner agencies;</li> <li>▪ an improved understanding of each others roles and responsibilities;</li> <li>▪ an environment of continual learning and professional development;</li> <li>▪ empowerment because people are given broader responsibilities and decision making;</li> <li>▪ job satisfaction;</li> <li>▪ improved recruitment and retention opportunities;</li> <li>▪ reduced professional remoteness and ownership between services.</li> </ul>
<b><i>Access to services/care</i></b>	<ul style="list-style-type: none"> <li>▪ increased awareness of services supporting access;</li> <li>▪ supporting a multi disciplinary team oriented approach to care planning and provision of care;</li> <li>▪ innovative approaches to care/flexible care;</li> <li>▪ promoting a better understanding of the social, cultural, environmental and economic factors that influence a community's health and wellbeing and consequently taking a more holistic client centred approach;</li> </ul>

	<ul style="list-style-type: none"> <li>▪ reorienting the service to a primary health care concept.</li> </ul>
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In effect flexible staffing helps link silos. Non clinical staff within partner agencies including health services can play an essential role in this because they often view problems or issues around health and the independence of a client differently from the clinician. This can often provide alternative ideas and options to care or services that may not be considered by a clinician. There is then more scope for a non clinical carer to support a client's care in a more appropriate environment outside a clinical setting and to also support that care in a residential or clinical setting if required.

Rigid roles and responsibilities are not conducive to flexibility or the concept of integration but in saying this, legislative requirements and conditions within the particular professional groups and awards must be carefully considered.

*The MPS program has legitimised and opened broader avenues for flexible staffing practice. Some examples of these are outlined and could be applied to suit rural health services:*

#### **Braidwood Health Service - NSW**

*Braidwood, near Queanbeyan, uses its flexible staff across residential aged care, hotel services, home and community care services and home care under the Health Services Association (HSA) award. The conditions under the award have suited the flexible approach across these service areas.*

*Braidwood also supports flexible staffing within nursing services across acute care, residential care and community health.*

#### **Ceduna District Health Services – South Australia**

*Ceduna undertakes flexible staffing/multi skilling across all service areas including inpatient nursing, community health, aged care, hotel services and outreach relief support to the Indigenous communities. The position descriptions of the Health Service reflect this concept.*

#### **Jerilderie Health Service - NSW**

*Jerilderie supports flexible staffing under the HSA award across the service areas of residential aged care, community aged care packages, diversional activities and hotel services. Staff within the NSW nurses award, also work across these service areas excluding hotel services if required and positions descriptions are in place to reflect flexible staffing and multi skilling practices.*

#### **Ottway Health – Victoria**

*Ottway Health supports staff working across different programs and staff use different position descriptions for the specific program area. Enrolled nurses can work across acute, residential aged care and community nursing. Personal care assistants within aged care can also work within hotel services.*

***Texas Multi Purpose Health Service – QLD***

*Texas has clinical staff working across inpatient services, aged care and community health, position descriptions are generic. Staff are employed by the Health Service to work across all areas.*

***Upper Murray Health and Community Services (UMHCS) - Victoria***

*UMHCS supports flexible staffing in many areas such as acute nursing to health promotion, hospitality services to residential aged care and home and community services, maintenance/gardening to home and community services and well men's groups.*

***Urana and District Health Services – NSW***

*Urana flexes staff under the HSA award across hotel services, low level aged care, diversional activities, home and community services and home based respite care support. Like Jerilderie it was found that this award provided more flexibility across a range of services and created more variety and decision making for those employed under this award who may not have had that opportunity previously.*

*Nursing staff at Urana also work across the primary health care and inpatient, residential interface which has helped remove boundaries between these areas.*

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## CHAPTER 4: SERVICE DELIVERY MODELS

Service delivery models refer to the way health and related services and their care are provided. Service delivery models support the process of integration between partner agencies by:

- the co-ordination, planning, implementation and evaluation of care and services provided by the partner agencies;
- improving access to health and related services by providing a formalised and co-ordinated pathway through the process of care supported by common policies and procedures guiding the partner agencies;
- promoting a multi disciplinary team approach to care and service provision; and
- enhanced continuity of care through the client 'journey'.

### Guiding Principles that can Support Service Delivery Models

It is not practical or realistic to provide a 'one size fits all' standard service delivery model in rural communities. Service delivery principles and processes must adapt to each individual community's needs. However, in doing so, there are commonalities between communities and these can help map a general framework for service delivery. General principles of service delivery model development:

- the model should be clear, practical and appropriate to the services and the catchment population;
- it must comply with national, state and local health priorities;
- it should work towards the vision and strategic direction of partner agencies;
- it should improve access, referral processes, care, information management and evaluation between the agencies and individual service providers;
- the model must extend across the dimensions of care including the pre and post discharge phases and include the agencies involved in providing these services;
- planned and regular evaluation of the model is essential. Ensure that changes made are consistent with the purpose and objectives of the model.

Strategies for implementing a service delivery model include:

- establish formal objectives for the service delivery model. The model will be a 'living document' and can change as it is used;
- continual communication between partner agencies and the community;
- identify gaps, duplication and fragmentation of services. Develop a model that provides continuity of support and a seamless approach to care;
- formalise policies and procedures between partner agencies that outline the client's care and transition through the services;
- establish interagency referral processes and how client information is managed, secured and communicated between the agencies;
- identify agency care 'styles' and opportunities for interagency links. Identifying these differences can lead to innovative approaches to client care and support that can take the client away from 'bed based' care.

## Implementing Service Delivery Models

A model of service delivery is based on a multi disciplinary care coordination approach between partner agencies. The approach should be based at the operational level and focus on the needs of the client, access to care and services. The six key steps for implementing a service delivery model are:

<b>Key Step Description</b>	<b>Process</b>	<b>Expected Outcome</b>
<b>Initial contact</b> – is the first contact by a client with a health service or agency.	<ul style="list-style-type: none"> <li>Formal processes direct the client to the right service or information;</li> <li>Current information about agencies and services is available.</li> </ul>	<i>The client has the correct information and is directed to the appropriate service in a timely manner.</i>
<b>Identification of needs</b> – the client's needs are identified by the initial contact agency.	<ul style="list-style-type: none"> <li>Formal registration of the client with the service;</li> <li>Client needs are identified by a broad screening approach;</li> <li>Confidentiality and information security is maintained;</li> <li>Appropriate information is provided to the client;</li> <li>The client is linked to the appropriate service.</li> </ul>	<i>The client has timely access to a range of services appropriate to their needs.</i>
<b>Client referral</b> – is a request by one service provider to another.	<p>Referrals are made because:</p> <ul style="list-style-type: none"> <li>The agency may not be able to meet the client's needs;</li> <li>The client requires a range of services and care that are best provided by another service.</li> </ul> <p>Referrals can be made by agencies at various points in the care of a client:</p> <ul style="list-style-type: none"> <li>Referrals link the client assessment process and information management between agencies;</li> <li>The referral process is formalised to ensure consistency.</li> </ul>	<i>The client has access to co-ordinated services to reduce duplication or fragmentation, providing a seamless approach to care.</i>

