Collaborative Health Care

A Model for Improved Outcomes for Regional Communities 2024

Whiddon
Award-winning care

Contents

Summary

Whiddon is an award winning, not-for-profit aged care provider, with over 75 years of experience, and is a long-term advocate for quality Rural and Regional Aged Care.

This paper addresses the pressing need for a collaborative and holistic approach to healthcare in rural and remote regions of Australia, particularly in light of the increasing population in these areas, and the ongoing challenges faced by regional health services.

Australians living in regional, rural and remote areas often have poorer health outcomes than people living in metropolitan areas, including higher rates of hospitalisations, deaths and injury, and poorer access to primary health care services (AIHW). Additionally, the Royal Commission found that people in regional, rural and remote communities are significantly more disadvantaged when accessing aged care services than those in metropolitan areas and called for the adoption of flexible funding and flexible service delivery in these communities.

Current health service delivery in Australia is fragmented, with separate state-based and federally funded systems often working in isolation, and even in competition with one another. This separation is particularly evident in the delivery of aged care services, which are governed by federal regulations and funding, contrasting with state-administered local hospital, community, and allied health services. This siloed approach has led to inefficiencies and gaps in care, which are negatively impacting individuals, families and their communities.

Each of the major stakeholders in regional communities are facing the same challenges in attracting and retaining staff, cost pressures and accommodation.

For the future benefit of our regions, Whiddon is proposing three critical areas where improved collaboration could enhance health outcomes: Resource Sharing, Integrated Health Care and Governance.

We are requesting urgent action to progress this Collaborative Healthcare Model, including the following initiatives:

- Facilitating a Roundtable with key stakeholders from multiple sectors to identify key regions for developing and piloting a Collaborative Health Care Model
- Developing an Evaluation Framework and Key Success Measures for the Pilots
- Developing a plan to ensure successful Pilots can be deployed across priority regions
- Following the trials, establish a joint Consultative Body to co-design models and guide decisions regarding collaborative health strategies into the future

This approach aims to create a more efficient, integrated, and community-focused health care system that better serves the needs of rural and remote Australians.

Background

More than a third of older Australians live in rural and remote locations and in excess of 600,000 additional people are choosing to live in the regions following the pandemic.

Demand for responsive, holistic health strategies within our regions is growing and requires urgent review. Looking specifically at specialist aged care, Australia requires another 3,500 aged care beds and another 2,500 home care support packages in the next decade to support people in remote areas (Prof. Blackberry -Centre for Rural Ageing Research).

Current health delivery in Australia largely operates through a dual system of State and Federally funded services.

This results in federally funded Aged Care and NDIS services operating alongside state-managed hospitals and health services in regions. Experience has highlighted, that despite efforts to improve outcomes, a lack of coordination and integration exists between services, despite many cases where operations are within close proximity serving the same communities.

Additionally, there is a premium that comes with operating homes in regional and remote areas. This is due to increased labour costs, shortages of skilled trades, and difficulties accessing supplies, with freight on basic stock items.

Financial pressures on Aged Care providers have been well documented, particularly for homes located in regional and remote locations. Aged Care finance specialist firm, Stewart Brown, most recently projected that if we see no government funding reform, the percentage of aged care facilities operating at a loss will swell to 75 per cent, leading to more Home closures.

The Governments' viability supplements exist to support these challenges, although, well documented gaps still exist. This has a compounding effect on investment and the expansion or redevelopment of aged care services within the regions, due to these viability challenges. Government grants and alternative funding models are required to meet demand and the complex health requirements in the regions.

In regional communities, local health services play a pivotal role, not only in providing essential health care, but also, keeping families and loved ones connected. Research conducted by Bernoth, Dietsch and Davies highlighted the trauma for families needing to travel due to the inaccessibility of local health services in regional communities.

It is essential that we develop long-term strategies to ensure consistent and reliable care in our regions.

The Challenge

Whiddon currently operates 17 Residential Aged Care Homes and 8 Home Care Hubs in rural, regional and remote locations in addition to our metropolitan services. We care for close to 2,600 residents and clients and employ a workforce of 3,000 across seven LHDs and 20 locations. We have witnessed, first-hand, the unintended friction created by siloed health systems in these communities.

While the Primary Healthcare Network exists to improve these outcomes, PHN's generally focus on local issues and are not empowered to work across broader state-wide collaborative health strategies. And generally, we do not experience their support in the context of the numerous challenges outlined in this paper.

We know that better collaboration is possible, and this was highlighted through the COVID-19 pandemic, when various levels of government forged closer health strategies to overcome the challenges of the pandemic, through the creation of collaborative steering committees and agreements.

