# PATIENT JOURNEY STORY BOOK

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Foreword

This year marks five years since Country Health SA began creating a more integrated health system to better meet country South Australian’s needs.

It was about building on the inherent strengths in country health services – strong community input, local wisdom and a deep sense of caring for one another – to deliver the best possible health care to rural and remote communities.

The Patient Journey Initiative Storybook is a record of a key Country Health SA strategy to improve the health care experience of rural people.

It is pleasing to see significant improvements in country health care achieved through the Patient Journey Initiative, including better communication and coordination between country and metropolitan health services.

For country South Australians, this initiative has meant: fewer avoidable referrals to Adelaide-based health services; less time spent in city hospitals; a better ‘journey’ in accessing health services away from home; more preparation to return home from treatment in Adelaide through improved discharge planning; and, development and improvement of appropriate health services and networks across the State.

A key to this success has been the strategic advice and practical solutions of the Patient Journey Initiative Steering Committee - a partnership between community advocates, non-government organisations, Country Health SA and SA Health staff.

I would particularly like to thank the Committee’s two Chairs - Associate Professor Anne Johnson who performed the role for the first three years, and Ms Stephanie Miller, Executive Director of the Health Consumers Alliance, who chaired the Committee for the past 18 months.

With strong commitments to consumer issues and in-depth knowledge of the health system, these two independent Chairs have made vital contributions to the success of the Committee and the Patient Journey Initiative.

"It is pleasing to see significant improvements in country health care achieved through the Patient Journey Initiative...”

The State government is proud to work together with government and non-government agencies, country and city health services, and community members, through the Patient Journey Initiative and other strategies, to achieve good quality, safe health care - no matter where you live in South Australia.

As well as smoothing the transition between services and locations for country South Australians, we are continuing to build up local health services and redevelop country hospitals so that more people can access treatment closer to home.

I am delighted that the experiences of the people behind this remarkable success story are captured in this Storybook.

Congratulations to all involved in its publication, and to all those who play a role in the success of the Patient Journey Initiative.

Hon. John Hill
Minister for Health
Dr Anne Johnson

Foreword

Addressing the needs of South Australians living in rural and remote communities to access the most appropriate health services and level of care, in a timely manner, whether they are provided locally, regionally or in Adelaide based services is a significant long term challenge facing country communities and the South Australian health system. The decision of Country Health South Australia (CHSA) to make the patient journey a foundation strategic direction for their new organisation in 2006 needs to be applauded. It was an important step towards reducing the inequities in health outcomes facing country people and improving access to health services.

I was asked to Chair the Patient Journey Initiative Steering Committee from its inception in October 2006 and continued in that role for three years when, due to increasing commitments, I regretfully had to step down.

At the time I began in the role I was Associate Professor of Public Health at Flinders University and had a strong interest in access and equity issues as well as a broad view of health. I also had a strong background as an advocate for consumer participation in health, which meant that my values were congruent with the intent of the Patient Journey Initiative and the role of the Patient Journey Initiative Steering Committee. My commitment to the Patient Journey Initiative strengthened when I moved to Penola, in the South East of SA, at the end of 2007 and I began to experience firsthand the patient journey issues from a country consumer’s perspective.

The commitment and passion of the members of the Committee was palpable at our bimonthly meetings. The initial membership shared a vision and had a work plan to focus our activities; we agreed on the way the group would work and how the three hour meetings would be structured; and were committed to ensuring things happened to improve the patient journey for country people. The partnership between community advocates, non-government organisations, CHSA and SA Health staff meant that people from diverse backgrounds were bringing their collective wisdom to the Committee. We knew as a committee that change didn’t happen quickly, that we needed to have short term and long term goals and be patient and persistent. This added to the energetic and extremely valuable discussions and achievements of the committee.

Having the top level commitment of George Beltchev as CEO of CHSA, and Karen Dixon in the Coordinator Patient Journey role, was instrumental to the success of the Committee and the Patient Journey Initiative. Members knew that if decisions were made, then Karen would follow through and make sure that things happened. If there were problems then these
were shared with the Steering Committee and they could contribute to the problem solving. I know before each meeting I personally had a sense of anticipation. I thoroughly enjoyed the meetings and the knowledge that as a group we were having a positive influence on the health reform process for CHSA and SA Health which was benefiting country South Australians.

This storybook is a really important initiative of CHSA and HCA as it shines the spotlight on the successes and learnings of many people across the state who have shared the commitment to make a positive influence on the patient journey for country South Australians. I was fortunate enough to be asked by CHSA and HCA to interview the people whose stories feature in this storybook and write their stories.

This provided a different perspective for me to the work I was doing with the Committee and it was a joy to hear how the Patient Journey Initiative had a positive influence on the innovative work to improve access to health services for country people. I was totally inspired by their work and their long term commitment to making a difference. I know that you will also be inspired. It is heartening to know that the focus of CHSA on the Patient Journey Initiative has empowered many of these people to work collaboratively to address patient journey issues for their own communities and across the state. It is vitally important that this work continues as the journey has only just begun.

Dr Anne Johnson
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Stephanie Miller
I was delighted to be approached to be the second Chair of CHSA’s Patient Journey Initiative Steering Committee and at the same time very nervous about filling Anne’s shoes. As the Executive Director of SA’s peak body for health consumers, Health Consumers Alliance (HCA), I saw it as an opportunity to strengthen the consumer voice and to extend the reach of HCA’s advocacy work. Also, I was born and raised in country SA so have a personal understanding of the issues.

The success of the Patient Journey Initiative and the significant contribution of the Steering Committee is evidence of what can be achieved through collaboration and partnership between consumers, carers and service providers. Patient or consumer centred care will only be realised if decision-makers and service providers partner with patients and their organisations, at all levels of our health care system. We are after all in the same business, that is, better health and wellbeing for all South Australians.

This publication documents the Patient Journey Initiative and celebrates what has been achieved, but there is more to done. There are stories of good and even great care in the pages of this book. However, affordable accommodation in Adelaide remains a serious concern for consumers and family carers.

The community members of the Steering Committee overall found the experience very positive and have stressed in their contributions the value of being able to influence and have direct contact with the CHSA Executive. With the winding up of the Steering Committee it will be vitally important for CHSA to establish a high level strategic mechanism within its governance structures to replace it. HCA looks forward to future collaboration and supporting CHSA to partner with patients.

Stephanie Miller
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Successful health reform doesn't happen by chance. It requires vision; the ability to communicate that vision and gain support for change; different levels of leadership with the right skill mix and authority to make change happen; authentic involvement of a range of different stakeholders to influence the direction of the change process; and the willingness of the health system to make change which will benefit consumers. The strategic direction for the Patient Journey Initiative has included all these complex elements that have contributed to its success and laid the foundations for a process of continuing change.

There is agreement that whilst so much has been achieved there is still much work to be done to improve the health outcomes of people living in rural and remote areas of South Australia needing to access health services, locally, regionally and in Adelaide. Change in the health sector is never easy, and it is rarely very quick, so a clear purpose, persistence and patience are important for people who lead, facilitate and participate in change processes.

This first section of the story book includes the perspectives of two people who contributed to the strategic direction of the Patient Journey Initiative and provided leadership and facilitated the change process from within Country Health South Australia (CHSA). George Beltchev was the CEO of CHSA until 2010, and Karen Dixon was the Coordinator of the Patient Journey Initiative from its inception.

Commentary is also provided by Barbara Hartwig who was the Chairperson of CHSA Board in the early days of the commencement of the Patient Journey Initiative, and Jackie Mansourian, who was conducting a project with a similar focus for the Health Issues Centre in Victoria. Her views from ‘across the border’ give insight into why the strategic direction of Patient Journey Initiative in SA is relevant to other states.

Perspectives of the Patient Journey Initiative from the CEO

George Beltchev was the inaugural Chief Executive Officer of CHSA and was in that position from 2006 to 2010.

Where did the term patient journey come from?

I liked the term patient journey because at one level it was simple and people could understand what it meant for country people who needed to access health services. On another level, patient journey can mean: travel; country patients’ experiences as they utilise different health services; country patients’ experiences of their changing health status; and the fact that country patients need to be ‘patient’ as it often takes them longer and is more difficult to access services than metropolitan health consumers.
What was your vision for the Patient Journey Initiative?

My vision had three aspects:

- Fewer country people would need to make a journey out of country, and if they did, it was swift, efficient and cost effective.
- Country people, if they did have to travel to metropolitan hospitals for care, stayed less time and had more supports available for them back home.
- People in metropolitan health services needed to be part of the country health system and be part of the solution for improving the patient journey for country people.

The Patient Journey Initiative was also identified as a high priority by the CHSA Board along with Aboriginal Health, Mental Health and Early Childhood health services.

What approach did you take to make the vision a reality for CHSA?

It came at a time when CHSA was forming as a new organisation and I made it our focus from day one. I travelled to every country area where CHSA had hospitals and health services. I talked about country patient journeys with Hospital Boards, CHSA staff and country GPs, and firmly placed it on the agenda for our new organisation.

We focused the Patient Journey Initiative on responding to immediate and undisputable problems and barriers and could show practical benefits quickly. We grounded the advice for directions of the initiative in a collaborative partnership between community members, non-government organisations, and country and metropolitan health professionals through forming the Patient Journey Initiative Steering Committee.

The CHSA Board at the time, which was made up of country residents, really supported the initiative. It became a fixed item on the agenda of Board meetings and the CHSA Executive. We provided leadership through Karen Dixon, in her position as the Coordinator Patient Journey, and she mobilised local resources. An example of how she did this was through formalising the Patient Liaison Nurses role in country health services and the formation of the Patient Liaison Network.

Country GPs were a focus, especially working with GPs to assist their patients by streamlining their referrals to metropolitan services. Part of this was also the need to influence metropolitan health services to be more aware of country people’s need for flexible appointment times and coordination of appointments to reduce the number of times they had to travel.

I worked closely with the other CEO’s in SA Health to consider the needs of country patients and to put resources into metropolitan health services for Rural Liaison Nurse positions where these positions were not in place. One small example of how we coordinated with metropolitan health services, which had a big impact, occurred when we made metropolitan health services aware of the difficulties for country people in accessing accommodation during the month of March in Adelaide when there were many big events on and all accommodation was booked out and at premium rates. We were able to reduce the number of referrals to Adelaide during that month and arrange alternatives for people requiring overnight stays in Adelaide.

“We grounded the advice for directions of the initiative in a collaborative partnership... forming the Patient Journey Initiative Steering Committee”.
What were the challenges?

There were several main challenges. Getting metropolitan systems to respond specifically to the needs of country patients was a main challenge. Also changing traditional practice was challenging, especially referral patterns from country to metropolitan services that had been long established.

Getting metropolitan health services to have more confidence in country health services was and is still a challenge. We have a long way to go in this area as too many country people still have to travel to Adelaide for outpatient appointments.

What worked well?

Many things contributed to the success of the Patient Journey Initiative. Keeping the focus on providing better access for country people for health workers and managers at all levels of metropolitan and country health services meant that it was always on the agenda across the health system.

Having the Steering Committee to keep the thinking and planning grounded was an effective community engagement process.

As CHSA was a new organisation, we were able to select a leadership group based on their commitment to improving access to health services for country people. This helped build a culture of focus on the patient journey across the health system as a whole. There was also an expectation that as a new organisation we would find creative solutions to the patient journey issues. This was driven from the top, as well as involved people at all levels of both metropolitan and country health services.

Karen Dixon’s position as Coordinator Patient Journey was central to keeping the focus and energy. Karen had the right skill set, motivation and commitment to make change happen.

What do you see as the most successful changes made?

There was a significant increase in the number of new services provided in country areas. For example, in Aboriginal health, mental health, early childhood, allied health, renal dialysis services, cardiology services and surgery. These all reduced the need for country people to travel to the metropolitan health services.

“We were able to demonstrate that fewer country people made unnecessary trips... they were getting the right people going to Adelaide at the right time, and they were getting the right treatment early.”

We were able to demonstrate statistically a decrease in the time that country patients spent as inpatients in metropolitan health services.