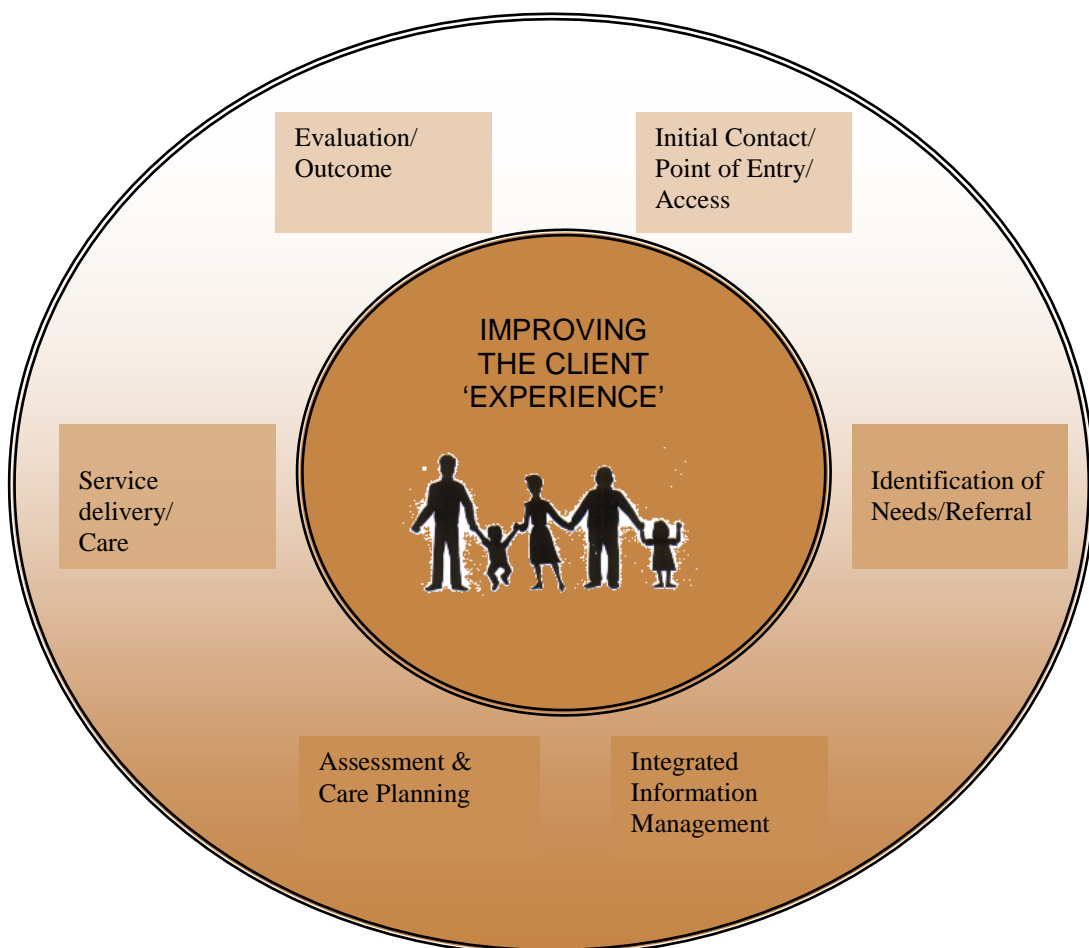
<p><b>Assessment</b> – of a client’s problem.</p>	<ul style="list-style-type: none"> <li>▪ Identify and if necessary diagnose the problem and develop an action plan;</li> <li>▪ additional needs may be identified at this stage;</li> <li>▪ a referral may be made if the agency can’t meet these needs;</li> </ul>	<p><i>Assessment and care planning identifies and addresses the client’s health needs.</i></p>
<p><b>Care planning</b> – is an action plan.</p>	<ul style="list-style-type: none"> <li>▪ identify strategies for client care from the assessment process;</li> <li>▪ actions of care address a client’s identified needs;</li> <li>▪ the process is a multi disciplinary approach;</li> <li>▪ and forms the basis of service delivery, review and monitoring of outcomes.</li> </ul>	
<p><b>Service delivery/care</b> – is provided to the client and could be from a range of agencies.</p>	<ul style="list-style-type: none"> <li>▪ follows assessment of client needs;</li> <li>▪ formalised by care planning;</li> <li>▪ agencies responsible for the delivery of these services are identified;</li> <li>▪ competencies required to provide services are determined by the relevant agencies;</li> <li>▪ all agencies involved provide health promotion and education to clients at all levels of the care process;</li> <li>▪ discharge planning encompasses all aspects of service delivery/care.</li> </ul>	<p><i>Services meet the identified needs of the client.</i></p>
<p><b>Evaluation of service delivery and care outcomes</b> – is a continual process.</p>	<ul style="list-style-type: none"> <li>▪ it is part of the larger framework of interagency care planning and co-ordination;</li> <li>▪ if outcomes do not benefit clients, service delivery/care must be reconsidered to meet the client needs.</li> </ul>	<p><i>The client’s quality of health and wellbeing is improved by the positive delivery of health services/care.</i></p>

The key steps in implementing a service delivery model represent a cycle of care for the client based on their identified needs. The cycle of care is a continuing process that supports a seamless approach to care, quality outcomes and improves the clients experience with the health service and partner agencies.

Agencies must have consistent and clear discharge policies and processes in place. Discharge planning is involved at all steps in the cycle of care and it needs to be relevant to the agency's model of service delivery.

In a service delivery model, agencies using common and consistent processes support a '**single point of entry/access**' model. This could be a physical single point of entry/access with needs being identified by a single provider and then referred or the first point of contact with any of the service providers. Agencies having the capacity to identify needs and facilitating appropriate referral at any point of initial contact supports the client to access services appropriate to their needs. This concept in effect also promotes a single point of entry/access to health and community care services.

### The Cycle of Care



## Considerations when Applying a Model

When developing and implementing a service delivery model, ensure:

- The model is client focused and fits with the community and service profile;
- The model supports improved access to services/care;
- The model helps improve the client experience with the services;
- The model is simple so it doesn't lose its practical application and becomes confusing. Problems with the model will become more difficult to resolve if it is complicated;
- That information management systems support continuity of care and less duplication and fragmentation of information gathering and services;
- That continual evaluation provides opportunities that can improve the model.

### ***Upper Murray Health and Community Services (UMHCS) - Victoria***

*UMHCS uses three strategies in its service delivery model to support integration and service coordination.*

#### ***Point of Entry Advocacy***

*No matter where clients make contact with the agency, all staff help to identify and support access for clients to relevant services. These can include the general practitioner, HACC services, allied health, community nursing, reception and the acute inpatient area. Staff receive training, skills and information to support the clients in this way.*

#### ***Standardised Multi-disciplinary Assessment and Outcome Based Care Planning***

*This strategy documents a multi-disciplinary approach to assessment and care planning. Management plans and outcomes are very client focused and developed collaboratively with the client and their family/significant others.*

*This single assessment tool is used across all UMHCS services to prevent duplication of information.*

#### ***Care Coordination***

*A continuum of care program works across all care settings and is coordinated by a health professional. The features of this program are:*

- *coordinated treatment or support programs;*
- *early identification of service needs and care coordination using a multi-disciplinary assessment tool;*
- *coordinated multi-disciplinary approach to care planning and service delivery;*
- *streamlined referral process to a broad range of acute, residential and community services;*
- *team responsibility for discharge outcomes through forward planning, networking and active involvement with the wider community and regional service providers.*

**Ottway Health – Victoria**  
**‘Community and Client First’**

*Ottway Health has introduced a service delivery model known as ‘Community and Client first’. This means that any decisions, programs, interventions, and care are measured against the impact on the client or community rather than the impact on staff or doctors.*

*One case manager is appointed to all clients regardless of the services they require. This means that for clients or community members the case manager is the primary contact person and will arrange whatever services are required. This single point of entry approach promotes ease of access and referral processes for the client.*

**Greater Murray Area Health Service - NSW**  
**Continuum of Care – A patient/client centred care approach**

*This model of care was developed at Urana a number of years ago. It was based on the Australian Council of Healthcare Standards EQUIP accreditation standards for continuum of care. The model effectively supports the objectives of the MPS program and facilitated the integration of a range of services at an operational level. Since its development, the model has been adapted into different formats to suit individual health services. The model comprises:*

**The Referral Cycle**

*All services involved in the provision of health and related services within the community are included. All service providers are able to refer clients to each other as required. Services that may be included in the referral cycle can differ between individual communities and catchment populations reflecting the different service profiles and individual circumstances of communities.*

**The Cycle of Care**

*The cycle of care involves the process of: initial contact with the service by the client, assessment of client needs, referral if required, developing the plan of care, provision of services/care, evaluation of care outcomes and discharge.*

**Notification of Client Access/referral**

*This is a standard policy and document shared by all agencies to notify of access/contact/referral of the client. This supports timely and appropriate access to services and continuity of care for the client.*

**Care Coordination**

*The formal care coordination process involves interagency planning, management and evaluation of care.*

*The objective of the model is to provide a seamless, integrated and holistic approach to client care, enhancing access to services and provision of care that is centred on the needs of the client.*

### **South West Area Health Service – Western Australia A Seamless Approach to Care the SWAHS Model**

*This model is being developed across the South West Area Health Service (SWAHS) at an area health service level. The model focuses on the client 'journey' through the health service. It recognises that the journey is often complex, difficult, unplanned, involves multiple people and agencies, multiple entry and exit points and that access to services is more difficult in the rural setting.*

*The SWAHS Approach aims to develop a client focused model. This model will guide health service planning, management and delivery by:*

- *establishing clear programs;*
- *define care pathways and protocols;*
- *linking and coordinating health and other agencies;*
- *co-ordinating client care and case management;*
- *providing a 'travel agency' approach to guide clients through the experience of accessing health services.*

*A feature of the SWAHS model is the Healthcare Framework. The Framework consists of:*

- *'Communities First' – aligning SWAHS with people and communities;*
- *10 health condition based programs;*
- *program planning and priority setting;*
- *specific program Frameworks.*