While these were positive steps, the legacy issues of the past remain and the absence of a collaborative strategy, between LHD's (hospitals), aged care providers and other adjacent health services, particularly in regional communities, is impacting health delivery.

It also represents an inefficient use of resources, which are already scant in regional areas.

Through our direct experience working in regional communities, we propose the formation of a collaborative health network to improve regional health services through key areas:

1. Resource Sharing
2. Integrated Health Care
3. Governance / Communication

Resource Sharing

Integrated Health Care

Governance / Communication

Resource Sharing

Given the well documented workforce challenges in the regions, compounded by the scarce resources and cost premiums associated with operating in regional locations, collaborative approaches to sharing resources between State and Federally run health services is an obvious, yet seldomly deployed, strategy.

The Royal Commission into Aged Care Quality and Safety itself called for the adoption of flexible funding and service delivery to improve access to aged care in rural regional and remote areas.

Looking at Appendix A – which highlights the significant proximity of Whiddon's regional Homes to local Hospitals – we can see the missed opportunity for collaboration between these services.

In particular, there are two critical services, central to the operation of both residential aged care and hospitals, which present the most promising opportunity for collaboration. These are Catering and Laundry – services which can be logistically challenging, costly and require skilled employees to operate. There is obvious merit in the development of a collaborative model that allows a single Kitchen or Laundry to service both operations.

This approach should also be considered in regard to workforce. Workforce challenges within the regions reached critical shortages during the pandemic, and while they have eased since then, they remain a significant and ongoing challenge.

Employment incentives are offered by both Aged Care Providers and State Health to attract suitably qualified people to the services – however, this inevitably results in underfunded Aged Care providers losing out to NSW Health funded State Hospitals.

Clinical staff, and particularly Registered Nurses, are extremely difficult positions to recruit in regional locations – yet are absolutely vital (and mandatory) roles. Some of our Whiddon services can experience delays of up to six months when recruiting and onboarding a new nurse. The Nursing Supply and Demand Study 2023-2035 (DOHAC, 2024) predicts an undersupply of 70,707 nurses by 2035, further supporting the need to work collaboratively to find viable workforce solutions.

Aged Care providers have closed homes due to these workforce challenges, while regional hospitals have been known to modify operating hours as a result.

In the nine-month period between June 2023 and February 2024, 23 residential aged care homes closed (Senator Anne Ruston, questions posed in Senate Estimates, 2024). When considering regional towns such as Bourke, Wee Waa or Temora, with populations ranging from 2,000 – 10,000, rather than compete for talent, these health services should consider a collaborative model.

We are aware of multiple examples where Whiddon's operations have been compromised due to the loss of staff attracted to NSW Health as a result of incentives offered. Obviously, NSW Health has a vested interest in ensuring that aged care residents are cared for by Aged Care providers, so that

hospital beds and resources remain available for primary care. However, as an unintended consequence of this siloed approach, the operational viability of these aged care homes is being compromised.

An alternative model could see joint recruitment and workforce planning, along with a potential shared services model, that deploys registered nurses across multiple locations (e.g. Hospital, Residential Aged Care, Home Care). We see other roles such as personal care, and even maintenance and administration, to be engaged under a shared services model.

This approach should also be extended to allied health, where numerous health providers continue to cannibalise limited resources. A planned and collaborative approach to the utilisation and engagement of physiotherapists, podiatrists, occupational therapists and other related professionals, has the potential to deliver more efficient and impactful outcomes for health services and the community alike.

Integrated Care

As was experienced during COVID, the siloed approach to care and service delivery in rural populations, can detrimentally impact the health outcomes for the community. Often, skills, knowledge, experience and health resources are only accessible to those accessing particular services, such as aged care or primary health.

By creating a truly collaborative community network, there are opportunities to explore a more impactful operating model, by integrating health and aged care services in these regional communities. Through real collaboration, involving joint planning strategies, programs can be developed that result in:

- Reduced presentations to hospital through outreach or telehealth services
- A wrap-around approach to caring for community-dwelling older people
- Joint wellbeing programs facilitated by aged care providers and offered to older people with extended stays in hospital to assist in maintaining their physical and cognitive health
- Seamless allied health support that encompasses a broader client journey

In addition to this, it is well documented that hospital bed blockages (access block) are having an adverse impact on health outcomes in many communities.

Data quoted by health authorities indicate that up to 1,200 beds are occupied by patients waiting placement in aged care or NDIS in NSW alone. Often it is older people awaiting assessment or nursing home placement that contribute to the blockages. Insufficient care staff at Homes is often cited as a barrier to moving more people from hospital into permanent residential aged care. Another is simply due to the complexity attached to the transition between State controlled hospitals and Federally funded aged care services.