We were able to demonstrate that fewer country people made unnecessary trips. For example, we nearly doubled the amount of renal dialysis services offered in country areas, which greatly reduced the need for country patient journeys to metropolitan dialysis units. Also the work that Dr Philip Tideman did with Cardiac Care Network (iCCnet SA) where he was able to improve access to specialist cardiac care for country people. He showed that even though there was an increase in the number of country people going to Adelaide for cardiac care, their health outcomes improved. This was because they were getting the right people going to Adelaide at the right time, and they were getting the right treatment early.

The key achievement was that the patient journey became part of the vernacular and is
part of the fabric of CHSA. However, there is also the risk that because of this the health system may lose this focus. It is important that it be kept fresh so that the patient journey continues to be a focus.

We have only begun to make significant progress, and there is still a lot of work that needs to be done. We all need to keep sight of what is important - that is to achieve the best health outcomes for country people.

Perspectives of the Coordinator of the Patient Journey

Karen Dixon was the Coordinator of the Patient Journey from its inception.

What is this story about?

The Patient Journey Initiative provided a strategic focus for CHSA to come together as a single entity, and to work collaboratively with a range of other government and non-government organisations to meet the needs of country people to improve access to health services.

Why were we doing it?

Population level information revealed that people living in rural and remote SA had poorer health than people living in metropolitan areas. Also there were greater inequities in accessing health services for people living in rural and remote SA. There was also concern about the large number of people from country SA needing to travel to Adelaide to access health services.

It provided a strategic focus for bringing together 64 individual country hospitals and other health services and non-government organisation to form positive partnerships so that there was a more coordinated approach to supporting patient journeys across all of country SA in collaboration with metro-based services.

When did this work start?

It had its genesis at a conference ‘One Country Health Region’ in May 2006, where the Minister of Health identified a vision for improvements in access to health services and supports available to people from country SA. He stated “... all residents of country knowing exactly what health services are available to them... This means being clear when you would need to go to Adelaide for a service or a regional facility”.

George Beltchev, the then CEO of CHSA, was very strategic in his vision for how this could be achieved. In July 2006 I was appointed to lead the Patient Journey Initiative as part of the health reform agenda for CHSA. I strongly believed in the need for a collaborative and consultative approach to this process. As part of this commitment the Patient Journey Initiative Steering Committee was formed in October 2006. This Steering Committee had broad representation, a neutral Chair appointed external to CHSA, and a very passionate membership who were committed for the long haul.
When did it start to change direction?

In March 2009 I was asked to prepare a report for CHSA Executive on the work of the Patient Journey Initiative to date, reflect where we had come from and propose where we needed to go in the future. This received a positive response and the strategic decision was made to integrate and embed patient journey strategies as part of CHSA infrastructure. An example of this was the appointment of the Patient Liaison Network Coordinator who had an existing Patient Liaison Nurse role in country SA.

Where was this done?

In the spirit of a metropolitan and country partnership, it had a statewide focus. Very early on I identified a key advocate from the Royal Adelaide Hospital (RAH), Jodie Altswanger, who has been in the Rural Liaison Nurse position there for many years and was a strong advocate for rural consumers and health workers. We made many road trips around SA to speak with country and metropolitan health service workers, some country hospital Boards, and the country Directors of Nursing forum. We listened to local issues and were then able to identify key patient journey action areas from a country and metropolitan perspective.

What were we aiming to achieve?

There were three aspects of our aims. One aim was to improve access to health services for country South Australians. The second was to improve the transition of care between health services; improve planning and create a smoother journey. The third aim was to promote one health system that was responsive to the needs of rural and remote consumers to access the most appropriate services locally, regionally or in Adelaide.

Who was involved?

The vision of, and continuous support from George Beltchev was instrumental in achieving what we were able to achieve to date. I worked as the coordinator with many team members with specific focus areas. We had significant input from the Steering Committee. There were key partnerships formed between metropolitan and country services (government and non-government). There were also fantastic champions within CHSA and metropolitan health services. Many of these same people are still actively engaged today, some four - five years on.

What did we do?

From a strategic perspective:

- The consultations we did identified six key action areas. These action areas became the strategic framework for our work.
- We identified barriers and enablers to change.
- Identified champions with a passion for making a difference.
- Engaged diverse people, groups, and organisations.
- Formed the Steering Committee with broad membership, which included university links, geographical representation, metropolitan, and country representation, and strong rural community advocates. This Committee had three hour meetings every two months and had an active role in advising on strategic direction and monitoring progress.
Provided regular progress reports – internal and external.

Kept the Minister of Health well informed.

In August 2007 we set up a regular Patient Journey Communiqué to profile good things that were happening and share information. This had a huge distribution list and was a major part of our communication strategy.

Developed a good working relationship with Leena Sudano, the Health and Community Services Complaints Commissioner.

Organised many forums with a view to coordinating activities and providing networking opportunities.

We listened to people and did not forget what they told us as the journey progressed.

**What did we find?**

There was a lot of goodwill. We found that there were a lot of activities happening across the state, but not in collaboration with others so that a more coordinated approach could be achieved. We also found there was good leadership to improve patient journey issues, but due to a fragmented and often competitive system; they were not always being supported in their endeavours.

There was also a real sense of them and us – that is metropolitan versus country.

**What changed?**

The most important change was that it became a collective responsibility to improve access to health services for country people in SA. The competitiveness and blame shifting ceased. There was better communication between country and metropolitan health services. There was a greater understanding of needs of country patients to more effectively access health services. SA Health policies for patient focussed booking systems became embedded so that the needs of country patients changed the booking systems to be more flexible.

**What worked well?**

- The creation of my role as a key contact point within CHSA for service providers and community members to go to for information, and to raise issues of concern. This improved communication and coordination, and also lead to coordination of action.

- Change has involved many people and we have shared information. As a result the commitment and impact has been widespread.

- Our communication strategy was effective. The communication strategy included:
  - Briefings to Executive. This meant that when CHSA Executives were part of community forums they had been informed of what was happening with regard to Patient Journey Initiatives and could talk about those, but they could also bring issues identified from community members back to me. This really helped the Executive understand the real difficulties patients went through.
  - The Patient Journey Communiqué, which was widely disseminated.
Getting people around the table to talk through issues. This was a key strategy for challenging myths and misconceptions and to enable people to become part of the solution.

Developing consumer information and making it accessible across the state.

Broad and passionate membership of the Steering Committee. This was a fantastic committee and consisted of many members who understood that change could be a slow process and required a long term commitment.

Consistent leadership that shared a common vision and value base.

Changes made to the CHSA website to make it easier for people to access information and also gave people a sense of the geography of South Australia and where the health services were located. This helped plan patient journeys.

Champions providing a foundation for other strategies and actions to take place.

What did not work so well?

I found it a constant struggle being part of the system and working with a steering committee that needed information to do its job properly. There were often times when I couldn’t say things and be completely frank and honest. I had to continuously balance the information I provided to the steering committee to do its job and work within restraints of being part of the system.

This was a period of constant change within CHSA and I had frequent changes to whom I reported and who provided administrative and project support. However, a constant was George Beltchev who had a strong commitment.

“What strong leadership from people who share the vision and are committed to making a positive difference for consumers.”

What can others learn from our work?

You need:

- A vision and strategic focus.
- Strong leadership from people who share the vision and are committed to making a positive difference for consumers.
- To be willing to engage with a broad range of people to gain an understanding of local issues and a consumer perspective.
- Broad membership of passionate people on a steering committee who are committed to a common goal.
- A good Chairperson of the steering committee who is external to the organisation.
- To communicate widely.
- Teamwork and collaboration of government and non-government organisations.
- Commitment over the longer term; not short term projects.

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Perspectives from the CHSA Board

Barbara Hartwig was Chairperson of the inaugural Country Health SA Board until 2008.

George Beltchev came to the CHSA Board meeting mid 2006 with a new strategic reform agenda for CHSA. The Patient Journey Initiative was recommended as a key strategy for CHSA’s reform agenda. The Board was ecstatic because we all lived in the country and knew firsthand the difficulties country people had to access appropriate and timely country and metropolitan health services. The Patient Journey Initiative was a priority from the Board’s perspective, and we gave our full support to the initiative. Our support gave weight to the initiative’s priority for CHSA. We approved the funds to employ a project manager (Karen Dixon) and the establishment of the Steering Committee.

We had the Patient Journey Initiative as a standing agenda item for our monthly Board meetings and sought continuous updates. We were keen that evaluations be done and that this information was presented to the Board. The evaluations were very positive and reinforced the need for continued commitment for this reform process.

During the time that the CHSA Board was in existence, our meetings were held in different country towns each month. During our travels we heard stories from country people. These stories gave us anecdotal evidence about how the activities of the Patient Journey Initiative were improving things for country people who needed to access health services in both country and metropolitan areas.

There is a need to continue this work to make the South Australian health system more responsive to the needs of country people to make health services more accessible.

“The Patient Journey Initiative was a priority from the Board’s perspective, and we gave our full support to the initiative.”

A View from Across the Border

Jackie Mansourian worked for four years at the Health Issues Centre in Victoria, which is a non-government organisation which has a focus on:

- Policy analysis and advocacy from consumer and equity perspectives
- Consumer-focused research
- Promoting and supporting consumer participation
- Disseminating information.

A project I worked on in Victoria was aimed at identifying the priorities of rural consumers who travelled for healthcare in Victoria. This project was initiated following concerns expressed by several metropolitan hospitals’ Community Advisory Committees (CAC) about the range of issues faced by rural consumers when using city hospitals. This project coincided with the CHSA Patient Journey Initiative in SA.

I was so excited when I first heard about the work being done in SA and I invited Karen Dixon to speak at a regional conference. The issues being identified in SA’s Patient Journey Initiative were similar to the issues identified by consumers across Victoria. The common key issues were (1) lack of coordination and continuity of service provision within country health services and between metropolitan and country health services, and (2) lack of information for rural consumers to navigate the health system.
What stood out for me as being very positive about the CHSA Patient Journey Initiative was:

- **The political commitment to improve access to health services for consumers from rural and remote areas.**
- **A clear vision and strategic direction.**
- **Provision of resources to lead the change process and coordinate the work with and between health services in rural and metropolitan areas.**
- **The involvement of the Steering Committee, with its broad membership and commitment.**

Crucial to the Patient Journey Initiative’s success were the establishment of Patient Liaison Nurse roles in country health services, and Rural Liaison Nurse roles in metropolitan health services, and the ongoing process of building relationships between these workers.

These roles provided both direct supports for individual country patients, and also initiated organisational advocacy. They were the eyes of the organisation in regards to the needs of rural consumers and the systems that needed to be changed to be more effective to support rural consumers. There was also a commitment to ensure they were able to build relationships with each other through networking opportunities, and to work together to coordinate issues of common interest.

There are many positive lessons for Victoria that I think we can learn from the SA Patient Journey Initiative work, even though the public health systems are different. A whole-of-journey approach is needed in Victoria – and the key elements of the Patient Journey Initiative work within SA remain very pertinent to the Victorian context.

**Storyteller’s details**
Jackie Mansourian
Senior Policy Officer
Health Issues Centre
2006-2010

“There was also a commitment to ensure they were able to build relationships with each other through networking opportunities, and to work together to coordinate issues of common interest.”
Nearly 30% of South Australia’s population live in country areas. Access to health services is equally important for people living in country SA, yet is at times made more difficult due to distance they live from health services and the range of service provided.

Improving access to the most appropriate health services for country people, either locally, regionally or in Adelaide has been a priority for CHSA. A key focus of the Patient Journey Initiative is to improve access issues, that is, to put in place strategies for service providers to work together to achieve more effective communication, cooperation and coordination, based on a greater understanding of the patient journey issues for country patients.

The formalisation of the Patient Liaison Nurse role in country health services and the Rural Liaison Nurse role in metropolitan based health services has enabled a network to form of like minded people with a common purpose to improve access to health services and the patient journey for country people. This section shines the spotlight on initiatives which have achieved significant changes for country people in this area, such as the Rural Liaison Nurse role at the Royal Adelaide Hospital, which is described by Jodie Altschwager, and the development and coordination of the Patient Liaison Network by CHSA which is described by Pam Pratt.

For change to be patient-focused there needs to be involvement of community advocates who can utilise their networks and contribute to discussions about the needs of country people, as well as feedback from country patients who have experienced the journey. Stories have been included from Margaret Brown, a community advocate who has worked for many years to effect change for country people to have better access to health services, and two country people who needed to access metropolitan health services; Margaret from the Mallee and Michelle Sellars who tells us her dad’s story.