*The specific program Frameworks are designed to:*

- *link communities and individual in their need for care to the health service agencies' response;*
- *plan and manage the range of services available;*
- *promote seamless delivery of services to communities and individuals;*
- *guide the development of care processes and protocols;*
- *identify health service priorities;*
- *provide a forum for decision making to determine the best use of limited health resources and include the right mix of services.*

### **Griffith Area Palliative Care Service (GAPS) - NSW The GAPS model of care**

*This innovative model in health service delivery commenced in October 2001. It was a joint partnership Griffith Base Hospital in Greater Murray Area Health Service, Griffith Community Health and the Murrumbidgee Division of General Practice. The aim was to improve access to and better integration of palliative care services in the region to support continuity of care for the client. The key partners also engaged other agencies within the catchment area as partners in the project. These included private nursing services, religious groups and volunteers.*

*The project objectives were to:*

- *provide a high quality and responsive service to patients and carers;*
- *ensure that appropriate care and expertise was available when needed;*
- *prevent the inappropriate use of services when better alternatives were available;*

- *use multi-disciplinary care planning so that services are coordinated, patient problems anticipated and services catered for patient preferences such as place of care;*
- *make palliative care available to all who need it in the community;*
- *improve job satisfaction for staff, by supporting their emotional needs, and better managing their workloads by sharing responsibilities.*

*The service delivery model is built around the following direct-care components:*

- *the adoption of common referral criteria for palliative services so that access is improved;*
- *the adoption of weekly case conferencing meetings including all partners;*
- *the creation of a single 1800 number to provide 24hour/7 days access to palliative care services;*
- *local GPs given visiting medical officer (VMO) status at Griffith Base Hospital to attend to their own palliative patients;*
- *the adoption of service delivery protocols that promote continuity of care;*
- *the creation of a 'patient held record' carried with the patient so that each service provider is aware of the care provided by others to avoid unnecessary delays and duplication;*
- *clear delineation of roles and responsibilities for volunteer groups.*

*Components that support the model include:*

- *a computer information system that enables detailed patient data to be stored and analysed. This supports a more consistent approach to patient assessment;*
- *professional education for staff, training for pastoral workers and volunteers;*
- *advertising of the 1800 telephone number to the community.*

*The GAPS model considered the unique issues of providing services to rural communities including distance, availability and retention of staff, communication between carers, pastoral care and volunteer support and information management.*

## **Flexible Care Approaches**

Flexible care approaches focus on different ways of providing services and providing options for care that are client focussed. They are able to move outside more conventional ways of providing health services and care. Flexible care can be based in the most suitable environment for the client and supported by a range of service providers.

There are many different programs that facilitate flexible care, which are supported and funded by both Australian and State Governments. Many of these support people close to or in their own home. These programs compliment many existing care options. But flexible care goes further by thinking laterally, outside institutional models, about what environment is most suitable for the client and how service providers can support this option.

Developing service delivery models, interagency partnerships with a primary health care focus enables service providers to consider different approaches to care and support for the client. In understanding the roles and responsibilities of other agencies, developing flexible staffing practices across different service areas and

multi-skilling, service providers can support flexible options for care, innovation and the sharing of resources.

Currently there are many challenges to providing health and related services in rural settings. Combining the different care environments and methods of providing services is not something that many health professionals and communities are immediately comfortable with. The boundaries that exist between services and professional bodies must be overcome in order to provide flexible care options and new approaches for the sustainability of services.

***Flexible Care Example 1: Consider Mr X, a patient with terminal cancer who was supported at home by his family in a small rural community.***

*Mr X was cared for by his family at home. The family were responsible for his medication and other care needs with some support from the community nursing staff who would visit during working hours to address any problems. There was also consultation with the local GP and area palliative care team as needed.*

*But Mr X's care needs were increasing and it was becoming more difficult for his family to support his basic care needs at home. His family felt Mr X needed to be admitted to the local health service for ongoing care but he wished to remain at home in a familiar environment with his family and friends.*

*All service providers involved were aware of the progression of Mr X's disease and his changing needs through the care planning and care coordination process. To co-ordinate and plan for Mr X's care in an environment that was most suitable for his emotional and physical wellbeing and that of his family, all the service providers including health service staff held a case conference with Mr X and his family. Mr X's needs, his family's needs and what resources were available were considered.*

*Enrolled nurses and personal care assistants were sent from the health service to help the family provide basic nursing care for Mr X. This involved a shared care situation where staff members were rostered to care for Mr X for certain periods through the when his care needs might be greatest. A staff member stayed overnight to support him and give his family the opportunity to rest.*

*This arrangement did not greatly impact on staffing within the health service as staff were not rostered to care for Mr X over the entire 24 hour period and it became a task share arrangement with staff. The cost of consumables was as it would be if he were cared for as an inpatient. It was not a long-term arrangement but was considered as appropriate at the end stage of his disease. Family remained responsible for Mr X's medication with support from the community nursing staff who only needed to visit if there were problems with care. There was consultation with the GP and other service providers as needed.*

*Resources also provided to the family included a bed for ease of care, manual handling equipment, commode and other necessary consumables. This plan enabled Mr X to be cared for in the comfort of his family environment. An OH&S assessment of Mr X's home was undertaken by staff prior to working there. This enabled them to consider any potential safety risks in caring for Mr X in this environment and to then consider strategies to minimise those risks.*

***Flexible Care Example 2: Consider Mr C a recipient of a community aged care package coordinated by the local health service.***

*Mr C lives alone in a small flat, he is aged, has a long history of arthritis, diabetes and heart disease. He has recently had numerous falls, episodes of alcohol bingeing and is not eating adequately or taking care of himself. His family live a long distance away, are unable to care for him and are concerned that he is unable to properly care for himself. They believe he requires residential aged care and currently he would meet the need for low level residential care.*

*The care coordination team are aware of these concerns and Mr Cs increasing needs. In considering the benefits to Mr C, the team had to take into account current resources and their effectiveness.*

*As part of the community aged care package, Mr C is provided with meals from the local health service, socialisation outings, assistance with housekeeping and other activities of daily living. But these services aren't meeting his changing needs.*

*The team reviewed Mr C's care plan and a small roster of community volunteers were engaged by his personal carer to visit Mr C on the weekend and take him his newspaper, socialise with him and delivery his weekend meal from the health service. Mr C was provided with all his current services under the package, but in addition, he was brought to the health service each morning and had lunch with the residents, many of whom he knew.*

*Mr C was included in socialisation activities, diversional programs and outings arranged by the health service. Consequently Mr C was able to remain in his own home environment without premature admission to residential aged care. Mr C was unwilling to be admitted for residential care and through flexible service provision he was able to continue living in the environment of his choice.*

Both of these examples are actual cases and were made possible because of the flexible care approach which included staffing, multi skilling and multi-disciplinary team planning. The concept of flexible care is about what best meets the needs of the individual client.

Consider now the advantages of flexible care and staffing for aged and frail clients trying to navigate their way through the system or alternatively not being able to access services or care. A flexible approach to care supports a seamless process for aged clients. The transition through all dimensions including community care, acute, high and low residential care is complimented by a flexible integrated approach because there is continuity and not fragmentation.

The multipurpose service program has been successful in providing continuity of care for aged clients and supporting an ageing in place philosophy. Aged care clients can move through the services within the local community as their care needs change and services are ideally focused and adaptable to meet those changing needs.

## Multipurpose Services

Multipurpose Services (MPS) provide the opportunity for flexible care. Under Section 49(3) of the *Aged Care Act 1997*, flexible care is defined as:

*"Care provided in a residential or community setting through an aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and community care services."*

Multipurpose Services provide flexible care in small rural communities. Care is provided as part of a coordinated service and accommodation arrangements are directed at meeting several health and community service needs. This flexible approach could be applied to any small rural health service.

The Commonwealth funds the MPS for high and low aged care at a category level three (3) and eight (8) depending on the number of high and low level care places allocated to the MPS when it is established. This funding is known as an MPS subsidy and is paid to the individual health service on a monthly basis. The commonwealth pays the subsidy based on 100% occupancy irrespective of actual occupancy.

The funding is known as a flexible care subsidy to provide flexible care services, therefore it is not paid according to the actual level of care provided unlike other residential or community care subsidies paid to aged care services by the Commonwealth.

This means that flexible care can be provided by an MPS depending on the individual needs of the client and community which could include home based care. This is often a difficult concept for staff, doctors and area bed management/coding personnel to understand and acknowledge. Currently in NSW there is no approval for hospital in the home based services although there is movement in this direction.

There may also be flexible use of beds within the health service which essentially means again that residential and inpatient services are provided depending on the needs of the client. Bed allocation within an MPS is not specifically limited to a particular number of acute inpatients, high and low residential and respite care clients. Bed allocation again reflects the individual needs of clients and community.