This problem is experienced across multiple regions and is currently under review through The Health and Aged Care Regional Action Initiative in the Illawarra. The focus of this project is to address why Aged Care providers have closed 400 beds over the past 3 years, and to generate practical remediation strategies. However, the needs of smaller regional areas are quite different to those of larger cities, and the opportunities for collaboration are of a different, more tailored nature.

An integrated approach that brings together Home Care, Aged Care, NDIS, LHDs and Primary Care has the potential to:

- Identify the needs of people within the community more proactively and employ early intervention strategies to eliminate or reduce the need for hospitalisation
- Streamline and support both short and long term stays between the hospital and home and / or the hospital and aged care home, to free-up hospital beds for more urgent care requirements
- Provide planning and support options for community members through an integrated model, which accesses all health channels, rather than a siloed approach (this has the potential to reduce ED presentations)

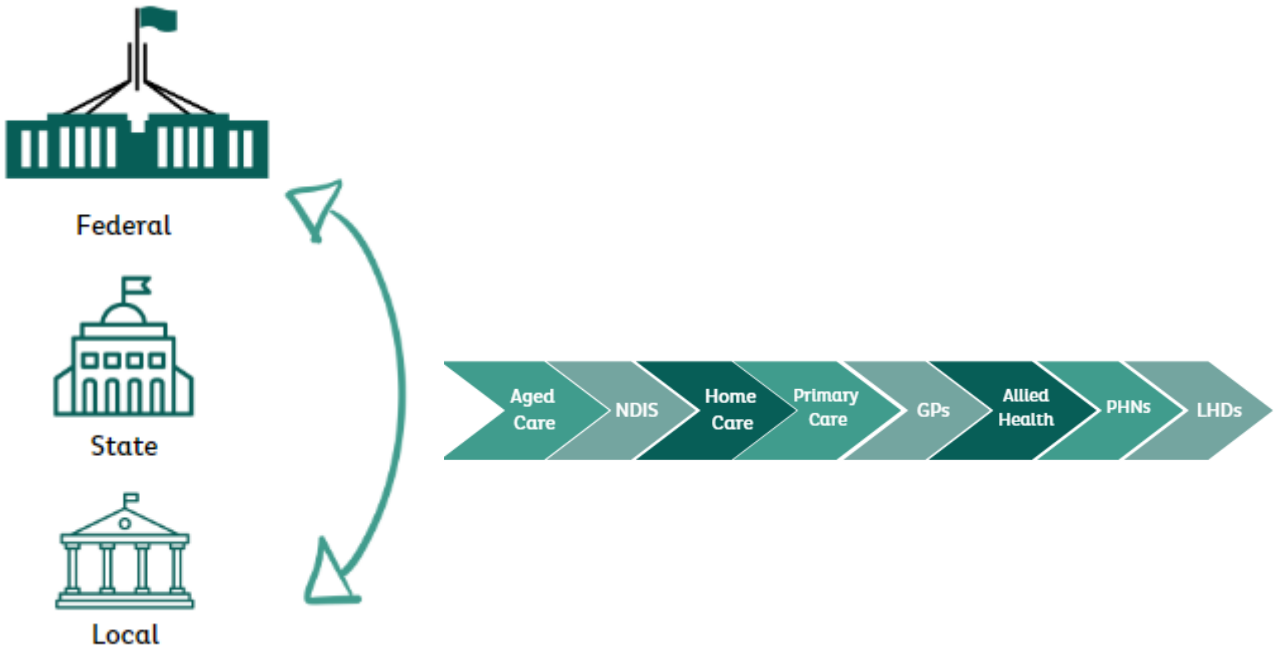
These intervention strategies will not only lead to proactive health care measures, which can free up hospital beds and resources, but pleasingly allow people to receive care at home, while remaining better connected with their community.

Governance / Communication

A strategic approach overseen by a collaborative steering group is a critical component currently absent from the current health landscape.

We see this as a major gap that offers the potential to enhance collaboration vertically, across jurisdictions and laterally across care provision.

Collaborative Steering Group



It is evident that significant funding is directed to health and aged care services, however, this results in a fragmented and confusing system. Commonwealth funded services include residential aged care, in-home care, transition care, and Primary Health Networks, while State funded services include acute care, community care, population health, and rural and regional health services.

For the collaborative model to succeed, improved planning, communication and ongoing governance is required. Further, and as emphasised within the Rainbow Model for Integrated Care, data and information sharing is another crucial component required, to ensure the success of these collaborative models and at this scale. This is critical, not only at the client or resident level (eg e-records), but also in terms of developing effective resource sharing strategies that optimise outcomes for taxpayers, at both the State and Federal level.

