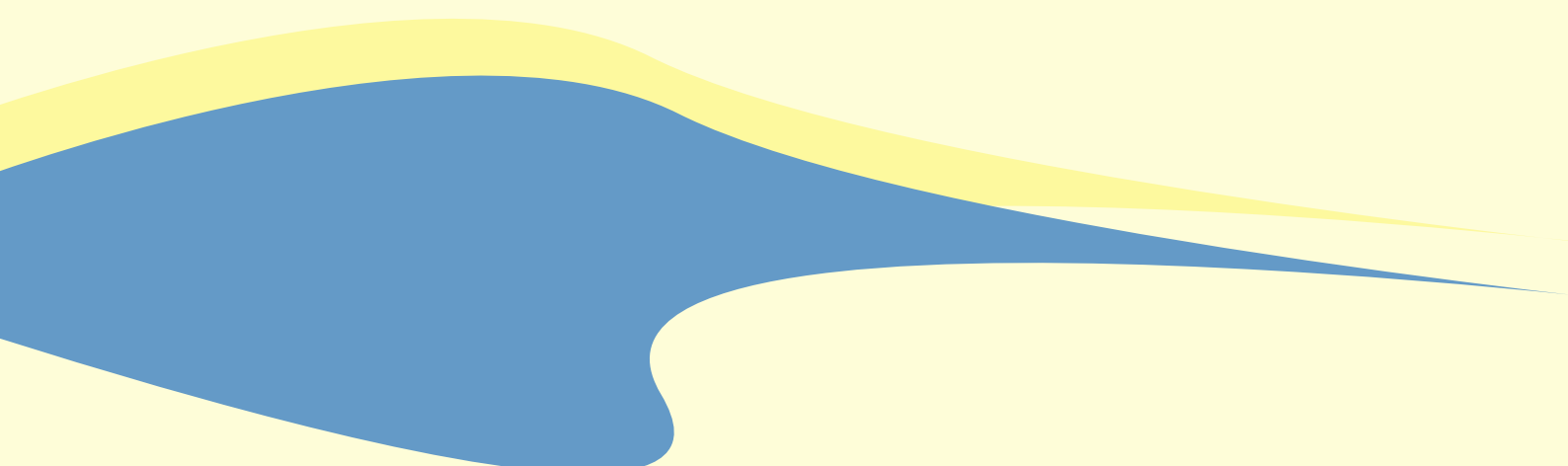


**Primary & Community Health Good  
Practice Models in NSW  
Centre for Health Equity, Training,  
Research & Evaluation (CHETRE)  
September 2005**

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Home Based therapy

**“There is hardly any health system reform in developed countries in the past five years which has not given PHC higher relative importance...It is clear that PHC continues to be a fundamental component of health policy, and of health systems, in most of the world.”**  
**(WHO 2003)**

# INTRODUCTION

Primary and community health (PaCH) services play a pivotal role in the health system and is the part of the health system where most people receive most of their health care, most of the time:

- Over 90% of the population will have direct contact with primary health care and community health practitioners every year (AIHW 2001)
- The workforce is substantial with over 5,500 GPs and 6,500 community health workers in NSW, 11,055 private and public allied health practitioners and of 3267 dentists, 415 work in the public sector (NSW Health 1999-2002)
- If funding from all sources is taken into consideration, including general practice, it is estimated that 40% of the total health budget is spent on primary and community based health services (AIHW 2004)
- PaCH services provide just under 60 million occasions of services per year. These figures contrast with public and private hospital activity, where on average each year 2.25 million occasions of service are provided (HIC 2002/2003; NSW Health 2002/2003).

There is compelling international evidence that primary care has an independent effect on improving health status and reducing health inequalities and that countries with well developed primary care systems have healthier populations and reduced health care costs (Starfield 1994, Macinko et al 2003, Shi et al 2003).

## Developments in Australia and in NSW

The focus of commonwealth reforms has been on general practice to enhance capacity and strengthen their collaboration with other health service providers, including community health services and specialised and acute services.

The thrust of NSW reforms have been in:

- **Policy development:** Strengthening Health Care in the Community, PaCH Conceptual Framework, Integrated PaCH Policy, Aged Care Framework, Sustainable Access Strategy, Chronic Disease Prevention Strategy,

- **New models of care and service delivery:** Families First, Integrated Primary Health Care Centres, Primary Health Care Networks, community packages of care (ComPacks), community acute and post acute care (CAPAC), After Hours GP Clinics and the Chronic Care Program.
- **Structural reforms:** To improve governance and quality across the continuum of care through the restructure of the NSW Health system

## The Primary and Community Health System

A broad range and mix of functions are undertaken within primary and community health and operate across the continuum of care. These can be grouped into four central and inter-related functions, some of which operate at the level of individuals and families, whilst others also operate at the community level:

- Assessment, referral & short term treatment for common health conditions
- Prevention, early detection & intervention for health problems & risks
- Ongoing care of chronic & complex conditions in collaboration with more specialised services
- Acute care in the community

The values and philosophical underpinnings of primary health care emphasise the social determinants of health and guide policy, planning, governance and service provision. These are reflected in the following core set of principles:

- **Equity:** a focus on caring for those with the poorest health and responding to those most in need/at risk.
- **Access:** providing affordable, locally based and available services that are culturally and linguistically appropriate.
- **Health & wellbeing:** a focus on improving and maintaining health and wellbeing of individuals, families and local communities.