The combination of high and low residential care does not have to reflect the funding allocation for beds and likewise an aged care resident can be admitted into an 'acute' bed as a residential aged care recipient or as respite care. The concept also applies to the provision of acute care for aged care residents who can be treated for acute problems if necessary in their own home environment which may be the residential aged care setting.

Another unique feature of the MPS model is the flexible use of funding which means that pooled State and Commonwealth funds can be utilised flexibly to meet changing community needs. This flexible funding also compliments the flexible care approach discussed.

Many multipurpose services have used this flexible use of funding to target population health or primary health care needs within those communities and significantly enhanced the range and access to those services. In these instances if there has been a change in the traditional service mix it has been because of the evidenced changing need of the community. When an MPS considers its mix of clients and their level of services required, it is important to consider the available resources including the workforce but this flexible approach could be applied to any small rural health service.

Home and community care Services and community aged care packages are important key players in supporting flexible care options as is the flexible utilisation of staff within a health service and between agencies. The multipurpose services that have community care services such as HACC, home care, CACPS, high and low level residential aged care well integrated at an operational level can provide a high quality, flexible and seamless aged care service across the care continuum.

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## CHAPTER 5: COMMUNITY PARTICIPATION and PARTNERSHIPS

Community participation and partnerships in health planning and priority setting has been actively promoted at various levels in the health sector for many years. Rural communities are generally close knit and very involved in supporting a range of agencies including health services. Communities consider they have a degree of ownership of health services, therefore community participation and partnerships have particular significance in rural health.

There are varying types of formal and informal community participation with rural health services across each state and territory. These range from boards of management to advisory committees and other community advocacy groups. These groups vary in their roles, responsibilities and relationships with local health services. A wide range of committees have community representatives. These people may be formally or informally involved in many different organisations within the local and broader community. Health services and partner agencies need to develop positive and participatory relationships regardless of the style or type of community group.

*“Participation helps to create a more inclusive and equitable society. Community consultation promotes active citizenship by encouraging individuals to provide real input into public life and decision making. Decisions that have been reached through a consultative process carry greater legitimacy and credibility in the community.”*  
(Western Australian Department of the Premier and Cabinet 2002)

Community involvement in setting health priorities, planning and implementation is very important. Communities have the ability to recognise services that could be valuable assets in partnership with health services and they can help make integration easier.

### Why is Community Participation Important to the Process of Integration?

The National Rural Health Alliance in Healthy Horizons (2003 – 2007) emphasises the importance of community participation in health planning and decision making. The report outlines the willingness of health care providers to enter into partnerships with communities. This in turn supports communities and helps them to adapt to changing social and environmental events.

Active community consultation and participation within a community as part of the integration process has a range of positive outcomes for health services and their partner agencies which include:

- a demonstrated commitment to accountability and transparency;
- assistance and support in decision making with increased legitimacy of decision making;
- building a more inclusive and productive relationship between agencies particularly if there is community interest/involvement in the agency;
- promoting of community involvement and empowerment;
- partnerships in planning and prioritising service options;
- facilitating knowledge within the community of the roles and responsibilities of the various agencies;
- revealing actual and potential problems/issues within the community;

- identifying the strengths and needs of the community; and
- supporting community capacity and social capital.

Community participation supports a primary health care approach in working with the community to enhance its health and wellbeing by:

- increasing an awareness of social issues/problems that can affect the community's wellbeing;
- building resilience within the community;
- advocating on behalf of the health service and partner agencies;
- broadening the scope of knowledge about the community to the community;
- recognising and supporting those who may be marginalised and not have a voice; and
- encouraging and engaging increased community action and participation in health education/promotional activities.

(Government of South Australia 2004)

There can't always be agreement or consensus between the community and health service providers on particular issues but community members must feel valued and supported. A relationship of trust and respect between the partner agencies and the community is crucial. In decision making processes there must be negotiated outcomes that each party are willing to reach agreement on.

(Western Australian Department of the Premier and Cabinet 2002)

During the course of this project, participating local government agencies expressed the view that health service managers in rural communities needed to form strong partnerships and participatory relationships with their community. These agencies acknowledge that health reforms including restructuring and amalgamation across broader geographical areas made these relationships crucial, facilitating community involvement in decision making and preventing communities feeling isolated from this process.

Local government agencies considered education and support for managers, community members and partner agencies was necessary to facilitate successful community participation and partnerships. This link with the community is needed to 'keep faith' in the health system, its changing focus and its ability to meet community needs.

### **Community Capacity**

Community capacity is the collection of characteristics and resources which when combined, improves the ability of a community to recognise, evaluate and address problems. The concept of community capacity must be considered in this chapter, as the level of community capacity will influence not only the health and wellbeing of the rural community but also the community's ability to become involved in a participatory relationship with a health service.

The University of Queensland Centre for Primary Health Care has identified that a community capacity approach within a community increases its level of resilience and sustainability. Community organisations and groups with appropriate resources can support and maintain a community's health and wellbeing.

Developing community capacity means building a community's skills. This strengthens its ability to define and achieve objectives, consult, plan, manage projects and undertake partnerships and ventures that support community sustainability.

Community capacity building is an important component of developing community partnerships with health services. Capacity building supports:

- participation and inclusion of all community groups including those marginalised, in decision making processes acknowledging that greater participation can lead to improved outcomes and solutions;
- an holistic approach - recognising the interdependence that exists between groups within the community and between the community and wider region;
- the recognition of diversity within the community through the identification and utilisation of resources from a variety of settings;
- being responsive to the community, recognising that change is an important part of community life therefore communities should be supported to work in an evolving and adaptive manner; and
- sustainability because the community and its groups are supported while developing abilities and resources to take on community initiatives.

(University of Queensland 2002)

Capacity building needs to be linked to the development of new ways of working. These new ways should encourage interagency cooperation, high levels of flexibility and adaptability, and a broadening of the sense of ownership of initiatives within a community (World Health Organisation 2003).

Community capacity is essential when assessing community needs and establishing health priorities. Its indicators are the characteristics of a community that link to the community's health and wellbeing. Consider Chapter 2 and the example of Boyup Brook and the community survey *'How is Your Life in Boyup Brook'*. The questions in that survey helped identify community needs for current and future planning and could also indicate the level of community capacity.

Another indicator of community capacity is social capital which is the established organisations, relationships and norms that build the profile of the community.

Indicators of the level of social capital can include:

- the level of volunteer support within organisations/groups/community projects;
- active clubs and club membership;
- employment;
- the level of violence within the community and family;
- rates of property crime.

(Australian Institute of Health and Welfare 2004)

### ***Jerilderie Healthy Community Committee***

*This local community committee was formed following a Jerilderie community forum. While generally the community was seen as strong and productive, some groups were identified as marginalised, particularly the aged population and those who did not have a means of transport to access social and recreational activities.*

*The forum recognised that recreational groups and other organisations could increase the social cohesion and wellbeing of the Jerilderie community by working together to plan and hold joint activities catering for all age groups. These would increase access to a range of social and physical activities.*

*A committee was formed and has members representing the various sporting organisations, community groups, local government and schools. The committee is supported by the community health service and the area health promotion unit, with the use of facilities, assistance with committee administration and help with planning and promotional ideas. While the health service encourages the committee to be self sustaining, it attempts to remain in the background providing support when needed.*

*Committee initiatives have included the formation of a sing Australia group, cooking classes for young adults, exercise classes for the frail and aged, lead lighting and furniture restoration courses, funding for improved lighting and paving around walking tracks and the installation of fire alarms in all home of people 65 years and over.*

*The health service Advisory Committee helped develop these initiatives and its representation extends to the healthy community committee.*

### ***Margaret River Community Project***

*Margaret River Health Service does not have a formal community advisory group as such but has formed a working group consisting of community service providers, local government, schools, police, recreational groups, private agencies and community representatives. This group aims to identify social issues that are impacting on community health and wellbeing and to develop and progress strategies to address these issues.*

*The working group focuses on a social model of health and supports an inclusive community approach to primary health care and building the community's capacity. The working group controls the development of this initiative and it is not directed by the health service. However, there is a positive and supportive working partnership between all representatives.*

*One outcome of this community working group partnership has been the start of a national research study into the increasing drug related problems in the local area.*

## Considerations When Progressing Community Participation and Partnerships

Each State and Territory has different laws and requirements about formal consumer/community participation in health services. Developing participatory relationships and partnerships with the community must allow for these differences. Local health services need formal systems to guide and promote meaningful community participation. This will not only improve communication between the health service, partner agencies and the community but also enhance integration within health services and between health services and other agencies.