Introduction

Perspectives of a Metropolitan Based Rural Liaison Nurse

Jodie Altschwager was the Rural Liaison Nurse at the Royal Adelaide Hospital (RAH) for 12 years and has facilitated significant changes to improve access to the RAH for country South Australians.

What is this story about?

The role of the Rural Liaison Nurse at the RAH and how it has evolved over the past 16 years to provide an essential service to improve the journeys of country patients.

Why were we doing it?

The RAH needed to improve the transition of care to country hospitals and community care. The RAH had been getting complaints about inter-hospital transfers, especially relating to transport, inconsistent approaches to discharge planning, poor handover of clinical care resulting in refusals by country hospitals to accept patients back resulting in long hospital stays for country patients.

When did this work start?

In 1995 when case mix funding came in, ‘bed block’ was identified as a significant problem for country patients. The Director of Nursing at the time was keen to understand the issues for why country patients had longer hospital stays than metropolitan patients and how the RAH could reduce the complaints related to country discharges. An Aged Care Liaison Nurse had been appointed to look at transition issues for older people and develop relationships with residential care services. This role had been successful in breaking down a lot of barriers and improving the flow of patients to residential care. On the success of this role, the decision was made to appoint a Rural Liaison Nurse. I was appointed to the Rural Liaison Nurse role...
in 1995, which initially was a temporary position for six months to look at the issues for country patients and country services.

I was keen to take on this role as I was from the country and had an interest in this area, especially as some members of my family had had a recent experience with the metropolitan health system which was a stressful event for them and it raised concerns with me about how people would manage without a family member in the city to assist in providing support.

This was the first time that issues for country patients at the RAH had begun to be identified. There was so much work to be done, that the six month temporary position was continued and after three years became a permanent position. It was a position I held for 12 years. The RAH found the liaison roles made a significant difference for the hospital and for patients. In addition to the Rural Liaison Nurse role, five key liaison roles were initiated over time: Aged Care, Rural, GP, Aboriginal and Disability.

Where was this done?

The Rural Liaison Role was at the RAH. When the Patient Journey Initiative began I was seconded to CHSA in 2007 for several months to work with Karen Dixon to consult with country health services and formalise the Patient Liaison Nurse role for country health services, and help develop a networking strategy.

What were we aiming to achieve?

The initial aim was to instill effective and consistent transfer/discharge planning practices for country patients and decrease the length of stay for country patients at the RAH. However, very early on when I began to become involved with country patients I found that many had special requirements that came about due to the dislocation from family and distance from their community; they needed to be linked into services for financial and social support. The aim became broader and more consumer focused as we identified the needs of country patients.

Who was involved?

Initially it was just me, as part of a network of five liaison nurses at the RAH with different portfolios, but sharing many of the same issues. In 1999 a second position was appointed to support the Rural Liaison Nurse role. This was initially a rotating position, where we appointed nurses from the RAH wards for six month periods. This lead to capacity building of staff across the RAH. They began to understand the issues for country patients, and learn how to address the issues. This in turn lead to developing a culture at the RAH which could sustain improvements for country patients.

What did we do?

When I was appointed I undertook work to identify the volume of country patients at the RAH. We found that on any given day 30% of patients at the RAH are from country areas in South Australia, western Victoria, Northern Territory and western New South Wales. Eighty two percent are discharged to their home, 12% to a country hospital, and the other 6% consists of people who have either have died, or require rehabilitation services or residential care. I was able to capture information about where people came from, where they went to at
discharge, gaps in services (pre and post hospital), inappropriate use of country hospitals as a discharge option (as opposed to being discharged to home with community support), and lack of knowledge of the range of transport options and the reimbursement schemes available to people from country SA, western NSW, NT and western Victoria.

On a daily basis I would visit country patients in the RAH and respond to the needs of individual patients and communicate with staff in the wards, country hospitals, community based country staff and General Practitioners. Every day I was able to have an impact on someone’s journey. I attended a number of field days across the state. The field days provided an opportunity to discuss with people the issues that they had when accessing metropolitan services and I could provide information to assist.

Over time I was able to identify more strategic issues and solutions, and became an advocate for inequities faced by country patients. I worked hard to build relationships with country health services. We identified that lack of information was a big issue for country people and we developed the booklet ‘Guide for Country Patients attending Royal Adelaide Hospital’, which was widely disseminated. We also identified that accessing rehabilitation services and financial support was problematic for farmers and farm workers who had been injured on their farms, and developed a rehabilitation guide for farmers. This was a big project in collaboration with many government and non-government organizations, including Divisions of General Practice, AgrAbility NSW and SA Farmers Federation.

“We identified that lack of information was a big issue for country people and we developed the booklet ‘Guide for Country Patients attending Royal Adelaide Hospital’”

When the Patient Journey Initiative began I became involved in identifying the key patient journey issues for country health services and building relationships between country and metropolitan health services.

What did we find?

Many RAH staff didn’t understand geographical distances and the complexities country patients faced when in a metropolitan hospital.

Each state had different Patient Assistance Transport Scheme (PATS) reimbursement schemes and this meant that there were considerable inequities between patients from different states, which had a direct impact on their patient journey and health outcomes.

There was a lack of responsibility for discharge planning and assessment of country patients on admission.

There was a need to up skill clinical staff and provide resources to enable staff to be more effective in meeting the discharge planning needs of country patients and to embed accountability into the practices of clinicians.

What changed?

There were many changes over the years. Most importantly:

- The leadership at the RAH became more aware of the needs of country patients.
- The RAH became more ‘country friendly’.
- There were improvements in continuity of care through more effective discharge planning.
- The RAH staff had a better capacity to do discharge planning through an increase in understanding about the needs of country patients, and through developing their skills.
We were able to create system changes based on the information we gained through developing feedback mechanisms about the needs of country patients.

We developed better resources for country patients.

We were able to get patients back to appropriate settings in the country more quickly, which reduced their length of stay at RAH and time spent away from home.

What worked well?

Having a single and consistent contact point for country health services to contact at the RAH. This lead to better communication and more effective working relationships between country health services and the RAH, which benefited country patients.

Through developing feedback mechanism there was more transparency about the inequities facing country patients, and we were able to make clinicians and managers aware of these inequities and the systems issues that were problematic. We could advocate for changes that needed to be made.

Through developing more effective working relationships between metropolitan and country health services, we were able to get standards for appropriate communication developed. The Patient Journey Initiative worked at addressing issues in country health that metropolitan health services couldn’t address on their own.

What did not work so well?

The Rural Liaison Nurse Role was too big and too busy and it was hard to sustain the workload. There were so many issues that needed to be addressed and so many country patients that needed help I found that I was spread too thin at times. It is easy to get caught up in patient stories, and it can be hard to manage and put in place boundaries. For some time when the role commenced an ‘us and them’ mentality between metropolitan and country health services meant that we weren’t always able to work together for the best interest of the country patients. The work of the Patient Journey Initiative has gone a long way to address this and improve relationships.

What can others learn from our work?

You need to know your patient group and their needs to make a difference. Tenacity and a long term view are important. You need to be able to operationalise changes and get them into place, while realising that strategically the system needed to change but on your own it was hard to have an impact.

You need good communication skills and to be able to liaise effectively with a range of stakeholders. Sometimes it is not possible to have your own way all the time with solutions to patient problems. You need to compromise, and meet in the middle.

Networking and building relationships is vital to the success of the work we do. It is important to not only build relationships within the health system, but to build relationships with consumer groups such as the Health Consumers Alliance.

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The Coordination of the Patient Liaison Network

Pam Pratt took on the part time role as Coordinator of the Patient Liaison Network in February 2010 and has combined this role with her other roles as the Patient Liaison Nurse role at Strathalbyn and the Rural Burns Nurse Link position.

What is this story about?

One of the key strategies to improve access to health services for country South Australians has been the formalisation and development of the Patient Liaison Nurse role in country health services, and Rural Liaison Nurses in metropolitan hospitals, where these roles were not in existence. Forming the Patient Liaison Network, through identifying and linking these key coordinating contacts in country health services and Adelaide-based hospitals, has been a key enabler in supporting the patient journey for people from country SA (and many from interstate) who need to travel to access services.

Why were we doing it?

We were passionate about the rights of country people to have the improved access to health care services locally, regionally and in Adelaide.

We were also really committed to ensuring that country patients, and their families, were better informed of their options for accessing health services locally, regionally and in Adelaide.

When did this work start?

The Patient Liaison Nurse role, in CHSA, formally began in 2007. It was recognised that there needed to be a key contact in country health services to better manage patient journey issues. Some health services had Admission/Discharge Coordinators. These roles were redefined and expanded to become Patient Liaison Nurse positions. However, some health services continued to call them Admission/Discharge Coordinators, or Clinical Managers, or in smaller places it was the Director of Nursing.

I had previously been the Discharge Coordinator at Mount Barker and chaired a multidisciplinary committee there. I then took on the Patient Liaison Nurse role at Strathalbyn, and combined this with the Rural Burns Nurse Link position. When the Patient Liaison Network Coordinator position was established in February 2010 I was successful in gaining that part-time position (I wear many hats). Through this position CHSA continues to provide a central contact point for patient journey issues.

Where was this done?

I am based at Strathalbyn Hospital where I am the Patient Liaison Nurse/Rural Burns Nurse Link, and also coordinate the activities of the Patient Liaison Network. The work of the Patient Liaison Network has an impact across the state of South Australia.
Access to Health Services for Country South Australians

What were we aiming to achieve?

- Improve the journey for country people needing to access health services locally, regionally, or in metropolitan health services.
- Actively ‘track’ our patients in metropolitan health services, and transfer them back as soon as it was clinically appropriate, thereby decreasing the length of stay in metropolitan health services.
- Improve communication between health services about patient journey issues.
- The ability to look at patient journey incidents and problems with a view to finding system wide solutions.
- Identify new and emerging communities and their particular patient journey issues.
- Standardise forms across CHSA so that transfer of information is consistent.

Who was involved?

Initially, Karen Dixon as the Coordinator Patient Journey, Jodie Altschwager the Rural Liaison Nurse at the RAH, and the members of the Steering Committee were instrumental in advocating for the initiation of more Patient Liaison Nurse positions in country health services and Rural Liaison Nurse positions in metropolitan health services, where they were not in place.

The first Patient Liaison Network forum was held in 2007, which attracted about 30 participants. It has become an annual event with over 120 participants in 2011. At the beginning it was people with a Patient/Rural Liaison Nurse role in country and metropolitan health services, but over time it has expanded to include Aboriginal Patient Pathway Officers, Aboriginal Health Workers, practice nurses from General Practice, community health workers, Better Care Facilitators, and any other service providers with an interest in country patient journey issues.

What did we do?

- Formalised and recognised the Patient Liaison Nurse role in country health services and Rural Liaison Nurse roles in metropolitan health services, where positions were not in place. We continue to advocate for these positions.
- Established a network of key contacts. There are key contact lists for Country Hospitals, Metropolitan Hospitals, Community Health Services in country, Better Care Facilitators and Aboriginal Patient Pathway Officers, who deal with patient journey issues on a day to day basis.
- Over time, with the inclusion of ‘interested others’ the Patient Liaison Network has expanded to over 400 members.
- Initiated communication strategies to keep Patient Liaison Network members informed. This includes me sending out regular emails as patient journey issues arise, and continually researching new and interesting initiatives and programs state wide to include in the monthly Patient Journey Communiqué.

What did we find?

Many positive and passionate health workers in country and metropolitan health services who really wanted to make a difference to the patient journeys for country South Australians.

“There is a stronger patient-centred-care focus about patient journey issues within country and metropolitan health services.”
When CHSA formalised and recognised these roles in supporting patient journeys, and provided the opportunity for them to come together, they realised they weren’t alone with their concerns: that there were others who shared their concerns and the desire to work together to find solutions. It was also an opportunity to network with like minded people who shared a common goal and knew that if they worked together they could have a greater impact.

**What changed?**

Advocacy about patient journey issues has become more effective and has resulted in significant improvements across country and metropolitan health services for individual patients, as well as system changes.

Members of the Patient Liaison Network are actively seeking opportunities to avoid hospital admissions, especially into metropolitan hospitals.