- **Community engagement:** the participation of consumers and communities in decision-making.
- **Responsiveness:** to local population needs through planning and service provision.
- **Collaboration:** developing and maintaining links with secondary and tertiary services and other sectors.
- **Multidisciplinary approaches:** especially for people with chronic and complex conditions.
- **Partnership approaches:** to address the social determinants of health and population health.

The primary and community health system can be described according to a number of defining characteristics which can be grouped together under the following headings: generalist and more specialised. This is illustrated in the following table:

<b>Generalist PHC Tier</b>	<ul style="list-style-type: none"> <li>• First point of contact for the majority of the population</li> <li>• Provides comprehensively for the major health needs of local communities across the lifecycle</li> <li>• Provides continuity of care</li> <li>• Filters access to Specialised Tier</li> <li>• Locally-based within community settings</li> </ul>
<b>Specialised Tier</b>	<ul style="list-style-type: none"> <li>• Access by referral from other services or specific access criteria</li> <li>• Provides specialised services for specific conditions (commonly disease focus)</li> <li>• Provides episodic/short term/crisis care</li> <li>• Refers to PHC for ongoing care</li> <li>• Serves larger geographic area, but smaller numbers</li> </ul>

## EXEMPLARS OF GOOD PRACTICE MODELS

The following exemplars of service delivery models illustrate the mix of functions, the contribution of generalist primary health care services and integrated approaches across the range of primary health care providers and with more specialised health services. All the models selected use approaches for which there is a well established or emerging evidence base and are underpinned by primary health care principles. They include a mix of examples from metropolitan, regional, rural and remote areas in NSW.

### Prevention and early intervention

#### The Mobile Outreach Therapy Team (MOTT), Mt Drutt Community Health Centre

##### What's the problem?

It is well established that children from vulnerable families are at risk of developmental difficulties (Andersen et al., 2003; McLoyd, 1998). The alarming results from Australian studies indicate that vulnerable families are also at risk of inequitable access to, and use of, appropriate health services. A poor beginning to life can lead to negative behaviours in adulthood such as poor school performance, unemployment, alcohol and drug addiction and crime.

Staff had observed that families who were experiencing significant challenges in their lives were less likely to access centre based health services. Even if they did access the service initially, they were unlikely to engage effectively and were discharged prematurely. In particular it was noted that families from Aboriginal and Pacific Island communities did not access community health services.

A significant lack of funded positions in the area meant that waiting times for occupational therapy and speech pathology services were in the vicinity of 15-18 months. This compounds the access difficulties faced by vulnerable families.

The opportunity to put in place a new model of service delivery was also timely with the statewide *NSW Premier's Department Community Solutions and Crime Prevention Initiative* and associated community consultations and research. The results and recommendations of these informed the development of the model, which was funded under this initiative.

### What was done?

The project is located in an outer urban suburb of Sydney characterised by high levels of disadvantage. It aims to increase school readiness for children from vulnerable families by providing therapy services (primarily speech pathology and occupational therapy, and where required, a counselor) that is specifically targeted to the needs of this population. The services are provided in families' homes, community locations such as pre schools and in two community based organisations: Daruk Aboriginal Medical Service and NEWPIN at Bidwill, a Burnside service targeting 'at risk' families.

The MOTT targets children aged less than 6 years at referral and prior to school commencement, who present with any combination of problems or delays in speech, language and/or motor skills. Specifically targeted groups are families who are unable to access community health services, families with complex psychosocial situations and/or who are identified as disadvantaged, vulnerable or at risk, and in particular children from Aboriginal and Pacific Island communities

Staff work in a multidisciplinary team approach with each family to collaboratively determine goals for the child and family to work towards over an agreed time frame. A framework has been developed to ensure that the goal setting process is consistent within the team. To date the progress of children and families in achieving their goals is positive, with 31% of children and families making high progress and 69% making moderate progress.