In many states there has been a move away from a board of management structure of community involvement to one of community representatives involved in strategic planning, liaison and advocacy working at a more regional level. The role of the health service in supporting community participation and partnerships at a local level and promoting transparency and supporting links to more regional levels remains crucial to effective management and provision of health services.

Local government agencies support consumer and community participation but they caution local health services in how they engage communities. The interaction should be meaningful and the community need to be supported in understanding how health issues affect their communities. Health service manager also need education and support in learning to work with communities.

In *Building Blocks for a National Health Policy* (2004) – papers on Australian health policy and reform – Menadue stresses the necessity for community participation in health issues. He says genuine community involvement is essential to determining priorities. When health services take this approach, he argues, communities are quite realistic about important health priorities.

### **Upper Murray Health and Community Services**

*The management board of the Upper Murray Health and Community Services has facilitated a 'bottom up' approach to service planning. The board encourages the community to set the priorities for health services. This enables the health service to respond effectively to the unique needs of each person and the community, as apposed to a 'top down' service approach that develops a range of services and then imposes them on the community.*

*A community liaison group was established by the management board and acts as a link between the health service and the community. This group is not part of the management board but represents a range of people from the community. The group has:*

- *provided information to the community about health services and access to services;*
- *participated in service quality improvement programs to ensure health services are relevant to client needs;*
- *provided feedback to the management board on health services and access to services;*
- *participated in health service and corporate planning;*
- *facilitated agency alliances and coordination between services; and*
- *participated in community planning processes.*

## Supporting a Process of Consumer/Community Participation and Partnerships

Encouraging client/community participation and partnerships with the local health service and partner agencies is facilitated by:

- having a clear and achievable vision for the health service that reflects its support and involvement with the local community;
- a commitment by management and staff to fostering an open and transparent working relationship with the local community;
- clarifying roles and responsibilities for community representatives including those within a formal Community Advisory Group (CAG) if established;
- establishing clear levels of accountability between the CAG and health service;
- developing an action plan by the CAG in partnership with the health service and partner agencies. This plan should detail clear and achievable objectives and strategies for the group to represent the wider community;
- detailing the action plan's media strategy and outline a feedback process for the community;
- involving the community in continuing service planning processes and ensure access to adequate and appropriate information regarding services enabling them to make active and informed decisions;
- include in the strategic plans of the health service and partner agencies the goals/objectives and strategies for community participation; and

The *Country Health Reform Community Participation Final Report* by the South Australian Department of Health acknowledges that to achieve active and committed community participation, health service providers need to let go of the expert model and develop skills to gain confidence in community participation. This supports local government comments emphasising the need for education of managers in the process of community consultation.

In 2003, the World Health Organisation identified a global trend to involve communities in participatory programs at the community level. To succeed, programs must include community participation and partnerships – imposing programs without consultation ignores important local knowledge.

The South Australian *Country Health Reform* recognises that health service providers and government need to acknowledge and incorporate community views and accept them as experts in their own wellbeing. Respecting community input and sharing information openly will build a foundation of trust.

Some examples of formalised community participatory arrangements approved by various State Departments of Health and Human Services are briefly described:

**Advisory Committees**

*Advisory committees represent a broad cross section of the catchment population of the health service. These committees are formed in communities that have Multipurpose Services in NSW.*

*An advisory committee's role is to act as an advocate for the local community, liaising with the health service and participating in the planning of health services. The degree of involvement by committees in these processes varies across NSW.*

**Consumer Health Councils**

*Consumer health councils function within the area health services of NSW and have a similar role to the advisory committees but represent a network comprising of a number of local government areas. Many are involved in projects relating to health promotion and planning initiatives in conjunction with area and local health services.*

**Area Health Advisory Councils**

*Area health advisory councils are being developed in NSW as part of recent reforms and a restructure of area health services. By making these changes the NSW Department of Health aims to ensure that clinicians and community members participate in decisions affecting the planning and delivery of health services at local, area and state level.*

**Management Boards**

*Victorian management boards are responsible for the entire management of a community's health service. By contrast the role of South Australia management boards is across a range of health services within a regional area with their role evolving to an advisory rather than direct management role.*

**Community Services Boards**

*Tasmanian community services boards support the three Multipurpose Services and have a similar role and responsibility to that of the advisory committees in NSW. Tasmanian multipurpose services have a strong participatory relationship with the health services and the health services are committed to working with the community services boards.*

**Community Advisory Networks**

*Queensland community advisory networks operate in communities that have multi purpose health services. Their role is to advise on community issues relating to health service delivery similar to those in NSW and Tasmania. They are made up of representatives from local government departments including education, police, local government and community members.*

## CHAPTER 6: DEVELOPING INTERAGENCY PARTNERSHIPS

Providing services that are streamlined, less fragmented and not duplicated has placed increased focus on partnerships across government and non government sectors and between health services and other agencies. The challenge is providing greater choice, improved access and quality services to clients.

*“Partnerships are essential for effective action to address health inequalities within the health system and with local communities and other government and non government organisations.” (NSW Department of Health 2004)*

Development of interagency partnerships depends on the compatibility of agencies and the capacity of each agency to provide services and undertake projects that are mutually beneficial to the client and agencies themselves. Positive interagency partnerships are characterised by:

- benefits for the client and partner agencies;
- a strong understanding of each others values, roles and responsibilities;
- a clearly defined vision and purpose shared between partner agencies;
- joint activities and ventures that have strategic value for the partner agencies;
- the involvement of managers, staff and community in the development of the partnership; and
- strategic interagency planning.

It's important to acknowledge that an integration process is not guaranteed simply by the 'cashing out', pooling of funds or the devolving of management and services to one particular agency. Research from this project has shown that in some cases where this has occurred, it has not necessarily led to improved service provision. And at the other end of the spectrum, those agencies that have not made a formal partnership commitment but have informally agreed to work together are not necessarily successful in the process either.

The Drucker Foundation in the USA, the United Kingdom National Health Service and the United Kingdom Audit Commission have developed practical and informative partnership and collaboration resource materials. The web sites where this information is available are provided in this document's resource list.

## Steps toward Developing Partnerships

When seeking opportunities for partnerships agencies seek benefits that will further their purpose, improve services for their clients, strengthen the organisation and achieve desired outcomes. The steps towards developing partnerships are described in the following table:

<p><b>Identify the strengths of the health service that could be of value to other agencies</b></p> <p><b>Rationale:</b> <i>Identifying what assets, resources and strengths the health service has that could benefit other agencies will assist in determining what agencies would be of value to the partnership.</i></p>	<ul style="list-style-type: none"> <li>▪ what is the vision of the health service?</li> <li>▪ does the health service have a positive profile within the community and what is the ability of the health service to increase its profile?</li> <li>▪ does the health service have well known and respected leadership representatives;</li> <li>▪ what type of clients access the service, what is the client profile?</li> <li>▪ existing communication systems both internal and external;</li> <li>▪ programs and projects in progress;</li> <li>▪ access to potential employees and volunteer opportunities;</li> <li>▪ staff skills and expertise;</li> <li>▪ fundraising capacity;</li> <li>▪ facilities and equipment;</li> <li>▪ education and professional development opportunities.</li> </ul>
<p><b>Determine the benefits the health service might seek in a partnership</b></p> <p><b>Rationale:</b> <i>Understanding the benefits the health service is seeking will help focus on potential agencies most likely to give the health service those benefits.</i></p>	<ul style="list-style-type: none"> <li>▪ consider other services that are valued by clients that could further the health service's vision and strategic goals;</li> <li>▪ information sharing that benefits the consumer and the organisation;</li> <li>▪ people working as volunteers or service providers;</li> <li>▪ sharing of resources;</li> <li>▪ improved relationships and access to new sources of benefits;</li> <li>▪ reduced fragmentation and duplication of services/care;</li> <li>▪ opportunities for professional development and education;</li> <li>▪ improved efficiencies.</li> </ul>

<p><b><i>Supporting a strong foundation within the organisation by effective management and leadership to build partnerships</i></b></p> <p><b><i>Rationale:</i></b> <i>The health service needs to critically review its vision and strategic goals and in doing so, consider objectives that could enhance partnership opportunities.</i></p>	<ul style="list-style-type: none"> <li>▪ how can the potential partner agencies help achieve the health services strategic goals?</li> <li>▪ is the agency effective and efficient in its work. Is there an effective governance process including: <ul style="list-style-type: none"> <li>- clear delegation pathways;</li> <li>- timely decision making processes;</li> <li>- performance management processes;</li> <li>- the capacity to establish sound policies and set clear directions?</li> </ul> </li> <li>▪ how does the health service demonstrate the ability to plan, implement and evaluate service provision and new initiatives?</li> <li>▪ what quality control programs are in place to demonstrate the ability to achieve results and progress continuous improvement?</li> <li>▪ will the health service's financial systems be able to support possible resource development and other effects of integration?</li> <li>▪ does the culture of the health service support innovation, openness to new ideas, challenges and learning from experience?</li> </ul> <p><i>Consider what the health service can do to improve its ability to develop and manage the partnership.</i></p>
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## Potential Partnerships

The agencies that could partner with health services may or may not have a health care role. It is important to note that a community's health encompasses many situations. An organisation that can enhance the wellbeing and quality of life for individuals and communities could add value through a beneficial partnership with the health service.