There has been a decreased length of stay for country patients in metropolitan hospitals and improved discharge planning back to home or local hospital.

There is a stronger patient-centred-care focus about patient journey issues within country and metropolitan health services.

The range of health workers interested in patient journey issues has broadened beyond the Patient/Rural Liaison Nurses roles.

**What worked well?**

*Patient Liaison and Rural Liaison Nurses Positions*

These roles have been identified as being integral to supporting country patient journeys. Most major public hospitals within the metropolitan area have Rural Liaison Nurses or like positions. There are Patient Liaison Nurses in country hospitals, alongside nurses and allied health staff in community health, many of whom are actively identifying and transferring patients back to country hospitals and communities, and seeking opportunities to support access to services closer to home.

Rural Liaison Nurses in metropolitan hospitals have reported that this system works well by providing a key contact and transition point within country health units for metropolitan services, resulting in stronger linkages and improved communication between points of care.

*The Country Health SA Nursing and Midwifery Transfer Form.*

An early issue identified by the Patient Liaison Network was the need to increase consistency of information provided on the transfer of patients between health units. The development and promotion of the Country Health SA Nursing and Midwifery Transfer Form occurred in early 2008. The feedback received from
Rural Liaison Nurses at metropolitan sites has been extremely positive. A review of this form and subsequent update occurred in 2010.

The Patient Journey Communiqué

The Communiqué has been a useful tool in the continued promotion of programs and strategies initiated to improve health service access and decrease the number of journeys for country patients and has a broad distribution and is available via the CHSA website at: www.countryhealthsa.sa.gov.au.

Information Technology (IT) Opportunities

There is continued advocacy through CHSA for IT enhancements and opportunities to avoid travel, and to build on to existing good examples of videoconferencing already in practice. For example, the Rural and Remote Mental Health Service.

What did not work so well?

Despite significant inroads by the dedicated efforts of the Patient Liaison Network the numbers of people travelling to access specialist services appears to remain unchanged. Referral patterns to outpatient specialist services and metropolitan based specialist review patterns don't seem to have significantly changed.

“What the dedicated efforts of the Patient Liaison Network the numbers of people travelling to access specialist services appears to remain unchanged.”

What can others learn from our work?

Together you can achieve so much; alone you can do so little. There is a need to recognise that having a contact, such as the Patient Liaison Nurse position within country and Rural Liaison Nurse position within metropolitan health services, is essential to improving communication and coordination of country patient journeys.

It is imperative that you be patient centred and involve patients/clients in identifying the issues and problem solving.

Improvements can be made to improve patient journeys for country people to metropolitan health services, and back to country (either to local health services or home with community supports).

Networks of people with a common purpose provide the opportunity for people to share concerns, learn from each other, increase collaborative efforts to identify issues and bring about change, and support each other.

Storyteller’s details

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**Perspectives of a Community Advocate**

*Margaret Brown has been a member of the Patient Journey Steering Committee since its inception in October 2006. Margaret has been a long standing advocate for improving access to health services for country people. She is currently the National Chair, Health Consumers of Rural & Remote Australia and Deputy Chair, Health Consumers Alliance of SA*

**How I became interested in patient journey issues, for example, from personal experience?**

I have lived in the country for most of my life and experienced firsthand the difficulties of accessing health services. I have become passionate about patient journey issues and strongly believe that country people have a right to access health services in a timely manner and to have choice. In the 1980’s I became involved in the Murray Mallee Health and Social Welfare Council, which gave me a good grounding in understanding the health system and advocating for change. During my involvement with this Council I was asked to present at a national rural conference about issues for rural and remote consumers and met a lot of like minded people. This was a very exciting opportunity and led to a group of us getting together and laying the ground work to set up a national rural health alliance so that we could advocate for change at a national level.

I was invited to be a member of the Steering Committee and have been involved since the first meeting in October 2006. I have really enjoyed being a member on this committee. It brought all the issues I had been concerned about for the patient journey into one forum and I was able to have an input into significant changes within CHSA and metropolitan health services.

**How I progressed the patient journey issues and advocated for change?**

Over the years I have developed extensive networks, both within SA and nationally. People know I am passionate about patient journey issues for country people. I have been able to utilise these networks to disseminate information and develop collaborative approaches to advocating for change. I have also spoken to many consumers who have experienced patient journey problems, as well as good experiences. This has led to me knowing many of the important issues for consumers. Also because people know of my interests in this area I am often called upon to make comment on the local ABC talkback radio.

Through my involvement with the Health Consumers of Rural and Remote Australia I have been able to meet with Federal Ministers and take issues directly to them. I believe that through doing this they become more aware of the real needs of people living in rural and remote areas.

I found the Patient Journey Communiqué to be a useful tool for disseminating information through my extensive networks.

**What changed?**

There are several patient journey initiatives which I think have brought about really positive changes for country SA health consumers.

Firstly, I think the formation of Patient Liaison Nurse roles in most country and Rural Liaison Nurse roles in metropolitan hospitals has been a fantastic change. This has meant that country people have someone to contact and connect to. Because the networking opportunities for the Patient/Rural Liaison Nurses was formalised, they were able to discuss these issues and have a coordinated approach to change.
Another significant change has been that metropolitan hospitals are becoming more country friendly, in that they allow country people to have appointments which suit their needs when they have to travel for appointments. The metropolitan health services are much more receptive to arranging several appointments in a day so that it reduces the need for multiple trips.

Also getting consumer information out there about transport and accommodation so that country people are aware of their options has been really important.

Finally, I think the range of voluntary transport schemes that have been set up in rural areas to assist people to access metropolitan or regional health services has been encouraging, but funding and support must be continued. Country people need to be aware that as volunteer drivers become older and aren’t able to drive, others within the community must be willing to take on the role.

**What worked well?**

The Steering Committee was a very positive committee and a very positive experience for me. The committee was action oriented, respected the voice of consumers, consisted of members who were working towards the common good, and were in it for the long term. They all realised that change can often be slow, but you had to be patient and not lose sight of the bigger picture. I found it helped me by being part of a forum which I could use as a sounding board for issues and ideas.

The support of the CEO of CHSA, George Beltchev and other senior CHSA staff was important in enabling and supporting change.

The Patient Journey Communiqué was a really useful tool to promote the work of the initiative and also raise issues that needed to be addressed across the health system, rather than in ad hoc projects.

**What did not work so well?**

So many different players impact on the patient journey. It can be difficult to connect with and coordinate new initiatives in a timely manner so that change does not create further inequities within the system.

**What still needs to be done?**

Now that the Steering Committee is coming to an end, it is important that CHSA create effective consumer and community engagement strategies so they don’t lose sight of patient journey issues from the consumer perspective. Consumer input is a vital component of any service improvement and change processes.

I am really keen that the ‘meet and greet’ at the airport for sick country patients coming great distances into an unfamiliar environment is improved.

I would also like to see PATS forms on-line so that they are more accessible to country people, and that there is a greater consideration by GP’s and specialists of the needs of country people to access health services.

There is a long way to go for affordable accommodation for patients and families accessing services at the new RAH and at the Lyell McEwin.

**Storyteller’s details**

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Perspectives of Country People Accessing Metropolitan Health Services

Margaret from the Mallee

Finding out that you have cancer, and all that is attached to that, can be rather daunting for any woman. However, add to the equation the fact that you are living on the land, the feeling of isolation can be quite overwhelming. Whilst I was in Flinders Medical Centre for surgery my husband and children stayed at Flinders Lodge, which is run by the Cancer Council. This was really helpful; having somewhere to stay that didn’t cost the earth. I know that my husband found the staff to be supportive and caring. In the early days, following surgery, I was blessed to have the services of the local Palliative Care Nurse from the Mallee who regularly visited me and gave much needed support. Knowing that I was not alone really helped me deal with things.

When I was told that I would need radiotherapy for five weeks in Adelaide, the specialist must have noticed my face drop and asked what my concerns were. I explained that my biggest concern was travelling and staying away from my children and husband during the week. She then suggested I would be a perfect candidate for the “Stay in Touch” program.

The “Stay in Touch” is a program run by National Breast and Ovarian Cancer (NBOCC) that lends you a laptop computer while you are away from home for treatment so you can keep in touch with your family. Your family at home also receives a laptop computer. Both are fitted with web cameras. We had one 20 minute call per weekday of free Skype video calls. It was SO GOOD to see my kids while we were chatting each night and this really did help all of us cope with being separated for all those weeks.

I also appreciated the fact that the staff at Flinders Medical Centre, Radiotherapy Centre, eased the separation factor of living in the country by scheduling my appointments to be in the afternoons on the Monday, and first thing Friday mornings. This meant that I could see the kids off to the school bus on Monday morning, do a few quick jobs and then head to Adelaide. Then on the Friday, because I had such an early appointment, I was home before the kids got home from school. This really did help me cope better over that period of treatment.

While I was in Adelaide for the five weeks of radiotherapy I stayed at Greenhill Lodge, also run by the Cancer Council. The apartment was lovely, the staff were friendly and caring, and there was even a mini-van that we went on each day to the hospital. This took away the stress of driving and parking at the hospital. Every aspect of staying at Greenhill Lodge was positive and is a really valuable service for country patients.

My cancer journey has had its ‘bumps and curves’ along the way, but the support that I’ve had, and the flexibility of the services to accommodate my needs, has made it easier to cope with and has highlighted the fact that I am not alone.

Michele Sellars about her dad William Campbell from Whyalla

My 86 year old dad had an appointment with a vascular surgeon at the RAH. My brother drove dad to Adelaide. They stayed overnight as the appointment was early the next morning and they expected to travel back to Whyalla that same day. However, dad was admitted to the ICU and I stayed at Greenhill Lodge... The apartment was lovely, the staff were friendly and caring.

“I stayed at Greenhill Lodge... The apartment was lovely, the staff were friendly and caring”
RAH on the day of his outpatient appointment for tests and observation and an operation was scheduled in a few days time. Although this was unexpected and dad doesn’t particularly like hospitals he was relieved to be attended to so promptly.

Dad was operated on and the operation was a success. He was an in-patient for 11 days. During his hospitalisation dad spoke very highly of his treating medical specialist, the nursing staff, allied health staff, and the volunteers. He was amazed at how hard they worked and also how they had to deal with some really difficult patients and situations.

The Rural Liaison Nurse came to check on dad and to see if he had the funds, transport or means to get back to Whyalla and also accommodation in Adelaide if needed. If not, she was willing to make these arrangements for him. Fortunately dad has family in Whyalla and Adelaide so this was not an issue for him. Prior to discharge the Pharmacist spent at least 10 minutes with dad and myself explaining his medication thoroughly, and also gave him a running sheet with medication instructions. Dad had to remain in Adelaide with me for another four days before travelling back to Whyalla with a family member. The RAH arranged for RDNS to visit daily to change his dressings. Appointments were also made by the RAH for specialist follow up in Whyalla to save dad coming all the way to Adelaide again.

Although it was a traumatic and emotional experience for dad, and he worried about his dog the whole time, it was a very positive experience and outcome and he is still talking about the great treatment he got and how he always felt he was in good hands.

“Every aspect of staying at Greenhill Lodge was positive and is a really valuable service for country patients”
Country Patient and Carer Support, Transport & Accommodation

Introduction

On any given day for country residents living in local government areas not adjacent to Adelaide and requiring an overnight stay in a SA hospital, approximately 70% are in country hospitals and 30% in metropolitan hospitals. In addition, a significant number of country people need to travel long distances to access medical specialists for appointments in regional and metropolitan areas. Whereas CHSA, and SA Health, are endeavouring to increase the range of medical specialist services available in regional health services to reduce the number of avoidable transfers and referrals to Adelaide based health services, travelling to access health services is an ongoing issue for country people.

Transport and accommodation expenses can provide significant financial pressures on country people, especially if extended stays are required in Adelaide. The Patient Journey Initiative was committed to seeing improvements made in these fundamentally important areas of transport and accommodation. This section includes insights into three important initiatives to address affordable accommodation and transport for country people.

“Community solutions to assist community members access Adelaide health services are a vital part of the transport options required.”