To successfully achieve these outcomes, it is proposed that a joint consultative governance body be formed that includes representatives from State and Federal Government, Residential and Community aged care providers, researchers and members of the relevant LHD, PHN, Local Government and private medical and allied health practices.

Objectives for the Joint Consultative Governance Body should include:

1. Development of broader collaborative statewide strategies
2. Creation of mechanisms that overcome the current funding, financial and legal constraints that prevent effective collaboration
3. Improving community focused health strategies at the LHD and LGA level
4. Increasing communication between all stakeholders at each level

5. The development of data and information sharing protocols and platforms that support collaboration
6. Ensuring an action-based approach is adopted and is focused on delivering outcomes measured against KPIs and community health benefits
7. Establishing a reporting mechanism to capture outcomes and benefits

Recommendations

We are proposing the following initiatives to explore the opportunities discussed in this paper, with facilitation by Sydney University:

- Convene a roundtable with stakeholders from multiple sectors (that may include State and Federal Government, Health Care Providers, Service managers across the public, not-for-profit, and private sectors and researchers), to identify key regions that may be open to designing, proto-typing and piloting a Collaborative Health Care Model.

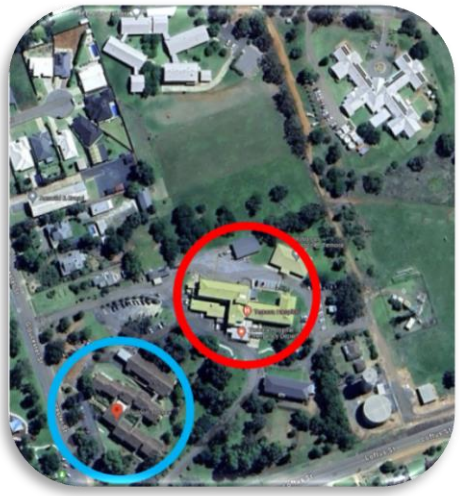
- Determine with key stakeholders what success looks like and develop an evaluation framework that can support the three key collaborative strategies discussed in this paper (Resource Sharing, Integrated Health Care and Governance)

- Deliver a set of actionable outcomes and a plan that ensures successful trials can be adopted and deployed rapidly across priority regions

Appendix A – Proximity of Whiddon Homes to LHD services

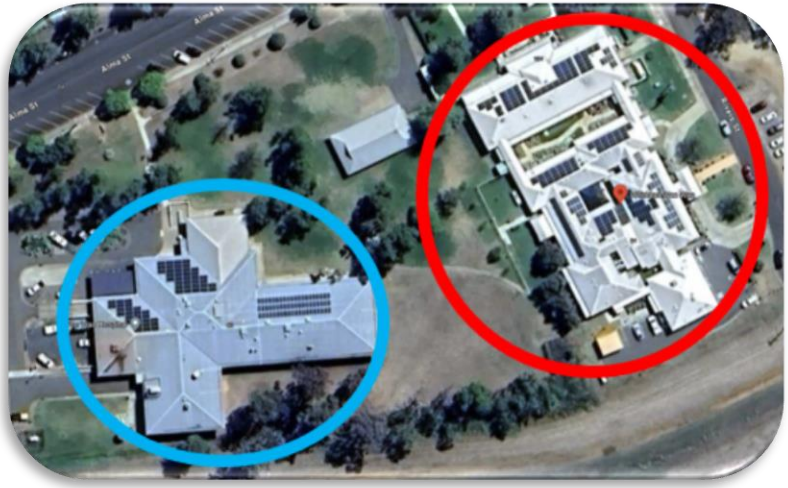
The images below depict LHDs in red and Whiddon Care Homes in blue to demonstrate the proximity of the services. Many other aged care providers in rural and remote areas are also co-located next to hospitals.