The health service needs to determine what agencies it has a relationship with and the nature of that relationship. Identifying joint activities and projects that compliment agencies, has strategic value when considering a potential partnership. However, when identifying the benefits of integration agencies should also identify and consider any non-benefits or negative impacts.

Potential agency partners should be compatible and benefit from the partnership. Integration issues to consider:

- will the partnership improve access to services and care between agencies?
- how will the partnership service clients and the wider community?
- are the health services values attractive and compatible to other agencies?
- what do the agencies want to understand about each other?
- what resources can be exchanged and/or shared within the partnership?
- how will the partnership be incorporated into the strategic and operational plans?
- what level of commitment does the health service want to obtain from the partner agencies?
- are there any risks to the health service and partner agencies reputation or financial position?

***Division of General Practice and Area Health Service Partnership in supporting sustainable allied health services***

*This is currently a proposed partnership between these agencies, local government, community representatives and health services in southern NSW. Its aim is to address the chronic shortage of allied health professionals in the region.*

*As each agency cannot individually fund or provide a full time position it is proposed that there be joint funding and recruitment between the partners to attract allied health professionals to this area.*

*Both the Division of General Practice and the Area Health Service will manage the services. They will be provided as a hub and will be integrated with existing primary health care services, GP practices and local health services.*

*The proposed allied health services will be accessible to both public and private clients. The allied health professionals will be part of a network multi-disciplinary team which will enhance client care and also provide the professional support and interface with other service providers.*

***Urana and District Health Services  
Integration of Home and Community Care Services (HACC)***

*In NSW HACC services are part of the Department of Ageing Disability and Home Care (DADHC). In 1994 it was agreed by this department to 'cash out' this service to the newly developing Multipurpose Service at Urana.*

*The health service at Urana employed a HACC coordinator and provided extensive training through DADHC and networking with external HACC providers to support the coordinator in their role. It was agreed that the health service would manage the finances of HACC and provide the services within the legislative and policy requirements of DADHC.*

*The integration of HACC at both a management and operational level continues to be a successful process for Urana ten years later. The coordinator is very committed to respecting the policies of that government department and ensuring that services are provided within those requirements.*

*What the integration of the service successfully achieved was linking the health service with primary health care services including community health. Having the HACC service as a component of the health service resulted in a range of benefits for the service providers and importantly the clients. The benefits included:*

- *Increased provision of community transport services, utilising the health service bus to coordinate and provide transport services for HACC targeted clients and non HACC targeted clients. This provided the opportunity to increase access to podiatry services, specialist appointments, physiotherapy service and social activities including shopping. Service utilisation increased with significant savings in community transport expenditure due to sharing of resources;*
- *Increased provision of respite care in the home supported by enrolled nurses and personal care assistants within the health service, again sharing resources and showing significant cost savings;*
- *Flexible utilisation of staff across a range of service areas;*
- *The ability of HACC clients to access health service diversional activity programs and associated activities that would not be previously accessible unless in residential aged care;*
- *Single assessment, referral and information management process to promote and facilitate continuity of care;*
- *A case management/care coordination process that flowed across and involved all levels of service;*
- *Early intervention and prevention of unnecessary hospitalisation due to timely identification of potential problems and multi-disciplinary team management;*
- *No duplication of services and assessment of clients, if a client accessed the health service for treatment or admission, the process was very streamlined and the integration of client records meant that the information was accessible to all relevant providers;*
- *A significant reduction in readmissions or crisis admissions as all relevant service providers including HACC, were directly involved in care coordination and planning for discharge throughout the care continuum.*

### **Victorian Department of Human Services Primary Care Partnerships**

*The Primary Care Partnership (PCP) Strategy was launched in 2000 by the Department of Human Services. Its purpose is to create a primary health care service system through a partnership approach. It is a major reform in the way services are delivered in the primary care and community support services sector.*

*The PCP is founded on the social model of health and aims to improve the overall health and wellbeing of Victorians by:*

- *Improving the experience and outcomes for people who use primary care services;*

- *Reducing the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support.*

*There are 31 primary care partnerships across Victoria with over 800 services participating in the partnership.*

*(Victorian Department of Human Services 2004)*

### **Responsibility for Developing the Partnership**

Those responsible for developing the partnership between agencies must be identified. They are then responsible for the dissemination of regular information on the development of the partnership. Included in the communication should be those responsible for the overall governance of the involved organisations.

Parameters must be set on ethical matters such as conflicts of interest, confidentiality and acceptable practices between the partner agencies. The legal and legislative requirements of the agencies and their level service provision must be made clear. Policies and guidelines must be discussed and formalised to support and legitimise the development of the partnership, consequent service provision and management of resources.

Memorandums of understanding and/or partnership agreements that detail responsibilities, management, utilisation of resources and service delivery should be developed in consultation with consumer representatives and all the partner agencies. Mutual expectations must be clarified and formal agreements established. This is to provide transparency, avoid misunderstandings and can be used to form the basis for continuing evaluation giving the partnership more credibility.

### **Greater Murray Area Health Service Draft Memorandum of Understanding**

*This partnership agreement was developed by the Greater Murray Area Health Service to support different types of health service and agency partnerships. This partnership involves a project where more than one organisation shares responsibility for a particular service or project. Each organisation contributes to planning for the project or service and has a role in the governance of the project. The memorandum of understanding includes:*

- *the purpose of the project, including objectives and outlining what the partnership is to achieve;*
- *the principles and values that underlie the partnership;*
- *evaluation, review and performance indicators to measure the progress and effectiveness of the partnership;*
- *identification of the key players;*
- *the roles and responsibilities of each of the partner agencies – what contributions are agencies expected to make?*
- *project governance clarifying accountability, reporting, delegation, funding, human resources;*
- *communication mechanisms including meeting procedures; and*
- *processes for dispute resolution.*

## **Promoting the Partnership**

Developing a partnership with other agencies is a positive step to improving services and providing care to the community. Partnerships developed between agencies need to be actively promoted:

- communicate the benefits of the partnership to the community and the partner agencies;
- update and distribute service information, including service profiles, contact names/numbers and how to access services;
- promote the joint vision and objectives of the partnership;
- invite and support community feedback;
- ensure that open communication between all key players including the community remains ongoing and consistent.

## **The Partnership Management Plan**

The partnership management plan complements any formal agreements between agencies. These plans should include:

- how the agencies will include each others strategic and operational plans, and practices to ensure continuity;
- how the partnership will maintain mutual trust and commitment;
- how to sustain open and continuing communication;
- how often to evaluate partnership performance and by whom; and
- how agencies will continue to learn about each other in order to strengthen the partnership, seek new opportunities and innovation.

## **Co-location Opportunities to Support Partnerships**

Many agencies are seeking opportunities for co-location arrangements with partner agencies. The benefits of co-location for partner agencies include:

- improved access to a wider range of services for clients;
- improved continuity of care;
- reduced fragmentation and duplication of services;
- the potential for sharing of resources including staff;
- understanding each agencies roles and responsibilities;
- increased opportunities for joint planning and initiatives;
- opportunities for developing innovative service delivery models;
- a more positive profile within the community;
- more meaningful community participation in joint service planning and projects;
- financial efficiencies between partner agencies.

To support integration at an operational or functional level, Co-location must be supported by formal partnership agreements, a partnership management plan, joint strategic and operational planning and continual evaluation of the partnership. Co-location alone can't support integration.