The therapeutic approach, supported by the literature, focuses at a number of levels including the child, their family, school and community and includes:

- ◆ **the individual child:** a child's skill development in speech and language, motor co-ordination, self care skills, behaviour, attention, emotional maturity, social and play skills (Dworkin, 1993).
- ◆ **the child's family:** empowering parents through education and training, parenting and life skills, parental relationships, the home environment, and access to health services (Sanson et al., 2002).
- ◆ **the child's school:** encouraging positive relationships between families and school staff, preparing the school and families, expectations of teachers, parents and children, supplying adequate programs for children to meet learning needs, the school environment (NSW Parenting and DOCS, 2003).
- ◆ **the child's community:** accessibility, resources and appropriateness of preschool programs, child care centres, play groups (Margetts, 1999), availability of appropriate play grounds, community services (eg a local library), education of individuals who effect a child's opportunities, and key links and collaboration with other services (Andersen et al., 2003).

The project was developed following consultation with key stakeholders, predominantly service providers in the area, through a series of focus groups. This resulted in substantial modifications to the model initially being proposed.

Other background research that has informed the model included a literature review on school readiness and the literature on speech pathology and occupational therapy models and approaches.

The project sits within the Child and Family Team, and therefore staff have access to resources and supports including clinical seniors, management and ongoing professional development

### What's been achieved?

The MOTT has accessed significant numbers of children who would never have been seen by existing community health services, as well as engaged effectively with a number of families who have failed to engage with centre based therapies. 110 children have received services from

MOTT up until the end of December 2004. Of significant note is the fact that 41% of children are identified as being of Aboriginal and/or Torres Strait Islander backgrounds, and 12% of children are identified as being from Pacific Island communities. This rate of service access for these communities is much higher than that achieved by centre based community health services. Both Daruk Aboriginal Medical Service and NEWPIN (Bidwill) are supportive of the outreach service and are keen for it to continue. There is sufficient demand at each site for this outreach to be increased if there was staffing capacity. In at least 53% of families that MOTT supports the primary carer is dependant on Centrelink benefits for their income (for 24% of families this information was not known).

Children were able to access services fairly quickly from MOTT with 67% receiving an assessment within a month of the referral. Of those children that required ongoing intervention (and met the MOTT eligibility criteria) 93% of children were able to receive this therapy within one month of their assessment. MOTT has been successful in its aim of children not having to wait extended times for an initial assessment. This is pivotal for early intervention for developmental delay and ensures that the child is engaged with the most appropriate service.

There has also been a flow on impact of the service delivery model to other centre-based services, with the multi-disciplinary components being adopted. The success of the project's therapy model has influenced services in other geographic areas to adopt a similar model.

### **Can it be sustained?**

Currently the project is funded until December 2005. Its ongoing sustainability is dependent on the funding being continued. Due to significant waiting lists for therapies the model cannot be sustained within existing resources. The limited geographical area covered by the project is a constraint. There are families with similar needs in other areas of the Blacktown LGA and there are no apparent reasons why this project could not be duplicated in other areas with similar populations, with sufficient staffing.

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## **Case study**

Joanne was referred to the MOTT at 4 months by the home visiting nurse with concerns about her motor development. The family had not sought paediatric follow up despite recommendations. Joanne lives with her mother, her mother's partner and 3 siblings. The partner of the mother is an alcoholic and frequent drug user. There is a history of domestic violence. The Department of Community Services are involved with the family. They live in a public housing residence which is poorly maintained, unclean and lacks a suitable environment for Joanne to play. The house contained minimal toys available for the children (with the exception of the video game).

During the assessment of Joanne it was also noted that a sibling of preschool age, Jason, required further assessment. He displayed immature play, hyperactivity, delayed motor skills, delayed language skills and his mother had difficulty controlling his behaviour. His mother stated that she planned to send him to school in the upcoming months. As a result of the MOTT intervention both children are now receiving appropriate therapy. Parents have agreed to send Jason to preschool instead of school. Without the multidisciplinary home visiting approach neither of these children would have received the therapy they require.

### **Kadeekamballa Clinic, Gunnadah**

#### **What's the problem?**

Gunnedah is located in the New England region of NSW and has an overall population of around 9,500 of whom approximately 10% are Aboriginal. Aboriginal perinatal health is a concern in many country areas. Women are not accessing appropriate ante natal care and present at hospitals in premature labor and at risk of complications. A



New and proud parents at  
**Kadeekamballa Clinic**

local GP's concerns with this situation, plus developments in the local community health service, presented an opportunity for a more coordinated approach to improving access to ante and post natal care for Aboriginal women. These other developments included initiatives to support the implementation of the ***Aboriginal Maternal and Infant Health and Families First Strategies***.

A series of focus groups was held with local Aboriginal women in 2003 and one of the recommendations was for the establishment of easily accessible and cultural appropriate pregnancy programs for local Aboriginal women.