Temora



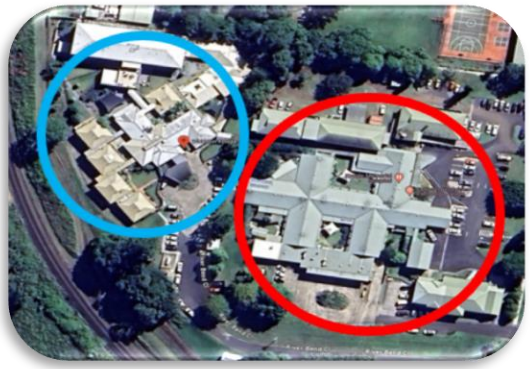
Narrabri

Wee Waa



Moree

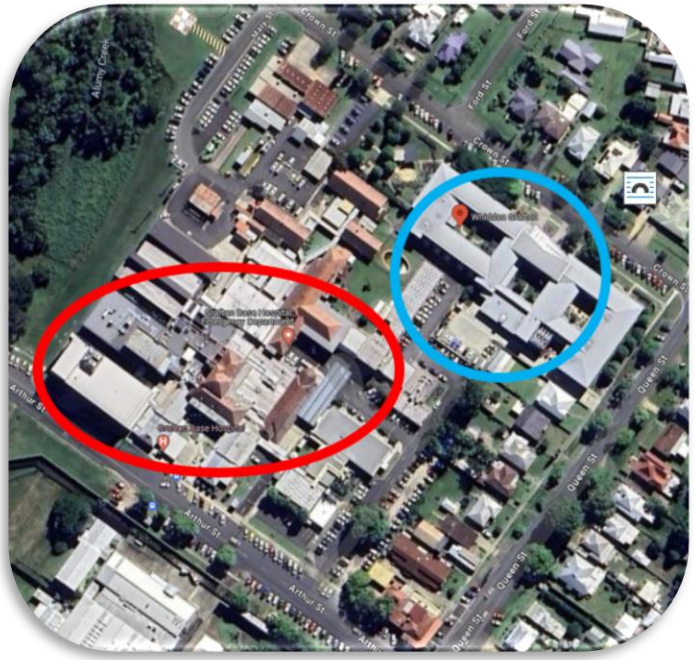
Kyogle



Maclean

Casino

Grafton



Appendix B

Stories That Paint a Picture

The stories below are variations of actual experiences and are included to demonstrate what collaboration could look like. The purpose of these examples is not to provide the solutions, but rather to highlight some scenarios for consideration.

Impact	Current State	Future State
Residential Aged Care (RAC) Home (Sunnyville)	• 2 RACs employing a Contract Physio 4 hours per week at $180 per hour • 1 Hospital with 1 FTE physiotherapist who works across Medical & Surgical wards, and outpatients but cannot fit in Transition Care hours • 1 CC provider who has 1 part-time physio 1 day per fortnight from a neighbouring town. • One Private Practice Physiotherapy Practice (who have a running advertisement on Seek and usually only attract interest from international clinicians requiring sponsorship).	• RAC, CC provider, Hospital and Private practice resource share 1 FTE physiotherapist. • Residents in Care Homes receive double the physio hours. • Falls prevention and mobility are the focus and there are reduced A&E presentations and hospital admissions. • When people have recovered from their acute illness in the local hospital, they are screened for frailty and falls risk, triaged and those at risk are provided with transition care by a physio that first met them in the hospital, providing continuity of care. • Those who require ongoing restorative care or rehabilitation are seen by either the private practice or via service provide through the CC provider who now has a physio 1 day per fortnight.
Consumer	• Mary had a fall at home and was admitted to local hospital where the team worked hard to address falls risk factors. • After a 5 day stay to stabilise her, she is discharged home on a waiting list for in- home rehabilitation though MAC (there are no allied health staff to allow the hospital to provide transition care). • Mary tries to do her own exercises at home using the pamphlet she was given, however gradually becomes less confident and more deconditioned while on the waiting list for community care.	• Mary had a fall at home and was admitted to local hospital where the team worked hard to address frailty and falls risk factors such as reduced strength & balance, poor nutrition, polypharmacy, use of multifocal glasses. • After a 5 day stay to stabilise her, she is discharged home on a Transition Care plan. • The hospital dietician designs simple, evidence-based options to address her risk of frailty. • The same physio who saw Mary in hospital visits her at home and supports her to carry out her exercises - this continues for 8 weeks • Mary is now much stronger, more confident and stable on her feet.