Affordable accommodation continues to be a challenge for country people who need to stay in Adelaide; however, there is a lot to learn from the model of accommodation and support provided since 1996 to country people by Cancer Council SA in Adelaide. This important accommodation and support service is described by Monica Byrnes and David Phillips from Cancer Council SA.

The SA Government’s Patient Assistance Transport Scheme (PATS) has recently undergone changes to streamline and simplify the service to make it more accessible to country people who need to seek reimbursement for travel and accommodation to access specialist medical services. Rae Winter describes the purpose of PATS and changes that have recently been implemented.

Community solutions to assist community members access Adelaide health services are a vital part of the transport options required. Julie Mason Manages the Yorke Peninsula Community Transport and Services Inc. She describes the Health Bus which the service provides from Yorke Peninsula to Adelaide, and return, five days a week. Pauline Phillips, from Kadina, describes the benefits of being able to access this community service for the frequent trips to Adelaide she needed to make for treatments.

Sue Wheal, a community advocate and long term member of the Patient Journey Initiative Steering Committee, describes her advocacy role as part of this committee.
Cancer Council SA's Model of Supportive Accommodation for Country People Requiring Extended Stays in Adelaide for Cancer Treatments

Monica Byrnes is Manager Cancer Support and David Phillips is Manager Motel Operations for Cancer Council SA. They provide insights into the development and expansion of the model of supportive accommodation and transport Cancer Council SA provides for country people needing to stay in Adelaide for medical treatment.

What is this story about?

Since 1995 Cancer Council SA has provided affordable and supportive accommodation, and transport to some cancer treatment centres, for country people who need to stay in Adelaide. This is a unique service which is in great demand, and is highly valued by country people. This story gives some background to how the service has come about and how it supports the patient journey for country people who need to come to Adelaide for medical care.

Why were we doing it?

In 1995 Cancer Council SA identified a lack of affordable accommodation as a major gap for people from country South Australia, Northern Territory, Broken Hill (New South Wales) and Mildura (Victoria) who needed to access cancer treatments in Adelaide – especially for those requiring extended stays.

“The lack of affordable and supportive accommodation was causing a significant financial burden on country people, already having to cope with loss of income and dislocation from family and community, in addition to the burden of their diagnosis of cancer and ongoing treatments.”

What were we aiming to achieve?

Cancer Council SA was keen to develop a model for providing affordable accommodation, which also provided a supportive environment for people with cancer and was a sustainable business model.

Who was involved?

Cancer Council SA planned and funded the initiative.

What did we do?

In 1995 Cancer Council SA bought Greenhill Lodge, a 55 room complex on Greenhill Road, just south of the CBD. In addition to accommodation Cancer Council SA provides psychological support through the services of an on-site social worker, and access to a recreation room, guest kitchen facilities and a dining room for evening meals Monday to Friday. The demand superseded the availability of rooms within five years of operation. Cancer Council SA then purchased Seaview Lodge in 2001, a facility which has 9 self contained units, and is suited to couples who have their own transport and are looking for self sufficient style accommodation rather than motel style. This type of accommodation is also suitable for people who have suppressed immune function who need to limit their contact with people. At Seaview Lodge there isn’t an on-site social worker and transport is not available from that site, however people can easily arrange to access both services at Greenhill Lodge if need be.

“Country Patient and Carer Support, Transport & Accommodation

“There is a need to continue to evolve our service to meet the changing needs of country people and changes in the provision of health services.”
In 2003 the Cancer Council SA Board undertook a review of accommodation and identified the need to purchase additional accommodation to meet the increasing and projected demand. The model for the new accommodation would utilise the same model of supportive accommodation provided at Greenhill Lodge. In 2006 Flinders Lodge was purchased, providing a 66 room motel located on Dequetteville Terrace to the east of the CBD. Flinders Lodge has a recreation room, guest kitchen facilities, and dining room service. It also has the same access to an on-site social worker and transport service that are available at Greenhill Lodge.

The transport service, which has operated since 1995, currently takes people to appointments and treatments at the RAH, St Andrews and Flinders Private Medical Centre. The service runs hourly loops from Greenhill and Flinders Lodges to the RAH and St Andrews between 7.30am and 5pm, and a twice daily return trip from these two lodges to the Adelaide Radiotherapy Centre at Flinders Private Medical Centre.

Whereas Cancer Council SA provides social support services, it is not a health service. If guests require health care during their stay, they access this through normal community and emergency health services.

**What did we find?**

The supportive accommodation works well and meets the needs of country people who stay for treatments.

There is a huge demand for supportive accommodation and transport assistance for country people. The lodges operate on close to full capacity throughout the year with an average overall occupancy around 80%-85%.

We provide home-style, low cost meals that are high in energy. We average about 80-90 meals in the dining rooms each night.

There is a need to continue to evolve our service to meet the changing needs of country people and changes in the provision of health services. For example, Lyell McEwin Health Service now has a radiotherapy service but our bus doesn’t go out there at this stage. When Adelaide Radiotherapy Centre started up at Flinders Private, they helped us purchase an additional bus so that we could take people out to Bedford Park to use their service. However, Cancer Council SA now covers all costs associated with providing the bus service, including replacement and maintenance of buses to ensure provision of safe vehicles.

There is a significant amount of community support for our accommodation and transport service with many country community groups being active fundraisers.

**What worked well?**

The support of volunteers has worked extremely well and is an integral part of our service offering to guests. There are more than 35 volunteer bus drivers and many other volunteers who provide a range of supports to our guests.

The relationship with PATS and CHSA has worked really well for both Cancer Council SA and guests. The ability to direct bill PATS on behalf of guests (if eligible under PATS) means that guests don’t have the added burden of having to afford to pay upfront for their accommodation.

The model of providing supportive accommodation works really well. The social workers are there to assist people in many ways, from psychological support to advocacy.

Social supports are highly valued by guests and well utilised and include the recreation room; regular informal morning tea between Cancer Council SA staff and guests; bus trips...
on weekends; shopping trips; social occasions; and a hairdresser who volunteers her time once a week. In addition, external organisations such as Look Good, Feel Better run sessions on site on a regular basis.

One of the most welcome outcomes for many guests are the bonds, friendships and discussions about mutual experiences that can’t be planned, but in themselves provide invaluable support amid health challenges.

The good relationship with the various treatment centres has meant that they are a lot more open to arranging appointments to suit the sometimes changing needs of our guests.

What did not work so well?

Trying to emulate the same supportive accommodation model that is in place at Greenhill Lodge in Flinders Lodge was a challenge. Flinders Lodge is a two story structure and Greenhill Lodge is a single story structure. The two story structure proved to be a problem for people with mobility issues. A South Australian Government grant has enabled us to install a lift so that it is safer for guests to get to and from their rooms.

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What can others learn from our work?

Anything is possible if appropriate due diligence is undertaken in the planning process. Identifying gaps and how best those gaps can be addressed, while basing decisions on sound principles to meet the needs of people who will be using the service.

Cancer Council SA explored accommodation models in place internationally and based its model for Greenhill Lodge and Flinders Lodge on Hope Lodge, which is affordable accommodation offering a nurturing and supportive home-like environment provided by the American Cancer Society.

There is a need to establish effective ways to fund the accommodation. Cancer Council SA relies heavily on donations and PATS reimbursements to fund our services and receives fantastic support from country community groups who fundraise and donate funds. Cancer Council SA also enjoys a good relationship with various state based accommodation and transport assistance schemes including SA, Northern Territory, New South Wales and Victoria, in that they reimburse us directly, and means that guests do not have to worry about the added burden of making their own claims.

Cancer Council SA understands the journey country people have to make to access health services and believes affordable supportive accommodation and transport services are essential to assist country people when they are away from home.
Changes to the South Australian Patient Assistance Transport Scheme (PATS)

*Rae Winter is the Manager of PATS and has been planning changes to the scheme for the past 18 months. These changes have commenced as of 4 July 2011.*

**What is this story about?**

The South Australian Government provides some financial reimbursement to country patients and approved escorts with the cost of travel and accommodation when they are required to travel over 100 kilometres (each way) to receive specialist medical treatment that is not available at a local health service. PATS is the service that manages the reimbursement process. There is a PATS Central Office in Adelaide, and regional offices in Whyalla, Riverland, Port Lincoln, Port Augusta and Mount Gambier.

There has been a focus on reforming PATS within a static budget environment over the past 18 months. I was appointed to the position of PATS Manager in November 2009 to lead this complex planning process. My appointment was a direct result of lobbying by the Steering Committee for a manager to be appointed to the PATS service, after two years of PATS being overseen by the CHSA Finance Department. I have brought fresh eyes to PATS, and an openness to consult with key stakeholders to plan for the significant changes we have made to PATS in South Australia.

**Why were we doing it?**

There needed to be an overhaul of PATS to provide a more patient-focused PATS reimbursement service for country people who needed to travel to access specialist medical services that were not available in their local area.

**What were we aiming to achieve?**

We wanted to provide a more streamlined PATS service that was more accessible to country people who needed to seek reimbursement for travel and accommodation to access specialist medical services. We also wanted to provide a more equitable, consistent and transparent PATS service.

**Who was involved?**

CHSA took the lead in the planning process, and I consulted and worked with many stakeholders across the state, especially those living in remote areas of the state where access to specialist services is much more complex.

**What did we do?**

I undertook a complex planning process to support the reform of PATS. This has taken 18 months. I talked to many regional and remote health staff and patients to really understand the issues faced by people living and working in remote areas of the state. This included workshops and face to face discussions. I sought input from organisations such as the Cancer Council who provide a significant accommodation service for many country people and their families, Rural Liaison Nurses, Aboriginal Patient Pathways Officers, Steering Committee, Health Advisory Council members, and various health service providers. I also utilised information from a review of PATS in South Australia in 2008, and a report prepared for a Senate Inquiry. Members of the Health Advisory Councils across the state were also invited by Minister of Health to provide comments.

Many of the system changes that were recommended from the consultation process have required input from experts in computer programming and finance systems. We have looked at simpler ways for patients to apply...
for reimbursement through redesigning the claim form and claim process. I looked at improvements to provide a more effective approach to coordinating services by the different PATS Offices around the state by developing one database that all Offices use. That way, once patient information is entered into the system; all PATS Offices are able to access this information from the same system. This has also involved an education process for the administrative officers. I also looked at ways of providing better information about the PATS service to the public and to health professionals and developed a series of Fact Sheets, which are now available on the CHSA website: www.countryhealthsa.sa.gov.au.

What did we find?

PATS is a scheme that evokes much discussion and debate and which has had a very complex history. There appeared to be a culture of PATS being an entitlement. Many people think the amounts that are provided to reimburse travel and accommodation expenses should be increased.

I identified many changes that would make a significance difference to streamlining PATS processes. However, even though we can do a lot to streamline processes, there is still work to be done to advocate for any changes to policy decisions regarding reimbursements.

What changed?

One change which happened just before I was appointed was the change to patients needing to provide fuel receipts. This has meant that people applying for reimbursement for private car usage no longer have to provide fuel receipts.

I have been planning for the changes to PATS over the past 18 months. The changes were launched on 4 July, 2011. From now on, eligibility for PATS (that is, the calculation of distance) will be worked out using a Global Positioning System (GPS) mapping system. This on-line tool is now on the CHSA web page for PATS. Decisions about eligibility for PATS are now based on up-to-date technology. PATS has also moved to providing fuel cards and an electronic funds transfer process instead of cheques for those people eligible for advances. The redesigned PATS claims form is now available on-line.

What worked well?

We trialled the new Electronic Funds Transfer process and learnt a lot from this, which has lead to improvements being made.

I put a generic PATS email address on the CHSA and SA Health websites. This has been fantastic in broadening opportunities for people to provide feedback to us.

“However, even though we can do a lot to streamline processes, there is still work to be done to advocate for any changes to policy decisions regarding reimbursements.”
The fuel cards work really well as it means that people do not have to pay for fuel and then wait to be reimbursed. The work PATS has been doing with Map Data Sciences has been very exciting and has enabled us to develop a more transparent and consistent process for calculation of distances travelled. This will be the one system used by CHSA for determining distance and will prevent discrepancies in calculations.

**What did not work so well?**

The length of time taken to plan for change has been difficult and I think is hard for many stakeholders to fully appreciate. The range of stakeholders with an interest in PATS has provided many challenges. PATS is a complex system to change within a fixed budget.