### **What was done?**

A culturally appropriate and friendly ante and post natal 'one-stop' primary health clinic was established in response to the concerns and recommendations from the women. The name of the clinic reflects its focus: Kadee means 'mother' Kamballa means 'a young woman'. The clinic is staffed by a GP (with bulk billing provided), the child and family health nurse, Aboriginal maternity service worker (an enrolled nurse) from the community health centre and a sessional play group support worker. A social worker is also available for referrals. The clinic runs fortnightly and offers up to eight ante natal visits and post natal care up to the six week baby and mother checks. This is consistent with best practice guidelines. Aboriginal women can see a GP, have relevant pathology tests done, appointments made,

immunisations arranged for their other children, meet with other Aboriginal mothers and arrange to attend supported play groups.

The child and family health nurse and Aboriginal maternity service worker also undertake home visits in between the clinic's operation as part of their core roles. The clinic and home visits are opportunities to screen siblings and identify other health issues and 'at risk' circumstances and enable referrals to other health and support services. Women are supported to attend the clinic through being provided with transport, a necessary strategy. The Aboriginal maternity services and play group workers, who provide the transport, are well known by the community and this has assisted Aboriginal women to feel comfortable in coming to the clinic.

Multidisciplinary team meetings, involving all staff, are held at the close of each clinic and ensures appropriate and individual care is provided to each woman for the safe delivery of a healthy baby. Medical care is shared between the GP and obstetricians and nursing care is shared between the midwives and child and family health nurse and maternity services worker. All client records are kept in the maternity ward to allow easy access for staff when the client is admitted.

The women are encouraged to take ownership of the clinic and they openly suggest improvements which are acted

on. This in turn fosters their self esteem and confidence. The waiting area is welcoming, with lots of information available, including videos on pregnancy, child birth and child rearing and has become a place where women meet and talk. The play group worker mingles with the women and discusses child care and parenting issues.

### **What's been achieved?**

The clinic has been very successful. The numbers of women attending have steadily grown and between 18-27 women present each fortnight. Aboriginal women are now receiving regular and appropriate ante and post natal care. Infections and complications such as gestational diabetes are being detected early and treated. Women are now being booked in for their delivery instead of presenting at the hospital in advanced labor or with preventable complications. As an indicator of its success and acceptability to women, the clinic time has expanded from 1-3 hours due to the demand.

It also appears that women who are transient and have recently moved into the community are also being seen. This suggests that the clinic's reputation is being spread by word of mouth amongst the community.

The partnerships between the midwives, the clinic team, other medical staff and clients have also been of considerable benefit and have contributed to improved continuity of care and good pregnancy outcomes.

### **Can it be sustained?**

The clinic's success has been dependent on the provision of a culturally appropriate service for Aboriginal women, the respectful and trusting relationships between the team and the community and the open communication within the team. While it is not always easy to engage GPs to work with community health services, in this instance the fact that the child and family health nurse was formerly a practice nurse has been an advantage. The clinic's sustainability is dependent on the continued contribution of the GP, as no other GPs in the town have expressed interest in participating at this stage. In addition as the clinic has grown in response to the need, there is some concern about the workload on the child and family health nurse

who has additional responsibilities in other towns. These issues are currently being examined in an effort to sustain the clinic over the long term. The provision of transport to support the women to attend the clinic and for home visits is also an essential component that facilitates access for women.

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### **Case Study:**

Trish is an eighteen year old Aboriginal woman's who's first pregnancy in 2003 resulted in her being transferred to the Base Hospital, some distance from where she lived and then to the major referral hospital. Trish had a spontaneous vaginal delivery at 31 weeks gestation with Apgars of 3&8 and birth weight of 1715gms. Trish was offered some antenatal home visits by the midwife and Aboriginal health worker who regularly encouraged her to attend her Doctor's appointments at the surgery. However, at the time of her delivery she had only attended two antenatal visits to the Doctor. Her baby was hospitalised before being discharged and also needed a further transfer for apnoea and received at least 25 home visits by the child and family health nurse and the Aboriginal health worker.

During her second pregnancy Trish regularly attended Kadeekamballa and was 8 weeks gestation at the first visit. She attended eight antenatal visits before delivering at full term with Apgars of 9&10, weight 2930gms, and was discharged on day three. The first home visit revealed that the baby had gained 110gms. Mother and baby continue to do well.

## Health Home Visiting in South Western Sydney

### What's the problem?

The promotion of health and well-being, and early identification and intervention in the early years is a national, state and local health priority to improve the health of infants and young children aged 0-8 years.

**Families First** is the NSW Government's prevention and early intervention strategy that helps parents give their children a good start in life.

### What was done?

In Sydney South West Area Health Service (SSWAHS) maternity services and child and family health services provide a universal entry point to the **Families First** network of services. Home visiting has become a standard approach for enhancing support and outcomes for families with babies and young children, and is a key strategy of the **Families First** initiative.