Impact	Current State	Future State
	• Mary as another fall and after being admitted at the local hospital for 8 days this time, it is decided that she is not coping at home alone, so she will need to move into RAC. • On admission to the RAC, a Comprehensive falls assessment identifies she needs targeted falls prevention to address multiple risk factors (Physio to individually prescribe resistance and balance program, dietician review nutrition, RN to design continence management). • There is 1 physio who visits 4 hours per week and therefore minimal opportunity to provide any specific care for Mary's needs. • Mary becomes more deconditioned. falls and factures her hip, requiring ambulance transfer to a hospital 2 hours' drive away for surgery. She is transferred post-op to the local hospital where she stays for many weeks.	• The physio works with the CC provider to organise for an Allied Health Assistant to visit Mary weekly to continue her exercise program and check in with the dietician about her nutrition.
Hospital	• Jack resides in a residential aged care home and lives with moderate dementia. • Jack has been unwell for the past 24 hours and as there is no doctor available to visit the service, he is transferred to hospital via ambulance for review. • When he arrives at the local hospital, there is only one doctor managing ED and Jack has to wait for several hours to be seen. • As Jack is in an unfamiliar environment, he becomes anxious and attempts to get out of bed unassisted. • Jack falls and fractures his hip. Jack requires surgery and is hospitalised for several weeks and	• When Jack becomes unwell, the residential aged care home contact A&E. • They discuss Jack's symptoms with the on-call doctor, and he completes a telehealth consultation when he has the opportunity. • The doctor suspects that Jack has an infection and orders blood and urine tests which the home arrange to have completed by the shared pathology service. • Interim treatment measures are prescribed until the test results are returned. • Jack remains in his home, receives appropriate treatment and the impact on both Jack and the health system is minimal.

Impact	Current State	Future State
	unfortunately Jack develops an infection and sadly dies 4 weeks post-op.	

Appendix C

Examples of Shared Strategies

Resource Sharing & Optimisation (WHAT)	Community Outcomes (WHY)
Shared employment of RNs, Care staff, Allied Health by LHD, RACH, Community Care, Private medical and allied health practices. Including shared provision of incentives to relocate e.g. accommodation/vehicle/mentoring	• Increased access to health care professionals. • Ability to commence and develop new outreach services, restorative care and community care service offerings. • Reduced bed block as patients can be safely discharged home or to RACH.
Shared sponsorship of international health care workers	• Improved health care by rosters being filled at both hospital and RACH. • Improved support contributing to culturally safe communities.
Shared education and training for health care teams	• Career development opportunities for local health care workforce. • Reduced expense for health care service providers to duplicate mandatory training – savings used to improve or expand service delivery.
Shared kitchen/laundry services	• Cost efficiency • Increased access to skilled professionals

Emergency management of residents from the RACH via direct communication with A&E via telehealth (phone or video conference)	• Improved resident outcomes – particularly for those who are living with Dementia or otherwise find transfers difficult • Decrease demand on the hospital (ramping, bed block)
Support for community dwelling older people	• Post discharge support provided by local Home Care providers resulting in a reduction of 28-day re-admissions.

Appendix D

Substantiating the benefits of Integrated Health: Professor Lee-Fay Low

The need for development and pilot of a model of integrated health, primary and aged care

Prof Lee-Fay Low, University of Sydney

May 2024

Challenges in accessing and delivering care for older people in regional Australia

Australian health and aged care system provides universal health and aged care, but is also fragmented, siloed and difficult to navigate (Low et al., 2021).Older people in regional Australia consistently have additional challenges in accessing services including primary care, specialist care, and residential aged care (Zheng et al., 2023). Regional services have difficulties attracting and retaining staff including specialists and aged care staff (Australian Government Department of Health and Aged Care, 2021). This results in greater responsibility being shouldered by primary care and staff acting beyond their duties (Zheng et al., 2023). The ageing of the Australian population will further exacerbate shortfalls in community care and residential aged care places in the regions (Blackberry & Morris, 2023).

Integrated care might be a solution through earlier intervention to prevent crises, minimizing duplication (e.g., in assessment and care planning), more effective staff resourcing e.g. workforces that can work across health and aged care such as in multi-purpose services.

Integrated care has been recommended to shift care system focus from administrative systems to the older person's needs and experiences

The World Health Organization defines integrated healthcare as 'the organization and management of health services' in order that people get the care they have, once they would like it, when they need it, in ways that are user-friendly, attain the specified results and provide value for money.

Integrated care has been shown over in many studies in developed countries to increase patient satisfaction and improve quality of care and access to care and may also reduce outpatient appointments and waiting times (Baxter et al., 2018). However there is a confusing diversity of integrated care models which are contextually dependent and implementation is a known challenge (Minkman, 2012).

A framework for integrated care

The Rainbow model of integrated care is an accepted framework for describing the different dimensions of integration of care within a particular system or model of care – see Figure 1 (Fares et al., 2019; Valentijn et al., 2013). Models of integration can be described on a continuum from clinical integration to system integration. Clinical integration means coordination of care services for individual patients (e.g. dementia key workers), professionals integration describes coordination of services across different disciplines (e.g. geriatricians and allied health collaborating within a hospital), organizational integration describes service coordination across organizations (e.g. residential aged care in-reach programs) and system integration occurs when there is alignment of rules and policies within a system. Functional integration describes the extent to which back-office and support functions (e.g., one helpline across services, shared medical records) are coordinated. Normative integration describes shared mission, work values by different organizations and clinicians within a system (e.g., NDIS and aged care in Australia have different values, for-profit aged care has different priorities to).