**What can others learn from our work?**

- Change does take time.
- A lot of the work is invisible and behind the scenes, so it may look to the outsider that nothing is happening, but it takes time to set up the most appropriate systems and bring diverse groups of people along with you.
- Embracing change and bringing people with you is difficult.
- You need to stand back from your own perspective and be aware that the process has to work for everyone, not just for your own interests or interest group.

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**A Community Based Health Bus Service**

Julie Mason manages the Yorke Peninsula Community Transport and Services Inc which provides as part of its service, a Health Bus from Yorke Peninsula to Adelaide and return five days a week.

**What is this story about?**

Yorke Peninsula Community Transport and Services Inc have provided a range of transport services for people living on the Yorke Peninsula for 25 – 30 years. This currently includes a service for frail aged and younger people with disabilities who are transport isolated in the communities of Barunga West, Copper Coast and Yorke Peninsula; and bus services throughout areas of Yorke Peninsula and Copper Coast, which includes Dial-a-Ride which operates within Copper Coast region two days per week, and is open to all residents.

In 2007 we began a trial of a Health Bus service which operates five days a week and takes people to Adelaide and back for health related appointments. This service is open to all residents of Yorke Peninsula and Copper Coast. The evolution of the Health Bus service is the focus of this story.

**Why were we doing it?**

With changes to PATS in 2006, we were approached by CHSA to pilot a Health Bus for the people of Yorke Peninsula and Copper Coast to access specialist appointments in Adelaide. Yorke Peninsula was selected for the pilot because it had a defined geographical area, and with changes to PATS there was a need to improve access to metropolitan health services, and reduce costs for people who needed to travel to Adelaide for specialist appointments.
When did this work start?

We had a volunteer service in operation for many years, where volunteers drove people to appointments. In 2006 we met with representatives from CHSA, PATS, Department of Transport, Energy and Infrastructure, and the Council of Yorke Peninsula to discuss a 12 month pilot of a Health Bus.

Where was this done?

We are based in Minlaton, Yorke Peninsula, South Australia.

What were we aiming to achieve?

The aim was twofold. To improve the health and wellbeing of people living on the Yorke Peninsula and to improve access to Adelaide health services and specialist appointments for people of the Yorke Peninsula at an affordable cost.

Who was involved?

Yorke Peninsula Community Transport and Services Inc is auspiced by Yorke Peninsula Council and provides the service with funding from CHSA, and Department of Transport, Energy and Infrastructure.

What did we do?

Prior to the pilot starting we held a series of provider and community forums to discuss what the Health Bus service would look like and who would use it. This helped us identify key issues we needed to consider which shaped the way the service was initially established. The pilot was initially for 12 months. This was extended to 18 months, and now is an established service.

We tendered Yorke Peninsula Coaches to provide drivers to cover the five day a week service. We now have one main driver, and
two others to back him up for days off. We also have a group of nine volunteers who act in the role of Bus Companions to support passengers. One volunteer is rostered per day. We have a staff of six people and we facilitate the service, including driving schedules, volunteers, and client bookings. The cost is $10 return for up to three trips a week, and for over three trips the service is free. If a carer accompanies a person travelling for health reasons, then they can travel for no cost. We have some central pick up points on the Yorke Peninsula and we do individual drop offs to the various metropolitan health services.

What did we find?

As this service is broadly funded the scope of the service reflects this. We are able to support the entire community, from those people who need to access specialist appointments to a range of people who need to access health services in Adelaide or visit family members in hospital. Carers and family members can travel with people who need to travel for health services and the Bus Companions support people who are frail, or unwell.

What changed?

Initially, clients had to ring the PATS office in Adelaide to book, and they in turn rang us, and we in turn rang the clients back. This created a lot of double handling of information and it was a very cumbersome service for clients. After about 6 months the process was changed so that we received the bookings and managed the whole booking process for clients. This has definitely streamlined the service and made it more consumer friendly.

A transit lounge was included in the initial vision for the service for the bus drivers to have a break, and for people to rest and wait between appointments. Flinders Lodge has been very supportive.

This is owned by the Cancer Council. New legislation introduced soon after the Health Bus service started, impacted on bus driving hours and the breaks drivers needed to have.

This meant that we had to make changes to the driving schedule such as:

- Change the driving route to be a more central one;
- Introduce other strategies such as providing taxi vouchers and organising the Health Bus to meet taxis to get people to some health services which are not on the central route; and
- Ensure drivers have adequate break times at Flinders Lodge which comply with the legislative requirements.

Data has been collected over time, and we now know why people are travelling and which services they are accessing. We have been able to feed that information back to CHSA to use in their planning processes. This has meant that arrangements have been able to be made to increase local services in some areas. For example, we found a lot of people were travelling to have ultrasounds and chemotherapy in Adelaide. Now ultrasounds are available at the private medical imaging service on the Yorke Peninsula, and there are discussions with Wallaroo to open a chemotherapy unit in the near future so that local people can have chemotherapy closer to home where possible.

What worked well?

The Health Bus has been embraced by the broader community. It is a well supported service and the feedback suggests that the community is pleased with the service and find it a reliable service. We have a great group of volunteer Bus Companions, and the support
they provide to passengers is vital and much appreciated.

Initially we found that it was very difficult to change appointments for clients with metropolitan health services. However, as the Patient Journey Initiative has progressed this has changed and the metropolitan health services are more willing to change appointments to suit the clients travel needs. Having Rural Liaison Nurses in the larger hospitals has made a huge difference as we now have a central contact point if we have to discuss clients needs. This has decreased the amount of time we have to spend advocating for individual clients.

Collaboration between various government departments has meant that we have been able to provide a more comprehensive service to meet the needs of a greater number of people with different needs.

What did not work so well?

Initially when we were undertaking community consultations and working towards starting the pilot, we needed to be able to communicate with the community through the local media. As with any community, information through word of mouth spreads quickly. We had to work through government approval processes which caused significant delays in being able to be proactive in getting information out to the community. This caused a lot of confusion and anxiety within the community and also for us, as we were not able to get the right information out there in a timely manner.

Changes to the driving legislation meant that we had to make significant changes to the driving schedule and route. Initially we hoped to be able to service people in the Southern Yorke Peninsula, and to do door to door pickups, but because this increased the driving time we had to organise a central pick up and route.

What can others learn from our work?

Working across government departments albeit difficult at times, is possible, and does have incredible benefits for clients and the community. It is definitely worthwhile. After time, as the relationship develops, trust does occur.

Storyteller’s details
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Perspectives of a Country Person Needing to Travel to Access Metropolitan Health Services

Pauline Phillips from Kadina, Yorke Peninsula

I live in Kadina and was diagnosed with breast cancer in July, 2007. My lump was initially picked up at a mobile breast screening unit at Wallaroo. They sent me to Adelaide to have further investigation. The feeling you get when told, “Well, you have breast cancer, you need to contact a surgeon to have tests, and you will have to have an operation, and radiotherapy and possibly chemotherapy”, is one of numbness, disbelief, and you don’t know until you have undergone a barrage of tests how far the cancer has spread. My main concern was how I was going to tell my husband Allen, two beautiful children Alana and Christian, and my beautiful 89 year old mother.

Not too long after I was diagnosed with breast cancer I found out about the Health Bus being trialled from the Yorke Peninsula to Adelaide. It was wonderful to catch a bus with a caring bus driver and support person, and be taken to the health service I needed to be treated at Modbury Hospital initially, and then after my surgery to the RAH for six weeks of radiotherapy. To catch that bus with other people who don’t necessarily have the same illness, but are still in need of medical attention, is a somewhat humbling experience. To travel the distance with caring, nurturing and supportive strangers, who become a big part of your life’s journey at that time, gave me the support I needed and made me feel like I wasn’t alone.

Before knowing about the Health Bus I had travelled to the Modbury Hospital on numerous occasions in our own car. The petrol costs added up to around $500.00 for those trips, so to be able to catch a bus for $10.00 return, and to be able to have a carer travel with me for free was a real bonus. I was lucky enough to be able to stay with my mother during the week and then return to Kadina on the Health Bus each Friday to be with my family for the weekends. This Health Bus is such an important service for us on the Yorke Peninsula, and must be kept going for future generations.

Perspectives of a Community Advocate

Sue Wheal has been a long term member of the Patient Journey Initiative Steering Committee who comes from Beachport. She has been a strong advocate for improvements to PATS and support provided to country people who need to travel to access health services.

How I became interested in patient journey issues, for example, from personal experience?

I have a background in nursing, and living and working in the country SA. I have strong community connections and networks in the South East of the state, and over the years have become increasingly aware of what the issues are for country people needing to travel for health services. In addition to this I was on the Millicent Hospital Board for over 9 years and during this time I became aware of issues from the country hospital perspective in providing health services. I was really pleased to be invited onto the Steering Committee soon after it formed. The two key patient journey issues that I came to the Committee with were (1) the lack of specialist services available in the country and (2) the lack of information available to the community about what services were available in their own community and nearby. Over time my interest areas broadened as I gained more information from members of the community and through my experience as a member of the steering committee.
How I progressed the patient journey issues and advocated for change?

The Steering Committee was a really good forum where we could raise issues that were important to country people, and have direct access to the Executive of CHSA. Through the Steering Committee we were able to work together, and as a group we made huge gains for country people. On several occasions I spoke on the local ABC radio to inform the community about the Patient Journey Initiative and to gather their stories. Many people raised issues with me, which I in turn took to the Steering Committee.

What changed?

With regards to transport issues, many local people had raised the issue of needing to provide fuel receipts to get the PATS reimbursement. For many people living on farms this was problematic as they filled up with their own fuel, not at a petrol station. I strongly advocated that PATS should be able to use mapping technology that was readily available to determine the distance travelled, rather than needing to provide proof of travel from fuel receipts. This suggestion was taken up by CHSA and PATS, and the change was made. Not having to provide fuel receipts has been a great relief for many country people and has simplified the process considerably.

To reduce the need to travel, CHSA and SA Health have increased the number of specialists travelling to larger rural and regional health services so people have the option of having treatments closer to home. Through the Patient Journey Initiative we also strongly supported the development of written resources for country people which provide important information to assist them in planning to travel for health services.

More generally, there was greater awareness in the metropolitan health services of the need for country people to be able to have appointments at times that suited the country person and to be able to cluster appointments to reduce the number of visits to Adelaide. This meant the system became more country patient-focused and more flexible. Having the Rural Liaison Nurses in the metropolitan health services made a huge difference for country people and the Rural Liaison Nurses really assisted in coordinating services and care in consultation with the Patient Liaison Nurses in the country areas. Formalising the documentation for patient transfer has improved communication between health services.

What worked well?

For the first few years, the Steering Committee was a balanced group whose membership was very committed to improving the patient journey for country people. It was a strong partnership of people from the coal face and community. It was a way that we could advocate for change and see results in many areas. It was a very proactive and practical group and had strong leadership.

What did not work so well?

Over time the Steering Committee membership changed and got a bit too big. There were also lots of changes in CHSA project staff and senior staff associated with the Patient Journey Initiative, so it meant that there was a lack of continuity.
The movement of different specialists to consult in rural and regional areas, whilst a positive move to reduce the need to travel to Adelaide to access these services, also has its negatives. Many country people, especially older people, have multiple health problems and when they travelled to Adelaide they could cluster their specialist’s appointments so they only needed to make one trip. With the different specialists coming to rural regional areas, they come on different days, and this has reduced the opportunity for people with multiple health problems to cluster appointments. This in turn has increased the number of patient journeys needed to be taken locally, with the distances travelled not qualifying them for PATS reimbursement. Due to the lack of community transport networks in our area, transport to Mount Gambier has proven problematic for many older people and young families living in smaller towns at a distance from Mount Gambier.

“*We need to be able to maximise the support for country people to have affordable accommodation if they need to travel to health services.*”

What still needs to be done?

With the cessation of the Steering Committee, and still a lot of important work to be done, CHSA need to look at ways to continue a small group of community members and grass roots practitioners to work in partnerships to advise on ways to address patient journey issues. Oversight of the PATS system by a small committee is vital and needs to be implemented, as it is extremely important to monitor health journeys and continue to improve the service based on the needs of the country people. It is important that we continue to raise awareness of the availability of PATS within the community.

