

Stakeholder Submission to the Green Paper “Delivering safe and sustainable clinical services”. One State, One Health System, Better Outcomes

Response: THO –North Primary Health Services. Community Options Service –North. 63 Rural Area Clinical Dementia Nurse. Christina Jackson M.N.

Q) Is the Tasmanian health system all it should be, or should we be open to change in order to improve outcomes for all Tasmanians regardless of where they live?

The Tasmanian Health Organisation system is in a process of review and change, demographics and logistics identify some significant difficulties in the quest to achieve best practice and improve outcomes of care and achieve quality service delivery. This needs to be an ongoing process using contemporary models of practice.

History of health care services reflects the redesign process has at times been both time consuming and expensive with limited outcomes. Best practice models of care may need to be considered different across different networks to meet quality, better outcomes and sustainable services. Metropolitan does not necessarily translate to rural isolated needs.

Tasmania has the unique dilemma of a small population across many local government areas, some with geographically logistic challenges. Some Tasmanians can have a belief not always realistically, that services should be available within their health service network. Organisational Health culture has to be accommodating to the needs of change, this requires an approach where staff are valued for the contribution they make but also are empowered to advocate for and implement change. This is required at all levels of the organisation.

Complexity of change can be also alarming i.e. the federal funding cuts and bed closures of the Jasmin Unit at Roy Fagan Centre Hobart. These 10 dementia beds are a limited and specialist front line service used across the state. The case mix of clients has complex care needs that are not able to be managed in other health care settings. Concerns now identified for the future of the J.L Grove Unit in Launceston as this has National Partnership Agreement funding and has been used as a collaborative process to develop Tasmanian health service.

Collaborative partnerships require further development to reduce the cultures of working in silos and at times parochialism. Some services in part are repeated or work in parallel. Collaboration and communication at times is limited i.e. Assessments both clinical and nonclinical can be multiple as various services or providers engage a patient /consumer.- A universal base line assessment tool requires development by multidisciplinary services. This assessment tool development then requires respect for the integrity, accountability and professional practice.

Dementia services differ widely across the current Tasmanian Health Organisation sites resulting in differing opportunities to referral assessment service options and modalities of care. Collaborative approaches and strategic planning difficult to engage and silo services have developed.

Consumer Engagement strategy offers an opportunity to forge partnerships in areas where there are complex bio psycho social determinants are difficulties are often historic for this consumer group, often resulting on resistance and marginalisation of consumers and service provision. A model such as consumer engagement has a strong place in working with this often disenfranchised

group including people with dementia who have multiple health co morbidities, poor health literacy and do not necessarily meet aged care service requirements.

Q) How would you find out about what travel support, information and services are available to you to get the right care, by the right person, the first time?

This is a complex area, ideally a 'One point of contact' model would be optimal but this requires a huge collaborative infrastructure whether public or privately administered. The information needs to reflect accurate, specific, and timely and appropriate services including i.e. Government and Non-Government. Accountability requires monitoring to ensure contemporary availability and throughput of services.

Waitlist lists for services need to be identified, the 'scatter gun' referral processes is not always helpful to consumers who are left overwhelmed and unclear as to 'who does what' and 'are you going to be helpful or just ask me a lot of questions'. Health literacy is a significant issue in Tasmania even in the referral process it is often not recognised or responded to. Health action and literacy principles still need to make data simpler with pictorial and oral communication strategies. Service availability in rural and remote areas across Tasmania is problematic at times only one provider of service is available.

Multiple assessments for consumers could be reduced with the use of a universal assessment tool.

An electronic interface with a centralised health information data base would be efficient time, services and resource identification. This data base needs to have varying levels of access of view whether the hospitals, GP, specialists, clinicians, community service providers. The database i.e. Citrix /Cerner needs to be state wide with log in available through THO.

Include in the data base a list of current services provided as consumers can be confused as to who is providing services.

A universal consent document would be a useful tool. To be raised at point of referral as some services have to proceed to assessment to identify if a referral and service provision is appropriate.

Travel outside metropolitan sites is often problematic difficult to access and expensive. For people with dementia this often requires a carer/companion i.e. access to secure day care may require community transport service who are also trying to manage transport for medical appointments.

Consumers are referred by other service provider's hospitals or GPs/specialists to the Clinical Dementia Nurse – Community Options Service –North as the position has a complex service agenda and acts more as a consultative and short term service liaison role additional to the sector support and service development role.

Q) If it improves the quality and safety of care, do you agree we should limit the number of sites at which some services are provided?