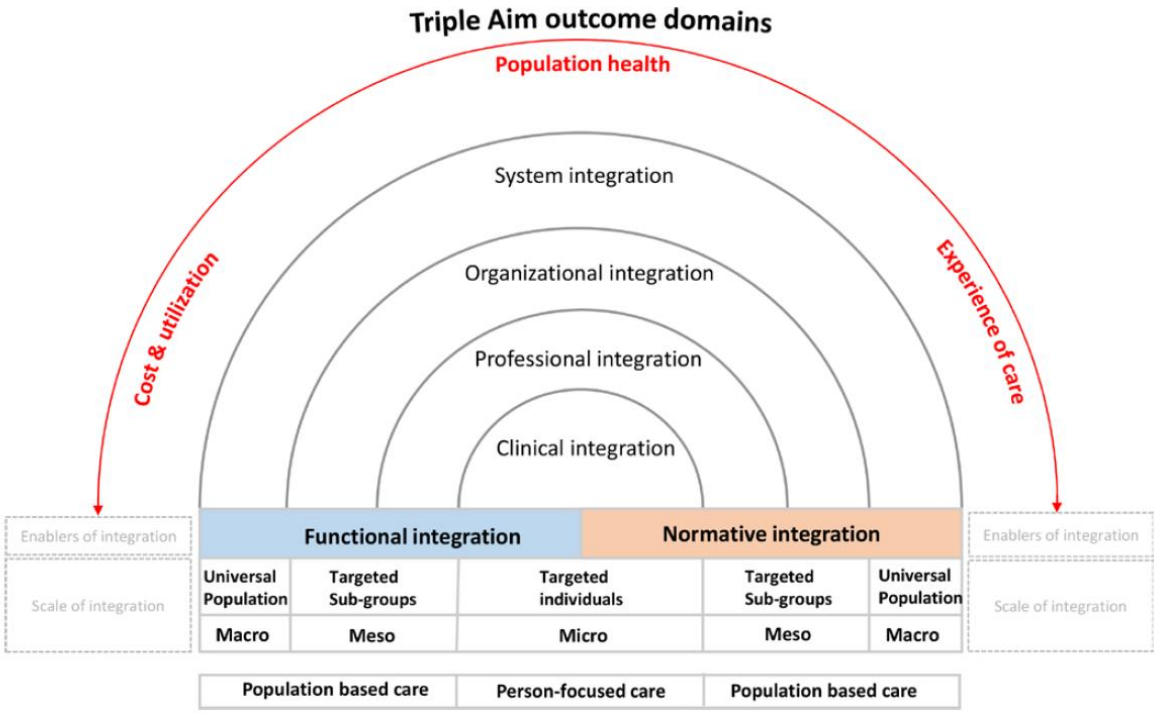


Figure 1. The Rainbow Model of Care (from Fares et al, 2019)

Integrated Care has been recommended but not yet implemented in Australia

The Royal Commission into Safety and Quality in Aged Care Recommendation four was for "integrated long-term support and care for older people" which included welfare support, community services to enhance social participation, affordable and appropriate housing, health care and aged care (Pagone & Briggs, 2021). Progress on this recommendation is ongoing through the Senior Officials Working Group and the 10 Year Ageing Well in Australia Strategy, but with limited frontline development work around integrated care (Office of the Interim Inspector-General of Aged Care, 2023).

Integrated care in Australia to date

Published Australian trials of integrated care for older people (n = 11) were almost all initiated by health providers (Mann et al., 2019) though all included aged care and primary care providers. With the exception of one model (LoGiudice et al., 2012) integration was through care coordination and linkages (i.e. clinical integration) rather than attempting to change organizational structures and inter-relationships and funding (Mann et al., 2019). This focus on clinical integration rather than organizational and systems integration is also reflected in the international literature (Briggs et al., 2018). Australian integrated care projects have not commonly used functional enablers such as data such as financial arrangements or electronic medical record data sharing and linkage (Angus & Valentijn, 2018).

Box 1. An example of an Australian integrated care project: the Aged Care Emergency (ACE) program. ACE provided telephone clinical support to reduce avoidable emergency department (ED) presentations by residents in 69 residential aged care facilities in the Hunter region of NSW. The ACE program evaluation found that 981 ED presentations were avoided annually and saved an estimated $921214 (Ling et al., 2019).