We need to be able to maximise the support for country people to have affordable accommodation if they need to travel to health services. There is a need to continue to lobby for affordable accommodation for country people travelling to Adelaide and to regional centres for health services. Lack of affordable accommodation is still a big issue, especially with the new RAH being built in the CBD and no accommodation included in the building plans. Also, the Lyell McEwin Health Service in the northern suburbs does not have affordable accommodation available close by or for that matter a frequent bus service. Taxi fares are outside the budget of pensioners and many families. The support for accommodation for carers is vital, especially since they are not covered by PATS if their family member is admitted to hospital.

**Storyteller’s details**

Sue Wheal

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Needs of Particular Groups of Country South Australians

Introduction

Having a vision, making a commitment to achieve that vision, and being passionate about making a difference to meet the needs of particular groups of country South Australians has lead to some important changes being implemented across the state. The work of the Patient Journey Initiative has supported this innovative work.

The four stories in this section provide different insights into how different health services and key personnel have contributed to the change process to meet the needs of particular groups of country South Australians. In the first story Glenise Coulthard from Port Augusta Hospital and Regional Health Service describes the key changes they have been implemented over the past eighteen years or so to ensure the Port Augusta Hospital and its staff, provide a culturally appropriate, sensitive and safe environment for Aboriginal people. This has been important to improve access to the hospital, and address patient journey issues for Aboriginal people in their region.

Sara Fleming from the Paediatric Palliative Care Service based at the Women’s and Children’s Hospital describes, in the second story, the supports they put in place to enable country children requiring palliative care, to return home with their families for the final stage of their lives.

The third story is by Tim Garfield from Yorke & Lower North Health - Community Health, and provides us with insights into how community palliative care has utilised an evidenced based approach to improve care for people receiving palliative care in their homes on the Yorke Peninsula.

Amanda Mitchell from the Aboriginal Health Council of South Australia has been a strong advocate for the need to address patient journey issues for Aboriginal people and has been a long term member of the Patient Journey Initiative Steering Committee. Amanda describes her ‘journey’ as a community advocate. Improving Access to a Mainstream Health Service and Patient Journeys for Aboriginal People.

Improving Access to a Mainstream Health Service and Patient Journeys for Aboriginal People

Glenise Coulthard is the Manager of the Aboriginal Health Unit at Port Augusta Hospital and Regional Health Service. This was the first Aboriginal Health Unit at a mainstream health service and has an important impact on improving patient journeys for Aboriginal people in that region.

What is this story about?

I am a proud Adnyamathanha woman from the northern Flinders Ranges. I have lived in Port Augusta for over 40 years and I am very aware that I am not living and working on country. I wish to acknowledge the local Aboriginal custodians of the Land and Waters and the many Aboriginal groups that live and work here.

Over many years I have contributed to the leadership at Port Augusta Hospital to ensure the hospital is more culturally appropriate, sensitive and safe for Aboriginal and Torres Strait Peoples to improve their willingness to access the hospital and its services. Considerable work has also been done to improve patient journey issues, especially for Aboriginal people who live great distances from Port Augusta.

When did this work start?

I initially came to Port Augusta Hospital with a secondment from the Education Department...
to work on a child health project. When that project finished in 1996 I was successful in gaining a position as a Senior Project Officer and went on to form the Aboriginal Health Unit with Garnett Brady. This was the first Aboriginal Health Unit in a mainstream health service.

It is in this role that I began to work with a team of highly motivated people to begin to identify expectations of Aboriginal people of the Port Augusta Hospital, and expectations of the Port Augusta Hospital of Aboriginal people. This was the first step in developing ways to address inequalities for Aboriginal people in accessing health services. Addressing patient journey issues, especially for Aboriginal people with chronic health problems, such as renal disease and who live great distances from Port Augusta, has also been a priority area for us to effect change at a local level and more broadly across metropolitan and country health services.

In 2000 I left the Aboriginal Health Unit for a couple of years to support the development of a family cultural tourism business at Iga Warta. Upon my return, in 2003, I took up a position at the Women’s and Children’s Hospital with the Children’s Renal Screening Program. During this time I saw the difficulties for Aboriginal people with renal disease, who had to leave country and get treatment to basically stay alive. The patient journey issues were hugely complex. It wasn’t until the Patient Journey Initiative commenced in 2006 that I was able to further advance many of the key issues affecting patient journeys for Aboriginal people in this region - issues that had been talked about over many years.

**What did we do?**

*Improve Access by Becoming More Culturally Appropriate*

I became part of the Hospital Executive when I was appointed to the Senior Project Officer position at the Port Augusta Hospital in 1995 - 96. This was a crucial turning point for how Aboriginal health was perceived in the hospital and region. It was very empowering and had a huge influence on our team being able to effect change at Port Augusta Hospital to facilitate it to become more culturally sensitive, appropriate and safe for Aboriginal people.

This has been a major strategy to improve access for Aboriginal people to Port Augusta Hospital. We have worked hard to increase the Aboriginal workforce, so that now we comprise approximately 8.6% of the workforce at the Hospital. As we have consulted widely with Aboriginal people, we know what traditional practices are important to them, and what we need to integrate into the hospital practices. It is my own cultural knowledge that has also influenced these types of practices at the hospital. For example, we have the hospital blessed and cleansed every six months by a Traditional Healer. We also arrange smoking of wards/rooms when required by Aboriginal people. This has decreased the number of Aboriginal people who refuse to go into hospital wards/rooms, and self discharge.

Another initiative of the Aboriginal Health Unit was to develop Cross Cultural Support.
Meetings which commenced in 1998, to improve services and communication for Aboriginal in-patients. Meetings are attended by Executive staff, Nursing & Allied Health and Services staff, Aboriginal Health Coordinator from RFDS, and the Aboriginal Liaison Officer from Pika Wiya. This forum was designed for staff to attend to discuss issues in a safe environment and identify issues before they became complex. Initially we met monthly, but over the years the number and complexity of issues that were raised decreased. We then moved our meetings to bi-monthly. Now there are very few issues we need to address, and we meet every three months.

Introduce an Aboriginal Cultural Awareness Program

A Project Officer was employed to:

- Design and deliver an Aboriginal Cross Cultural Education Package.
- Provide workshops with personnel within Port Augusta and surrounding health units.
- Support the coordination of services to improve the health status and outcomes for Aboriginal people in the region by providing advice, information and support to service providers, community councils, health units and other stakeholders.

There are two stages to the Aboriginal Cultural Awareness Program (ACAP):

- Stage One is a full day program; and
- Stage Two is a three hour program.

The Program is mandatory for all staff to attend, and they must do Stage One, before accessing Stage Two. The local Aboriginal community has approved the content of ACAP and advise us about the local community input into the facilitation of the Program.

Develop Cultural Respect

Each year we plan for NAIDOC week activities with the objective of heightening awareness of mainstream health services of the celebration event for the Aboriginal community. This is to promote respect and acknowledgement of the Aboriginal culture by engaging local artists to have Aboriginal art reflected throughout the health service.

‘Step Down’ Accommodation Unit

At Port Augusta Hospital, our separation average for Aboriginal people is 35-37% each year. It was identified that the average length of stay of Aboriginal people was a lot longer than other inpatients, mainly because they had to wait for transport back to country before they could be discharged. There was a need for a ‘Step Down’ accommodation unit where Aboriginal people from remote communities could stay whilst recuperating and waiting for transport back to country. The first ‘Step Down’
accommodation was opened in March 1996 utilising the facilities of the John Thompson Ward of the old Hospital.

With the planning of the building of the new hospital we also included the purpose built ‘Step Down’ unit to be part of the main hospital campus. During this time the ‘Step Down’ unit services were located away from the hospital, firstly to a double unit and then to the Lois O’Donaghue Aboriginal Hostel. This proved problematic in many ways: there was limited medical coverage; staffing was ad hoc as there was no dedicated staff to supervise the service; and there were transport issues to attend specialist and allied health appointments. The Aboriginal Health Unit found on review that GP’s were no longer referring patients due to these myriad of issues. Therefore, the ‘Step Down’ unit became part of main hospital campus in about 1997.

In 2007 with the support of Karen Dixon, Coordinator Patient Journey, and the strategic focus of CHSA on patient journey issues, we were able to gain a more secure funding base for the ‘Step Down’ unit so we could realise our vision for the service. I was able to appoint Noel Jackson to develop the business case for 24 hour coverage, seven days a week, and to have a full time Project Officer employed to supervise the service and coordinate the patient journeys for Aboriginal people, and casual staff to provide coverage of the service after hours. This business case was successful and in 2008 the ‘Step Down’ unit was able to be staffed 24 hours a day, seven days a week.

The ‘Step Down’ unit now provides short term accommodation for all patients from pastoral properties and remote communities serviced by Port Augusta Hospital, while patients are preparing to access hospital services as well as discharged patients awaiting relevant outpatient services and transport back to their respective remote communities. The ‘Step Down’ unit has 15 beds, and has an average occupancy of 10 people at any one time. However, this number fluctuates depending on seasonal sicknesses and a range of other factors. Through the work of the ‘Step Down’ unit’s Project Officer, the people staying in the unit are well cared for and referral and follow up systems for Aboriginal people are now very well organised. Without the utilisation of the ‘Step Down’ unit facility, many remote clients would not be able to access specialist’s appointments and acute services.

Transport

We have a good public transport system, for example, to Coober Pedy and Ceduna and as much as possible we utilise this service for patients to come to hospital and return home to country. If public transport is not an option, we always explore the capacity of the patient and their family first. If necessary, we then utilise our Patient Journey bus which is coordinated by the Aboriginal Patient Pathway Officer (APPO) to get people back to country. We often coordinate with staff in Ceduna and meet them half way to reduce distances we need to travel if clients need to go West to get home.

Coordination of Care

Another strategy we implemented to improve the patient journey for Aboriginal people was to organise an Aboriginal Health Team meeting at 9.30am each weekday to discuss each Aboriginal person who is an inpatient of the Port
Augusta Hospital. Their role is to discuss and coordinate all aspects of each person’s patient journey, including discharge planning, referrals, and follow up. This team includes the Out of Hospital Strategy Team, RFDS, Aboriginal Health Coordinator and the Aboriginal Liaison officer from Pika Wiya Health Service, ‘Step Down’ unit Project Officer, and the Aboriginal Patient Pathway Officer. Setting in place these types of sustainable communication strategies for teams to work effectively together is vital for effective coordination of care.

Through the work of the Patient Journey Initiative, we have also seen an improvement in the communication with metropolitan hospitals, RFDS and country health services to meet patients’ needs and improve coordination of care. This has greatly improved transfer of care issues that had previously occurred.

Aboriginal Patient Pathway Officers (APPO)

The development of the Aboriginal Patient Pathway Officer role has been another important innovation which has come through the Patient Journey Initiative work and has been of great benefit to Aboriginal people in hospital. These are critical positions for improving the patient journey for Aboriginal people and assisting people to navigate the health system in a more culturally safe way. They also work to empower Aboriginal people to ask questions and to feel more in control of contributing to health decisions.

What can others learn from our work?

- Leadership is important. Aboriginal people need to be a part of the Executive Team.
- Aboriginal people need to be at the table influencing change. Leaders need to walk the talk and lead by example.
- Aboriginal Cultural Awareness is mandatory and a designated position to facilitate this program is essential.
- You need to develop good relationships with Aboriginal communities and work out with them what they think is important and how things will work.
- Utilising networks is vital to getting things done.
- Health services need to get involved in NAIDOC, Reconciliation weeks and other cultural events, and be seen in the community supporting these.
- Artwork needs to be displayed throughout the health services so it creates a welcoming respectful place for Aboriginal people and communities.
- There are always going to be challenges, but if you have a strong team you can usually work out a way forward.

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Improving Access to Paediatric Palliative Care Services for Country Families

Sara Fleming is a Nurse Practitioner for the Paediatric Palliative Care Service based at the Women’s and Children’s Hospital, North Adelaide.

What is this story about?

This story is about developing the best journey for country families with a child who need palliative care. In my role as Nurse Practitioner for the Paediatric Palliative Care Service I assist families to define what is important for them and their child during the last phase of their child’s life. Through this work I have looked at ways to meet the needs of country families who would like their child to receive palliative care in their own home and community.

Why were we doing it?