*"A person...who's got more than one child, isn't likely to go 'oh I'll just get me keys, grab my kids, grab enough nappies, get a change of clothes and throw everything in the car and go and see this support service....The support has to come to the place where that person is".*

(Draft Families First Area Review South West Sydney, 2003)

Child and Family Health Nurses (CFHN) play a key role by ensuring that every family with a new baby in the south western region of Sydney is offered a first home visit and that, as the universal entry point to the interagency service network, parents, and parents-to-be are provided with the best possible assessment of need and pathways to available services. The universal health home visit is part of a continuum of care beginning in the antenatal period and allows families identified as vulnerable to receive additional support.

Ongoing contact with the interagency service network is encouraged through a trusting and empowering professional and parent partnership, where the family is supported to identify resources and skills within the family

and community, and to build on their strengths to address issues and solve problems.

In addition, CFHN provide a range of other services including centre-based and other support activities (such as parenting groups, telephone support and other services). CFHN also ensure referrals onto other service providers where required to optimise the family's care and work in partnership with other agencies to provide the best care suited to the family. Research tells us that prevention and early intervention services have the best impact when services work in a coordinated way to address a broad range of issues.

The model has required a reorientation of CFHN nursing services to the provision of home visiting and enhanced focus on supporting mothers and families before problems develop.

*"Engagement is the key and it has to be done on a personal basis. Creating more of a personal link is the answer".*

(Leaps and Bounds: Linking Young Pregnant and Parenting Women to Education, 2003)

The program is underpinned by strength and solution-based approaches (which are well supported by the international evidence) and fits into an overall provision of services within the south west network which can be grouped into three categories:

- ◆ **Primary, universal home visiting programs** for all mothers of newborn children which focus on primary prevention and aim to enhance existing protective factors. Services provided include home visiting by Child and Family Health Nurses.
- ◆ **Secondary programs** which are targeted more towards vulnerable and 'at risk' populations that aim to prevent and minimise risk through the provision of support and assistance by sustained nurse home visiting and family support. Services provided include Aboriginal antenatal home visiting, multicultural sustained home visiting, young parents programs and volunteer home visiting.

- ◆ **Tertiary programs** which actively target and work with high risk groups with existing problems. Services provided include family support, drugs in pregnancy services and disability programs.

Most services provide a mix of psychological, educational and instrumental interventions to meet specific needs and include:

- ◆ Psychological interventions which focus on reflecting behavior, goal setting and family empowerment and providing differing perspectives
- ◆ Providing information and linking families into community resources
- ◆ Educational interventions including parenting skills, child development and health promotion.
- ◆ Practical help such as child minding or transport

### What's been achieved?

A number of evaluations are nearing completion. The impacts and outcomes identified by program managers and staff have been based largely on observation, clinical assessments and both formal and informal client and community feedback, and have included:

- ◆ Increased client confidence and improved problem solving
- ◆ Improved networks and relationships
- ◆ Increased use of programs and services, including uptake of preventive services
- ◆ Improved health behaviours including breast feeding
- ◆ Greater client control over their lives
- ◆ Improved parenting skills

### Can it be sustained?

The effectiveness and sustainability of the range of home visiting programs are influenced by the varying levels of capacity of clients and visitors as well as the capacity of the services themselves and the broader organisational context in which they operate.

*"Because it is the core business of our service we all have a part in implementing Families First."*

*"Because our policies and philosophies have been made to fit the Families First aims and objectives, it feels like everything we do is towards implementing and maintaining Families First".*

(Draft Families First Area Review South West Sydney, 2003)

Funding, staffing and resource constraints have been identified as threats to long term sustainability. In addition the use of short term project funding can contribute to program instability in and make it difficult to retain staff and plan in sustainable ways.

The capacity of the service system to meet the demand of referrals has been identified as a particular issue. In addition the beliefs and attitudes of other professional groups can potentially affect client take up and continuation with services. Staff also require supervision and ongoing training.

The universal home visiting program has been implemented across NSW. Flexibility in the provision of other CFHN services such as clinic services is appropriate to ensure models fit the needs of the local community.

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### Case Study

Angela is discharged from hospital after giving birth to her second child, Sam. There are no vulnerability factors noted antenatally or following delivery. The CFHN contacts Angela after receiving her Obstetric discharge summary to arrange the first home visit. During the conversation the CFHN notes that Angela sounds stressed and prioritises the visit for the next day. The CFHN completes a bio-psychosocial assessment for the family and carries out a physical

assessment on Sam. During the visit Angela reports that Sam is more unsettled than her first child, she is having feeding difficulties, and her toddler is reacting badly to having a new baby in the house. Angela also discloses that she is hard up financially. The CFHN provides support and education on feeding, settling and toddler behavioural issues. Family support services are discussed and the mother consents to referral for financial and parenting support. Follow-up care is provided by the CFHN.