We need to develop and pilot models of integrated care in regional Australia

Two important mechanisms for successful implementation of integrated care programs for older adults are having trusted multidisciplinary team relationships, and provider commitment to and understanding of the integrated care model (Kirst et al., 2017). Ideally the model is co-designed (or co-adapted) so as to be feasible in the local context and to facilitate by-in from local providers. Time,

resources, and incentives are required to support providers (organisations) and individual staff to participate in the development and implementation work.

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Appendix E

About Whiddon

Whiddon is an award-winning care provider that aims to inspire every day in its 23 residential aged care homes, dedicated community care and NDIS support across New South Wales & Southeast Queensland. Its purpose is to enrich people's lives and make a real difference.

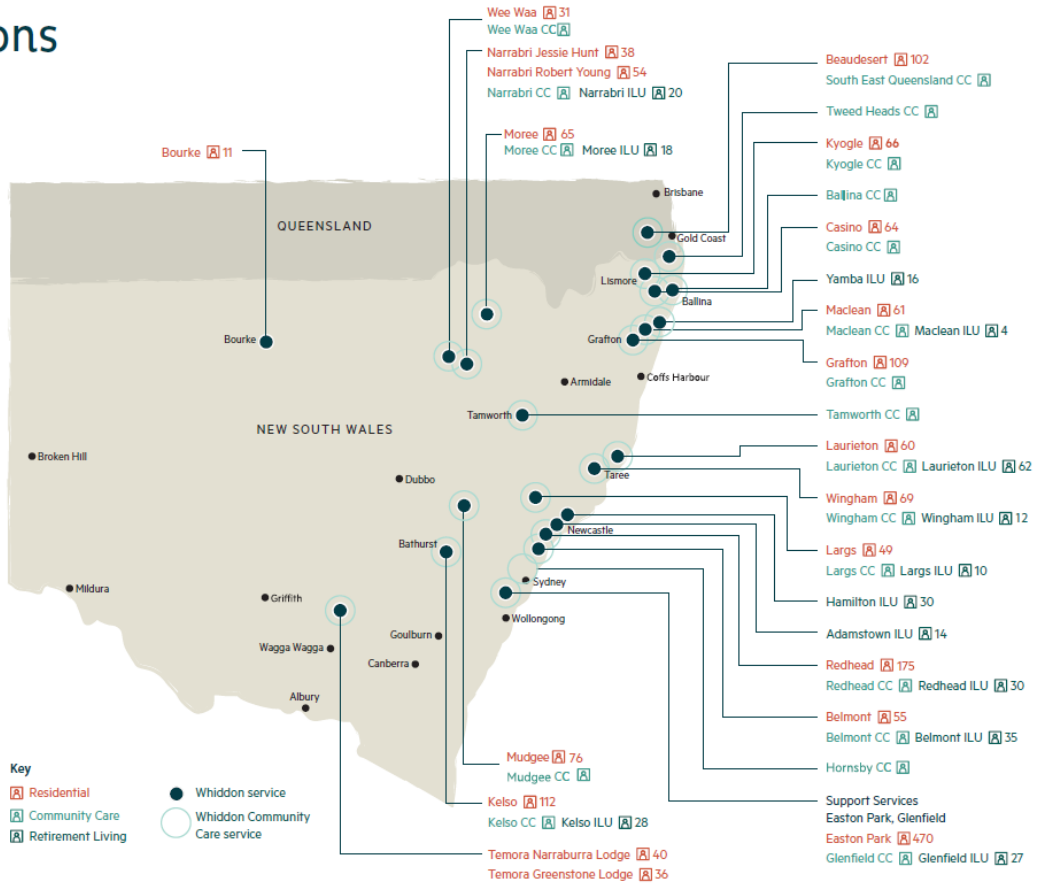
We have been providing exceptional care to older Australians and people with disabilities across regional, rural, and remote NSW and QLD for more than 75 years. We proudly partner with academics and universities to remain at the forefront of innovation as it leads the latest thinking, programs, and training around quality of life and ageing.

Whiddon has been a strong advocate and innovator across aged care and support for regional communities, this includes:

- Championing the inclusion of MMM5 homes for the regional viability supplement through the AN-ACC funding
- Pioneering Rapid Antigen Testing throughout COVID to improve outcomes for regional care homes and subsequent subsidised testing across the aged care sector
- Expert witness at 2 Royal Commissions
- Representation at the Fair Work Value 3 Case advocating for improved conditions and care for indirect care employees

Whiddon locations

Service	Locations	Beds/Units
Residential		
Residential	22	1742
Retirement Living		
Retirement Living	13	306
Community Care		
Community Care Service Hubs	10	



Whiddon