Yes for some services. Resources need to be reframed in some areas; the services not withdraw as economic rationalism resulting in the services being lost.

Q) If yes, what should we consider in deciding where a service is located and what support needs to be considered to ensure patients have equitable access?

The role delineation framework will require flexibility and fluidity in adapting services and communication to meet future care needs in a safe, quality focused sustainable way.

Consideration to the access to services:

Tele health and increased use of videoconferencing for clinical assessment, case conferencing and service and discharge planning with patients & separately with clinicians and service providers.

Clinical skill mix and scope of practice of service providers around dementia and complex and chronic care needs in smaller health sites/community.

Patients with diagnosed dementia requiring high level or after hours service needs are often slow to be offered Home & Community Care packages by providers. The cost of service package is also a determiner of clients/carer declining services especially those on an aged pension.

Acute and ambulatory care services often struggle to manage care needs for people with dementia. Admission to hospital is often complex and either discharged quickly to carer or admission to a busy ward where resources are already stretched.

Consider the impact on waitlist and wait times in issues of clinical care and co morbidities. The impact on transport, access & options when services are not locally accessible. All service options both private & HACC funded being aware of the logistics of travel and telecommunication access. Discharge Planning & Communication- The importance of improved discharge planning and communication to consumers GP and service providers.

Q) What services do you currently receive in a hospital setting that you think could be safely delivered in your community?

A range of less /low invasive procedures can be carried out in smaller rural sites .i.e. Dialysis, transfusions, minor operations, preoperative treatments preparations for patient no safe/ able to administer the treatment alone.

GP practices are increasing the scope of adjust clinical care services offered. This reduces hospital presentations but more GP outreach needs to be considered. Medicare funded after hours clinic adjacent to hospital facilities to manage non ambulance related care needs.

Medicare funding need to reflect item numbers and altered models for care re costings and rebates.

Bring programs like 'Quit', 'Falls prevention', Patient education, Dementia awareness programs to the community not back to the acute settings. Referral to falls prevention programs would dramatically reduce incidence of ambulance response 'call outs' with or without presentation to hospital.

Early Intervention health literacy, health promotion needs to be multimodal and collaborative to view 'holistic intervention strategies' not target single event or the post diagnosis group.

Partnerships from community services providers with hospital/ acute care for continued liaison when a patient is admitted to liaise with staff and patient to compliment care and aid in discharge planning. These supports can reduce length of stay and reduce failed discharge and readmission rates. Current mandate from Primary Health Services is to place community clients 'on hold or discharge' them, resulting in additional impacts on work load and frequent failed communication.

Medication changes in hospital is a frequent difficulty as GP and dispensing Pharmacists are not advised of changes and patient not always able to identify the change, stop changed medications, especially if predispensed medication aids are used. Fax to chemist and GP from the hospital ward the day of discharge would reduce problems identified.

Q) How can we better help you understand the standard of care you are entitled to, and support your involvement in your healthcare decisions?

Health literacy strategies. Media education, Marketing at large community events. Several appointment with staged levels of detail suitable to client /carer needs.

A person centered approach to care whether through models of Consumer Engagement or Valuing People.

Seek clarification of information not just assume information has been heard, and processed a hospitalised person unwell and usual ability may be diminished. Write information down utilise health literacy principles

Q) What public-private partnerships should we explore for the delivery of health services in Tasmania?

THO – North. Clinical Dementia Nurse Service is a collaborative consultation with Specialist medical clinician at Memory Disorders Clinic in Launceston. This is an opportunity to develop a holistic service and identify current and future needs at point of presentation rather than have the consumer with memory issues be referred sometimes years later when health, circumstances and situations have changed sometimes to stage where palliation is the only option.

Collaborative partnerships with services like Older Persons Mental Health, Medicare Local and Dementia Behaviour Management Advisory Service DBMAS.

General Practitioner education and support with dementia assessment diagnosis and treatment options. This currently happens in an ad hoc with GPs making contact with referrals or seeking support.

University training to trainee doctors and all future health practitioners need greater levels of education about dementia. Currently this is in the Aged Care module.
Consider Dementia as a chronic and complex illness.

Increased review and remodelling of environmental design in hospitals areas to reflect safe management of patients with dementia / delirium in the acute setting. This also needs to include monitoring aids and specific equipment.

Current HACC funding of the Clinical Dementia Nurse to provide clinical support service in the acute care setting is limited and not core business. This has caused a gap in service development and support.