## Ongoing care for chronic conditions

### Aboriginal Health-Link, Arrunga Community Health Centre, La Perouse

#### What's the problem?

The poor health and burden of disease experienced by the Aboriginal population is well known, as are the cultural, financial and geographical barriers to using health services. In La Perouse and Botany, these access barriers were significantly worsened with the closure of Prince Henry Hospital, which provided health services and employment for the local Aboriginal community. The dislocation experienced and the reluctance of the community to use the Prince of Wales Hospital (POWH) was associated with a rise in late and critically ill presentations to the emergency department. GP shortages in the area coupled with a lack of bulk billing practices and low utilisation of specialised health services also contributed to the problems.

#### What was done?

In response to these concerns, a culturally appropriate and community-based primary health and medical specialist clinic was established at La Perouse in April 2002. The clinic specialises in chronic disease prevention and management for Aboriginal people and is staffed by a geriatrician from POWH and an Aboriginal health education officer (AHEO) from the community health service.

The clinic runs weekly and clients are seen in the clinic or in their homes by the geriatrician accompanied by the AHEO. While the major focus of the geriatrician's role is on assessment and clinical management, the AHEO's role extends beyond ongoing client self management support to a community focus, especially in linking the community

into current Aboriginal health education activities, including swimming and walking groups. Community education workshops have also been run on a range of health topics, including dementia, stroke, medications and smoking cessation.

By being part of the POW health service, the clinic has strong linkages with other community health services and programs, including Aboriginal diabetes and vascular health programs, POWH, other health agencies, including GPs and the wider local community. Linkages are also enhanced through the clinic being based in the grounds of a local school that houses a range of other services for the Aboriginal community including drug and alcohol, mental health, diabetes and maternal health clinics.

To ensure that the model was culturally sensitive and appropriate and responded to the needs identified by the local community, the community was engaged through majority Aboriginal representation on a consultative committee, (local community elders and Aboriginal organisations), that also included representation from mainstream health services, including the POW health service and GPs. This committee is now an implementation group that meets bimonthly, although it has been difficult to maintain ongoing representation from local GPs.

Over time as the relationships between the local community and health service have developed the need to provide a more comprehensive range of population based and more targeted primary health care services has been identified. Plans are underway to provide a child health clinic, as well as ear, nose and throat clinics, with a focus on prevention and ongoing maintenance and also a more targeted vascular health clinic. Partnerships are being formed to progress these proposals in 2006. These partnerships with existing services are seen as being critical to the long-term success of any proposals.

#### What's been achieved?

The number of direct and indirect referrals to other community based health services has increased, especially to generalist community nurses and aged care services as well as health promotion programs and also specialist services including mental health, aged care and diabetes.

There is also evidence of a reduction in overall hospital admissions, as well as less critical presentations and more planned hospital admissions and better discharge referrals.

### Can it be sustained?

The clinic is now part of core business. Care is provided in accordance with the relevant chronic disease management frameworks and self-management protocols and the infrastructure support (for example information systems, records, care management tools and overall coordination) is provided through the community health service. As the clinic moves into its next phase, greater infrastructure and management support will be required. For example inequities in access to public/community transport has been identified as a key issue that impacts on access of the Aboriginal community to health services and requires a sustained and coordinated effort across a range of different organisations and agencies beyond the local level. The training and support of the AHEO has been important and has included training in self-management support. By being part of the Aboriginal Health Worker Team within community health, she is part of both local and statewide networks for support and training.

The principles that underpin the model: sustained community engagement, a primary health care philosophy, responsiveness to emerging needs and issues, and strengthening linkages across generalist and specialist services are all generalisable to other locations. However the nature of a 'bottoms up' and essentially pragmatic approach that has been adopted means that different communities might develop a different range and mix of approaches.

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## Case study

Mr WP is 53 years of age and has been a heavy drinker since childhood. He is the only child of parents, who were also both heavy drinkers and was removed from their care by the State at 6 years of age. Mr WP is separated from his wife and lives alone; most of his friends and companions are also heavy drinkers. Despite his ongoing problems with alcohol, he has managed to work for some time as a chef.

Mr WP had about 10 hospital admissions with acute and chronic pancreatitis prior to his presentation at the Arrunga Health-Link Clinic when it first opened. He has continued to be seen at the clinic since then for ongoing care and receives frequent phone calls from the AHEO. The frequency of his admissions to hospital has markedly decreased and the duration of each admission is reduced. With the support of the AHEO, a family carer has been put in place and a range of other community supports have been made available to support Mr WP and improve his quality of life.

## Generalist/specialist interface

### Far West Mental Health Integration Project

#### What's problem?

It is well established that access to specialised mental health services in rural and remote areas in Australia is limited and that recruitment and retention of staff particularly in remote areas remains a challenge. This is also true for the Far West of NSW which encompasses a large geographic area, occupying one third of the total landmass, and borders Queensland, South Australia and Victoria. While almost half of the area's population live in Broken Hill, the remainder are dispersed across 20 or so small communities. The area also has a large Indigenous population, pockets of culturally and linguistically diverse communities in mining towns (eg Lightning Ridge) and experiences high levels of socio-economic disadvantage.