## Critical issues that affect Sustainable Partnerships

<p><b><i>Performance</i></b></p>	<ul style="list-style-type: none"> <li>▪ develop an agreed vision or purpose between agencies and support this by having realistic and achievable outcomes;</li> <li>▪ the partner agencies must be flexible when sharing resources to achieve partnership goals;</li> <li>▪ performance tracking systems must be established;</li> <li>▪ establish clear criteria for the allocation of resources based on the objectives of the partnership;</li> <li>▪ ensure partnership resource availability through effective resource management;</li> <li>▪ develop performance indicators to monitor the effectiveness of partnerships;</li> </ul>
<p><b><i>Inclusion</i></b></p>	<p>Key players including partner agencies and the community must have opportunities to contribute to the partnership in ways relevant to them.</p>
<p><b><i>Governance and accountability</i></b></p>	<p>Governance arrangements between agencies and within agencies must be fully considered as agencies may be risking their finance and reputation:</p> <ul style="list-style-type: none"> <li>▪ each agency must practice its professional practice and governance standards;</li> <li>▪ agencies must formally document, communicate and include in a memorandum of understanding and or partnership agreement their roles, responsibilities and accountabilities;</li> <li>▪ decision making must be made at the correct delegation level;</li> <li>▪ procedures for dealing with conflicts of interest must be formalised;</li> <li>▪ systems must be in place to control, monitor and report on service activity and finances.</li> </ul>

## Evaluation of the Partnership

Evaluation of the partnership should occur periodically. This is to review the progress and continued effectiveness of the partnership. The results of this evaluation need to be incorporated back into operational plans and future strategies. By establishing an open and transparent review process, health services and other community care agencies can form productive, professional and equal partnerships with a range of agencies. In doing so, they develop strong leadership roles and healthy inclusive and cohesive communities.

## CONCLUSION

This resource provides practical information to support integration at an operational level for small rural health services. While some of the initiative examples are from larger areas or organisations, they are still relevant and applicable to a small rural health service and its potential partner agencies.

The MPS program in particular has addressed sustainability issues for many rural communities across Australia. The program has challenged ideas held about the constraints to partnerships and coordinated flexible service delivery and has led to this project.

Rural health services can no longer continue to work in traditional ways if they are to effectively meet the needs of their communities. This project has identified many variables that can impact on a health services ability to integrate and form partnerships. But the key issue is about looking for positive opportunities and being willing to cross the boundaries between services and realistically focus upon the client/community needs.

All those who participated in this project, saw a reorientation to primary health care encompassing service integration as the direction for rural health to address community needs in the future and to be able to continue to provide appropriate and sustainable services.

The project has identified the need for more education within rural health services. Lack of education was viewed as a barrier to change and impacts on the quality of service provision.

Education takes commitment and planning from managers and they also need to participate and learn. There are many health services that are part of the MPS program and have not been researched in this project. These health services can also share experiences, knowledge and innovation. An education process is not only the responsibility of the area/region or state department to instigate or manage. The local agencies also have a responsibility to undertake the initiative of education, different ways of working, to make contact with and research innovative services with support from relevant departments.

To ensure integration keeps progressing and continues to be effective, there must be ongoing planning and education embedded in the organisation. This will support new key players to understand the concept and to continue to drive the process.

## GLOSSARY OF TERMS

**Access** – The physical access and availability of locally based services and the use of broader networks supported by larger regional or metropolitan centres. Access must be supported by an understanding of cultural diversity and the various settings in which people live (Healthy Horizons 2003-2004).

**Client/Consumer** – Includes all people who use or potentially could use a service (WA Department of the Premier and Cabinet 2002).

**Community** – A group of people or town that has common interests. They may share social or cultural backgrounds or hold similar aspirations (WA Department of the Premier and Cabinet 2002).

**Community Aged Care Packages** – Community Aged Care Packages (CACPS) are planned and co-ordinated packages of community care services to help older people with complex care needs remain living in their own homes. They are designed for each individual and are based on their particular needs (Australian Government Department of Health and Ageing 2004).

**Empowerment** – People taking control over their lives, setting their own agendas, developing skills and solving problems and increasing their self confidence (WA Department of the Premier and Cabinet 2002).

**Equity** – Equity in health is about fairness. “It is not about eliminating all health differences so that everyone has the same level of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest levels possible” (WHO, The concepts of equity and health as cited by NSW Health *In All Fairness 2004*).

**Health** – A state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity (WHO 1986).

**Health Promotion** – The process of enabling people to increase control over and to improve their health (WHO 1986).

**Home and Community Care Services** – The Home and Community Care (HACC) Program is a cost-shared program between the Commonwealth, State and Territory Governments. The program provides funding for a range of services which support people who are at risk of inappropriate admission to long term residential care. The Program also supports their carers (Australian Government Department of Health and Ageing 2004).

**Participation** – The range of formal and informal activities whereby individuals and community organisations contribute to government decision making and the planning and/or management of community resources and services (Illawarra Health Service 1997).

**Performance** – The organisation's progress and achievements (Drucker Foundation 2002).

**Primary Care** – Essential health care based on practical, scientifically sound and socially acceptable methods made universally acceptable to individuals and families in the community (Council of Australian Governments 2004).

**Primary Health Care** – Encompasses efforts to address health concerns for the entire community. Primary health care aims to promote and support the maintenance of good health, including equipping people with the skills to manage and maintain their own health. It is often the first point of contact for a person with the health system (Healthy Horizons 2003-2007).

**Purpose** – Why an organisation does what it does, the organisation's reason for being (Drucker Foundation 2002).

**Resources** – Any persons, equipment, or material needed to perform a task(s).  
[www.georgetown.edu/uis/ia/dw/GLOSSARY0816.html](http://www.georgetown.edu/uis/ia/dw/GLOSSARY0816.html)

**Strategic Planning** – Strategic planning sets the framework for service delivery for a designated period of time. The strategic planning process requires a number of steps to identify the issues in current service delivery and develop strategies to address these issues (Greater Murray Area Health Service 2003).

**Sustainability** – Sustainability is a state in which health, related knowledge and expertise of the workforce and the community are not diminished over time. As the requirements of a community change, resources must be able to adapt to the change in a planned way (Healthy Horizons 2003-2007).

**Viability** – To remain practical or workable (Macquarie Dictionary 1998).

**Vision** – Vision is the 'strategic intent', taking the organisation beyond its comfort zone to future ambitions. The vision must give a strong sense of what the organisation wants to focus on. It is a future ambition articulated today, managing the present from a stretching view of the future (Stace and Dunphey 2001).

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## REFERENCE LIST

Australian Government Health Care Summit (2003), *A Blueprint for Reform*.

Australian Institute of Health and Welfare (AIHW) (2004) Chapter 5. *Health Resources*.

Australian Institute of Health and Welfare (AIHW) (2003). Rural, Regional and Remote Health: information framework and indicators. Version 1. AIHW cat. No. PHE 44. Canberra: AIHW.

Bates, A., Lovitt, A., & Orpin, P. (2003) Campbell Town Health and Community Service Health Map Project *A Report Summary*. November 2003.

Centre for Primary Health Care University of Queensland (2002) *Community Capacity Index Manual* Version 2.

Chapman, J., & Neumayer, B. (2000) *Report on the Evaluation of Flexible Rural Health Services in NSW*.

Commonwealth Government Aged Care Act 1997.

Commonwealth Government Australian Health Minister's Advisory Council's National Rural Health Policy Sub-Committee (December 2002). *Multipurpose Service Model* (pp. 2-4) Commonwealth of Australia 2002.

Commonwealth Government (2002) National Resource Centre for Consumer Participation. Commonwealth Department of Health and Ageing.  
[www.participateinhealth.org.au/ClearingHouse/Docs/cfevidence.pdf](http://www.participateinhealth.org.au/ClearingHouse/Docs/cfevidence.pdf)

Council of Australian Governments (2004) *Report on Government Services, Health 2004*.

Dade Smith, Janie., (2004). Australia's Rural and Remote Health *A Social Justice Perspective* (pp. 2, 16, 48). Pub: Tertiary Press, Croydon, Victoria Australia 2004.

Duckett, S. (2004) *Threats to Universal Health Care* Health Reform Transcripts September 2004. Whitlam Institute University of Western Sydney.  
<http://www.whitlam.org>

Eagar, K., Garrett, P., & Lin, V. Health Planning *Australian Perspectives* (pp. 138-148) Pub: Allen & Unwin Sydney Australia.

Evans, F., & Hoodless, M. (2001) The Multipurpose Service Program *The Best Health Option for Rural Australia*. The Australian Journal of Primary Health Vol 7 Number 1 2001.

Harris, E., & Simpson, S. (2003) *Strengthening Health Care in the Community* Consultation Report. University of New South Wales Centre for Health Equity Training Research and Evaluation.

Greater Murray Area Health Service (2003) Strategic Planning Process *Developing a Strategic Plan*.

Greater Murray Area Health Service (2004) *Draft Guidelines for Working with other Organisations*.

Government of South Australia Department of Health (2004) *Country Health Reform Community Participation Final Report* Department of Health Country Division, July 2004.