#### What was done?

The Far West Mental Health Integration project is a tripartite initiative of the Australian and NSW governments and

(former) Far West Area Health Service as a demonstration project of the **National Mental Health Integration projects**. It has involved cashing out and cashing up to national and state averages of MBS and state funding. The aim was to improve access to specialist mental health services and visiting psychiatrists for residents and primary health care providers in remote communities. The project fits well with the existing primary health care model of service delivery in the Far West as depicted in the following diagram.



There are five primary mental health and counselling hubs across the Far West. Four of these hubs are located in community health services, with one located in the Maari Ma Aboriginal Medical Corporation. These hubs comprise specialised mental health workers as well as clinicians in the areas of drug and alcohol; sexual assault/ domestic violence; child and adolescent mental health; and prevention of abuse and neglect of children.

The project involves contracting visiting psychiatrists to support the hub model. The psychiatrists work in partnership with GPs, mental health and counselling services, other front line primary care workers, including Aboriginal health workers, community health staff, Lifeline volunteer counsellors and a range of other government and non government organisations such as the NSW Police Service, Department of Education and Department of Justice Health.

A pool of psychiatrists from Adelaide and Sydney are flown in on a regular rotating basis to each of the 5 hubs and the communities within each hub. Their core functions are to enhance the capacity of GPs and other health workers to provide the ongoing care for clients with mental illness through primary consultations with clients (via scheduled

clinics, video conferencing), secondary consultations with other health service providers (case conferences, clinical reviews, clinical supervision, education and training), contribute to community wide health improvement initiatives, such as radio programs on mental health and wellness issues, and participate in community liaison initiatives. Standard assessment tools and forms, such as the Mental Health Outcome Assessment Tool, are used across the range of providers that enhances a coordinated approach.

The community was involved in the needs assessment phase and also is represented on the steering committee that oversaw the development and implementation of the project.

### What's been achieved?

Unplanned and expensive evacuations of patients to far away psychiatric hospitals are now rare and clients who previously refused to travel for treatment are now cared for locally. Clients in remote communities have regular access to mental health services, including psychiatrists with a range of expertise in child and adolescent, adult and older person's mental health. Local mental health and primary care staff are supported by regular visits by experienced psychiatrists providing case review, continuing education and patient care. The model has strong support from the range of stakeholders.

### Can it be sustained?

As a demonstration project, it is time limited and was funded between 2001-2005. While the visits by the psychiatrists are still continuing, its long term viability is dependent on funds being made available and the options are currently being examined from within the area health service's funds. The project administration and management resources are crucial, for example overall planning and coordination, organising travel arrangements for the psychiatrists, arranging appointments and organising transport to enable clients, particularly Aboriginal clients to attend the services, and engaging the psychiatrists in broader area-wide initiatives.

The model is simple and essentially transferable but requires funds for local consultation, design and

administration. In principle it is also transferable to rural and regional areas where there are few public or private psychiatrists.

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## Alternatives to hospitalisation

### Acute and post acute care community-based service (APAC), northern Sydney region

#### What's the problem?

Across NSW, due to a mix of changing population demographics, technological advancements, and cost constraints there are pressures on hospital resources including lengthy waiting lists for elective admissions and problems in moving people through the system. Developments in treatments suggest that there are a number of people who whilst acutely unwell and requiring treatment, are medically stable and could be looked after in the community, provided clinical treatment and support services were available.

#### What was done?

The model is a hospital substitution/prevention program that has been operating since June 2000 across the northern Sydney region from the harbour bridge, north to the Hawkesbury river and west to Cherrybrook. The service involves five hospital campuses and three geographically based community nursing teams. Administrative and support staff are centralised at Royal North Shore Hospital which is also the single referral point. The APAC team comprises community care aides, registered nurses, a clinical nurse consultant, nurse specialists and educators, a pharmacist, occupational therapists and physiotherapists. Senior medical officers and general practitioners provide medical management.

The program targets clients who are medically stable and who have an acute episode that can be treated at home. Clients can be referred to the program from emergency

departments, hospital wards, GPs or aged care facilities for an initial assessment by an APAC community nurse. Data shows that the majority of referrals come from hospitals. In addition, the APAC community nurses seek out potential clients from the emergency departments and hospital wards. This proactive strategy enhances the visibility of the program. The nurses also have an educative role in hospitals, and increasingly aged care facilities, to promote the program.

Clients accepted into the program undergo a comprehensive health and well being assessment and have a care plan developed and, depending on need, this may include a home assessment by an occupational therapist within 24 hours. Clinical care is delivered according to agreed clinical pathways and polices, which are based on the National Institute of Clinical Excellence framework. The service operates 7 days per week between the hours of 7am and 11pm with senior medical hospital staff and GPs providing medical management.

Clients are visited on average 1-2 times per day usually by the APAC community nursing staff, with other allied health practitioners visiting as required. The duration of care ranges from 3 days to 6 weeks.

Linkages with a number of other community-based services are maintained including palliative care, pulmonary and cardiac rehabilitation services. These linkages can involve joint case management, for example weekly multidisciplinary meetings with Breast Care.

Clients are managed by a senior medical officer, GPs or both in shared care arrangements. GPs are routinely informed by letter/phone of clients who have been referred to the program and ongoing contact is maintained, with GPs tending to provide after hours call. All clients are referred back to their GP on discharge from the program.

The maximum number of clients on the service at any one time is approximately 70, depending on staffing and requirements for nursing and /or allied health and the age range is from 16 years onwards, with the peak age groups being between 56-85 years. The service also works closely with the ASET (Aged Services Emergency Team) aiming to streamline the flow of elderly people through

the emergency and hospital system. People who are not accepted into the program include those not living in the regional boundaries, who have no social support, who are medically unstable, who are unable to consent to the service requirements and where safety is an issue (for either staff or clients).

The model adopts a primary health care approach, and it is expected that staff providing services do so from a holistic and health promoting approach that encourages client empowerment and self management, through for example, education and information on healthy eating, smoking cessation. Staff have been recruited from a range of backgrounds, with advanced clinical skills being an employment pre requisite. They undertake a three week orientation program, which includes the principles and practices of primary health care and patient advocacy.

### What's been achieved?

The sorts of conditions that have been treated through the service include pulmonary embolus and deep vein thrombosis requiring anticoagulant therapy, infections (for example pneumonia, cellulites, urinary tract infections) requiring intravenous antibiotics, and exacerbations of chronic pulmonary disease. Early discharge post-operative clients who have had surgery for breast cancer, the insertion of Stents following heart attacks, and total hip and knee replacements are also major client groups referred to the service.

Client feedback surveys have indicated that the service is well accepted, clients are satisfied with care received and in particular have commented on the usefulness of the cardiac and respiratory health booklets with their self management focus. The service has also been responsive to client feedback and is in the process of updating patient brochures and leaflets and looking at ways of providing clients with a better indication of the time of day that the nurses will be visiting them.

### Can it be sustained?

One of the key success factors has been the confidence and acceptance by the senior medical officers. They have been involved at all stages including the development of policies and procedures and clinical guidelines, the medical

management of clients and their review prior to their discharge.

There are formal processes in place to routinely review current research and evidence which informs regular updates of the policies and procedures. This initiative also enhances the acceptability of the service by medical clinicians, and ensures that clients are receiving care based on the best available evidence.

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## Case study

Mrs C is a 45-year-old mother of two who presented to her local GP after she noticed a lump in her left breast. Her GP organised an ultrasound, which showed possible cancerous changes. A mammogram, and core biopsy were then performed which confirmed a high-grade invasive carcinoma. Mrs C was referred to Royal North Shore Hospital (RNSH) and met with a breast cancer surgeon and a breast care clinical nurse consultant (CNC). Mrs C and her surgeon discussed surgery options and due to the high grade of her tumour she opted for a full mastectomy and axillary node clearance. The CNC provided Mrs C with support, and a comprehensive information package on what to expect from her journey through the following months of surgery and treatment.

Following surgery, Mrs C was discharged home with the support of the APAC team. The team provided daily nursing care, education, support, monitoring, clinical nurse specialist assessment, physiotherapist treatment, and occupational therapist assessment for anxiety. The community care aides also provided domestic assistance

One week after her surgery Mrs C met with the multi-disciplinary breast care team, which included her surgeon, oncologist, nurse specialist, APAC team member, radiotherapist, pathologist, and psychologist. She recovered well from her surgery and is currently undergoing chemotherapy treatment.

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### Who we are

This work undertaken by the Centre for Health Equity, Training, Research & Evaluation (CHETRE) as part of a two year project aimed at Strengthening Health Care in the Community that was funded by NSW Department of Health.

CHETRE is one of the Centres for Primary Health Care & Equity Research in the Faculty of Medicine at the University of New South Wales, Australia.

### Contributors

Thanks go to the people who freely gave their time to be interviewed for these exemplars and who ensured that the information was accurate. These people are Joe Kelleher, Jenny McManus, Tracey Popham, Tuana Sanders, Emma Walford and Carole Young

This report was produced by Julie McDonald from CHETRE

### Other resources

There are a number of other companion documents to this report, including:

- ◆ **Guidelines: Core functions & services for primary & community Health Services in NSW (2005)**
- ◆ **Conceptual Framework for Primary and Community Health services in NSW (2005)**
- ◆ **Literature review on the contribution of primary and community health services (2004)**
- ◆ **Overview of Primary & Community Health Service Reforms in Canada, New Zealand and the United Kingdom (2004).**

These documents and other resources are available on our website: <http://chetre.med.unsw.edu.au/phc>

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