Government of Western Australia Department of the Premier and Cabinet (2002) Citizens and Civics Unit. *Consulting Citizens a Resource Guide* April 2002.

Menadue, John. (2004) Building Blocks for a National Health Policy November 2004. <http://www.newmatilda.com>

National Rural Health Alliance Healthy Horizons Outlook 2003-2007  
*A Framework for Improving the Health of Rural, Regional and Remote Australia*.

NSW Department of Health (2004) *In All Fairness – Increasing equity in health across NSW* May 2004.

NSW Ministerial Advisory Committee on Health Services in Smaller Towns (2000) Report to the NSW Minister for Health *A Framework for Change*.

Neumayer, B., & Chapman, J. (2003) Original Article *Role of Multipurpose Service Program Providing Residential Aged Care in Rural Australia: A Discussion Paper*. Australian Journal of Rural Health (2003) 11, 287-291. Accepted for publication: June 2003.

Robertson, Jamie. (2004) Phase one IF Implementation plan facilitator community living services – Ministry of Children & Family Development. Community Mapping: *Some Questions for discussion and related resources*. February 17, 2004. <http://www.communitybuilders.nsw.gov.au/>

Schneider, Stuart. (2004) The Australian Journal of Rural Health *Functional Integration of Rural Health Services* Australian Journal of Rural Health (2004) 12, 36-37.

Stace, D., & Dunphy, D. (2001) *Beyond the Boundaries Leading and re-creating the successful enterprise* 2<sup>nd</sup> Ed. Pub: McGraw-Hill Australia.

The Drucker Foundation (2002) *Meeting the Collaboration Challenge*. [www.drucker.org](http://www.drucker.org)

The University of Queensland Centre for Primary Health Care (2002) *Community Capacity Index Manual Version 2*.

United Kingdom National Health Service Integrated Care Network  
[www.integratedcarenetwork.gov.uk](http://www.integratedcarenetwork.gov.uk)

United Kingdom National Health Service (NHS) Modernisation Agency (2002)  
Improvement Leaders Guide to *Managing the human dimensions of change: Working with individuals*.

Victorian Government Department of Human Services Aged Community and Mental Health Division (2001) Primary Health Care Partnerships *Integrated Service Planning: Interim Guidelines* April 2001.

World Health Organisation (1986) The Ottawa Charter for Health Promotion. World Health Organisation, Geneva.

World Health Organisation (2003) Primary Health Care *A Framework for Future Strategic Directions* Global Report.

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This project was sponsored by the Greater Southern Area Health Service NSW and the Australian Government Department of Health and Ageing. There are a range of recommendations from this Project that would assist in facilitating more sustainable health and community care services to rural communities.

The recommendations from this Project are as follows:

- That Community Advisory Groups are formed within rural communities and these Groups are active in supporting service planning and primary health care initiatives in partnership with Health Service providers.
- Key stakeholders including health service providers, consumers, external agencies and community groups have education and support around the concept of primary health care and service integration;
- Local primary health care services are integrated under a single management structure of health services within rural communities;
- If services are managed independently, formal partnerships and associated agreements are formed with external agencies to support continuity of care, access to services and flexible service provision for consumers.
- Extensive needs assessments and service planning are undertaken regularly to identify the appropriate mix and level of health services for small rural communities;
- Health Service Managers and staff are orientated and supported to understand the concept of service integration and how this can benefit their organization and client outcomes;
- There is increased accountability of Health Service Managers to engage and work with local communities in service planning and initiatives. Performance agreements with Health Service Managers reflect consumer involvement, primary health care initiatives and integrated models of service delivery;
- The State government and Area Health Service enable small rural health services to develop flexible care options and care closer to or in the home environment for clients rather than a typically hospital bed based model;
- The State government and Area Health Service support rural health services to introduce broader, flexible workforce models across service areas. This would include the increased use of non clinical staff supporting client care within the health service or the home environment of the client.

## **FUTURE DIRECTION FOR THIS PROJECT**

The future intent for this model is to:

- Source further funding from State and/or Australian Government to implement this model across the Greater Southern Area Health Service – this would be an extensive three year process;
- Form a Steering Committee of 'like minded' people including Area Health Service Executive to develop a very detailed implementation plan to support the introduction of this model;
- Liaise and formalize a partnership with the NSW Department of Ageing Disability and Home Care to progress the management and operational integration of those services within a selected range of small rural health services across the Area Health Service;
- Develop specific and individual resource packages to support introduction of this model for consumers, health service managers, staff and potential partner agencies.

The Chief Executive and Senior Executive Staff of Greater Southern Area Health Service have reviewed this integration model and believe it can support the new structure of services within the Area Health Service. The overall intent is to implement this integration model across a range of small rural health services within the Area Health Service.

This model fits with the strategic direction of the Area Health Service and NSW Department of Health. That strategic direction supports increased focus on primary health care; consumer participation and partnerships with health; provision of services closer to home; a more flexible approach to service provision; a flexible multi skilled workforce; improved access and a client centric approach to care.

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**Charging at Multipurpose Facilities \*(needs to be printed on A3 paper)**

This table is to be used in conjunction with the Australian Government Department of Health and Ageing's Residential Care Manual

ITEM	MPS			ADMITTED PATIENT CARE		
	HIGH CARE	LOW CARE	DVA	PUBLIC	PRIVATE	DVA
Accommodation Charge	Resident Contribution	Resident Contribution	Resident contribution <sup>30</sup> .	No charge	Patient charged either single or shared rate	Code as DVA financial class
VMO and Salaried Clinicians and Diagnosticians	Billed directly by practitioners.				Doctor charges patient	Charge DVA when treated within rights of private practice
Pharmaceutical <sup>31</sup>	Resident pays	Resident pays	Resident Pays		No Charge	No Charge
Medical Supplies <sup>32</sup>	No charge Clinical Practice Guidelines determine appropriate items	No Charge	No Charge			
Surgical Treatment Supplies, e.g. Bandages, dressings items	No charge	Provision in accordance with local policy comparable with community nursing service to Hostel residents	See level of care			
Oxygen	No charge	Not Applicable	No Charge			
Continence Management <sup>33</sup>	No Charge	No Charge Clinical assessment for PADP	No Charge			
Enteral Feed	No Charge	Not applicable	No Charge			
Toiletry Goods	In accordance with the Residential care Manual	In accordance with the Residential care Manual	See level of care		Hospital provides basic toiletries. Patient required to provide other luxury items	
Allied Health Services	Services for assessment short term treatment provided no charge <sup>34</sup>	Private practitioners resident pays <sup>35</sup>	Check resident's eligibility for DVA provision. Where not eligible for DVA resident pays.		No Charge	
Aids & Appliances	See Section 1.5 Fees Manual	See Section 1.5 Fees Manual			Patient Charged	
Crutches, Walking Frames, Wheelchairs Orthotics, E.G. Calipers, Splints <sup>36</sup>	No charge	Provision in accordance with local policy comparable with community service to Hostel residents e.g. PADP access			No charge	
Motorised Wheelchairs And Custom Made Aids	Resident Charged		NA			
Laundry <sup>37</sup> (General laundry)	No Charge		See level of care	NA	NA	No charge
Telephone	Resident pays costs					
Social Activities <sup>38</sup>	Local Management Decision					
Hairdressing	Resident Pays					

<sup>30</sup> For former prisoners of war who receive the higher level of care, including respite, the Department of Veterans' Affairs will meet the resident contribution for the full length of stay in a residential aged care service<sup>31</sup> See DoH Circular Outpatient Pharmaceutical Charges And Safety Net Arrangements. Where local policy requires use of medication management devices the MPS pays.<sup>32</sup> Clinical Practice Guidelines determine appropriate equipment and items required.<sup>33</sup> The MPS is able to select the type of aids, which meet the individual needs of residents. @ If a resident requests an alternative they can be requested to pay for the item of their choice.<sup>34</sup> If a health practitioner determines that a resident requires allied health services the MPS will provide these services at no cost to the client. However, if a client privately organises podiatry or other allied health services, the payment of privately arrange services is the responsibility of the resident.<sup>35</sup> The MPS is to assist, if required, low care resident's access to GPs, allied health services etc. If a cost is incurred in seeking such services it is to be met by the client.<sup>36</sup> The MPS is required to provide adequate number of aids to meet the general needs of residents, where a resident requires a specially designed or modified piece of equipment the resident will be charged.<sup>37</sup> See Residential Care Manual 12.3, List of Specific Care and Services – 1.8 General Laundry Resident pays for other than general laundry<sup>38</sup> See Residential Care Manual 12.3, List of Specific Care and Services – 1.11 Resident Social Activities