To give country families a choice of where they want to be when their child requires palliative care during the last stages of their child’s life. If that is home, in their own community, then families need to be supported to do that and make the best of the time they have with their child. It is an important way of reducing inequities for country families and improving their access to palliative care services in their place of choice. Geography should not be a barrier to providing quality palliative care in the home. Palliative care in South Australia has undergone many changes in recent years and it has created opportunities to change models of care which can make a huge difference to getting children and their families to the place they want to be, at what is a very difficult time.

When did this work start?

I began working in this service 12 years ago, but have worked in cancer care for children and families for many years. I have had a long standing concern for country families of children who we couldn’t cure. I was really keen to look at opportunities to provide options for these families and to give them a genuine choice about where their children were cared for. Initially, we did some research where we interviewed ten families from country areas whose children had died from cancer. We found that families from the country had a pretty awful time. We learnt a lot from this research, especially how we could help families to be better supported to care for their child in their own homes and communities.

Where was this done?

We are based at the Women’s and Children’s Hospital in North Adelaide. We have developed relationships across the state and offer support through visiting country areas, phone, email, and tele-health.

What were we aiming to achieve?

There were three aspects to what we were aiming to achieve. We wanted to ensure that:

- Families from the country had a choice of where their child is cared for in the final stage of their life, and that they feel safe and secure in caring for their child at home.
- The child is living as well as they can in their home environment.
- Families have a ‘nest’ of supports built for them in their local community.

“Geography should not be a barrier to providing quality palliative care in the home.”
What did we do?

We provide the opportunity for country families to define their needs, and if that choice is to take their child home for palliative care, and then we make that happen. We work hard to develop partnerships with the various country GPs, schools, community nurses, country adult palliative care services and country hospitals, pharmacies, and pastoral care/counselling services to build a ‘nest’ of support around the families in their local community.

We also set up genuine supports for them from people who know the child and family through me, in my role as Nurse Practitioner, and the Paediatric Palliative Care Team. They can access this support 24 hours a day, seven days a week.

I usually visit the community to find out what professional supports are available locally and meet with them to determine what their concerns are, and what supports we need to put in place for them to support the families.

“*The capacity of country communities to rise to this challenge has been absolutely extraordinary.*”

Who was involved?

The families of children requiring palliative care services in their home in country SA were involved in defining their needs, and we work to address these needs. This means that we have to identify local services and people who can help address these needs with support from the Paediatric Palliative Care Service based at the Women’s and Children’s Hospital.

What did we find?

We have found a heart-warming response from country health professionals and communities to facilitate the return of children requiring palliative care in their home. The capacity of country communities to rise to this challenge has been absolutely extraordinary.

We also found that most things are possible to achieve, and that families are overjoyed at being able to have the choice to go home and be with their extended family and friends in their own community. This means that the extended families and friends, GPs, and the community more broadly, understand what the families are going through and can provide better support, especially ongoing bereavement support.

We found that the child’s quality of life is a lot better and they generally are happier if they are able to be at home.

There sometimes is a price to pay for being cared for at home, in that there may be a slower response to address some issues. For example, it may take a bit longer to get certain medications. However, families think this is a small price to pay.

Providing 24 hour, seven day a week, genuine support from me and the Paediatric Palliative Care Team is invaluable to families and health professionals.
What changed?

Country families get to go home and have time with their child, and be in a familiar environment with community support. Parents have stated they have a sense of satisfaction in being able to care for their child in their home with community support, and the support of the Paediatric Palliative Care Team.

Our understanding of the needs of families has continued to grow and evolve. Also our understanding of the needs of country professionals and palliative care providers has continued to grow and evolve. Families develop better relationships with their local GPs when they re-engage with them to care for their child at home. This means that GPs are able to provide ongoing support, especially bereavement support.

Acute care teams are able to better understand that they need to plan care options with families at an earlier stage, so that families have a choice to go home at the right time for them. We have had to develop better educational resources to support families and health professionals. For example, we developed a resource for families titled ‘Journeys: palliative care for children and teenagers’ (2010) with Palliative Care Australia, which takes families through four stages of the journey. There is a special focus on the needs of country families.

This is available through the Palliative Care Australia website: www.countryhealthsa.sa.gov.au. It is an amazing resource for families, which they can read and reread at their own pace. It has made a huge difference to families’ knowledge and confidence.

The handbook we prepared for health professionals has been really well received and valued. This provides written support for professionals and has helped to increase their capacity to manage families’ needs. We have been challenged to developed mobile equipment that families can take home with them.

What worked well?

The fact that I visit country communities when a family makes the choice to go home with their child, and I often take other members of the Paediatric Palliative Care Team, has meant that their awareness and knowledge has increased.
This has increased the team’s capacity to provide a better palliative care service for country families.

Visits to the country have enabled me to develop really strong partnerships with health professionals and other service providers, which are based around the needs families. Because we have met each other and we are aware of the local issues we are able to build partnerships built on respect.

The professional support we provide 24 hours a day, seven days a week, including offering debriefing and psychological support for professionals has worked well.

Keeping in contact with families and professionals on a regular basis has meant that they feel genuinely supported. This is because they haven’t had to make contact with us when something is wrong or they are worried, we have made the effort to be proactive and contact them.

The resources we developed have been invaluable to families and professionals. In addition the relationships we developed to produce these resources has been invaluable for networking and sharing our knowledge and expertise with others working in paediatric palliative care across Australia. It also means that we get a consistent message out to the families and the community.

Being part of the Patient Liaison Network meant that I was more aware of changes and initiatives within CHSA which impacted on the patient journey. This also helped increase my networks throughout country SA.

What did not work so well?

Sometimes it gets a bit tricky negotiating between the acute care teams in metropolitan and country areas if there is a pre-existing difficult relationship. However, this has been less of a problem over the years.

Bereavement support is not as good as it could be in country areas. Also, it can be difficult for families to have lots of people in the community know ‘your business’, and then those people not knowing how to help those families. Families can feel quite isolated after their child dies.

What can others learn from our work?

Go to the country - it isn’t difficult and is so beneficial for all concerned.

If you are willing to invest the time and develop relationships based around the needs of families, then magic can happen. Having one consistent contact, such as my position, is important for developing meaningful relationships, and being able to follow up with people.

You need to provide back up for families and professionals providing support to these families. It needs to be in writing and available by phone, email, telehealth, or visits to the community; and genuinely available 24 hours a day, seven days a week by people who know the family and the child.

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“If you are willing to invest the time and develop relationships based around the needs of families, then magic can happen.”
Using Evidenced Based Palliative Care to Improve End of Life Care for Country People

Tim Garfield is the Team Leader Community Nursing and Palliative Care with the Yorke & Lower North Health, Community Health.

What is this story about?

The model of community palliative care on the Yorke Peninsula has undergone significant change in recent years to apply evidence based palliative care for the purpose of improving client outcomes and the standard of care. This has resulted in an increase in the number of people who have able to be supported to die at home with more effective symptom management.

Why were we doing it?

Country people deserve access to quality palliative care services in their own community to increase their choice of where they would prefer to be when they die. We were keen to improve the way we worked as a team to meet the needs of people in our community who had a strong desire to receive community palliative care and support to die at home. Even though we felt we were doing a good job, we knew we could make significant improvements by adapting and utilising the evidence based tools and technologies which had been developed by Palliative Care Outcomes Collaboration (PCOC).

The aim of PCOC is to develop and support a national benchmarking system that will contribute to improved palliative care outcomes, and improve practice to meet the Standards for Providing Quality Palliative Care for all Australians. The ability to collect data and measure outcomes and benchmark nationally was an important reason why we decided to collaborate with PCOC. This was in contrast to basing decisions on our own subjective assumptions about the quality of care we were providing.

When did this work start?

In 2008 we started looking at PCOC and developing site specific data collection. We have been continuously implementing, reflecting, and adapting our service since then.

Where was this done?

Our team is based across seven sites and we provide community palliative care services to the whole of the Yorke Peninsula and Lower North. The initial work for implementing the new model of care was across the Yorke Peninsula. Based on the success of what we have done so far, we are in the process of expanding this approach across the cluster to the Lower North.

What were we aiming to achieve?

To utilise an evidenced based approach to community palliative care so that we continuously improve the standard of community palliative care we provide to our clients.

Who was involved?

The Community and Palliative Care team of the Yorke and Lower North cluster in collaboration with PCOC. The PCOC team provided excellent support and education to assist us to establish our outcomes based community palliative care program. See their website at www.ahsri.uow.edu.au.

Wendy Salmon, the Palliative Care Nurse, and I provided support and leadership to the
team of community health nurses across Yorke Peninsula.

What did we do?

The team made a commitment to improve the outcomes of the clients we were providing palliative care to, through applying the tools and technologies of PCOC to our community palliative care service. We began by trialling some of PCOC’s tools and reviewing what worked well and what did not work as well for us. We adapted the tools and these now provide us with excellent clinical assessment tools and outcomes measures.

Deb and Robyn, who are associated with PCOC, initially came and helped us provide education to our team, particularly focusing on collecting information using clinical assessments.

They have provided ongoing support to us. We are required to submit data in line with PCOC’s information collection systems and practices. We receive six monthly reports with feedback which forms the basis of our quality improvements.

What did we find?

Working with PCOC has enabled us to become more evidenced based and to benchmark our services nationally with other services that are part of the collaboration.

We have direction now with our clinical practice, and are using the feedback from PCOC as evidence to continuously improve our care to clients and their families.

Utilising an evidenced based approach to palliative care and measuring outcomes has greatly improved the standard of care we are able to provide to people receiving our community palliative care service. Because our clinical assessment of symptoms is more comprehensive and relevant to the needs of our client group, we have been able to more effectively manage their symptoms. This has meant that more clients, who choose to do so, are able to stay at home with their families to die. The percentage of our clients who are able to die at home, due to more effective symptom management, has increased from about 20-25% over the previous seven years to 40-50% in the past couple of years. The national average is reported as approximately 10%.

We set up link nurse groups in collaboration with the Division of General Practice to up-skill nurses working in acute settings, aged care and community health to build their capacity to provide evidence based community palliative care. We found that if nurses have education, support, and the right tools to assist them in assessing and providing care, then their practice improves.

Working in partnership with the Division of General Practice was important and improved collaborative practices. We have found that early referrals to our service by GPs means that people have better palliative care outcomes.

We have found that bereavement follow up is problematic for families that we have been working with, and we are working with social workers at the Lyell McEwin Health Service to assist us review a tool which will enable us to work more effectively with bereaved. We are now going to trial this tool to assess grief in the families.

“Utilising an evidenced based approach to palliative care and measuring outcomes has greatly improved the standard of care we are able to provide to people receiving our community palliative care service.”
When nurses use the tool and identify family members who need assistance with bereavement they are able make more informed referrals to social workers for bereavement support.

**What worked well?**

As mentioned previously being part of PCOC provided us with the right tools, technologies, and support to be more evidence based in our practice, which has meant that our community palliative care clients have had improved palliative care outcomes.

The six monthly reports provide hard evidence of what we are doing well and what we need to improve. This means that we were not basing our practice on subjective assumptions, but on meaningful information from measuring our clients’ outcomes.

The team approach to improving community palliative care has worked really well. We recognise that any service is only as good as the team who provide that service, and as a team we share responsibility when things go well and when things don’t go as well.

Inservice education needs to be put in context for nurses. We found that using case studies and scenarios made it real for our team and they could better relate to practice.

**What did not work so well?**

You can learn a lot by your failures. Early on we struggled with providing palliative care education. We felt we needed to do it quickly. However, we found that this was not possible and we had to take on a long term plan to achieve this with different groups of nurses working across the Yorke Peninsula. We also had to break down the education into discrete parts and develop different education styles and techniques to meet the individual staff members learning needs and learning goals.

Initially the barriers to change were challenging. We found that nurses needed a good rationale for why they should change their practice, especially if they felt they were already doing a
good job. We had to convince them that they could do even better and improve palliative care outcomes for their clients.

What can others learn from our work?

You need to have a vision and nurture that vision with patience and resolve.

All team members need to be part of the change process as each individual has something to offer through their experience. Also support team members to share their thoughts and ideas when you are building a service as this means that the end product is well thought out and right for the workplace and community.

You need to spend time developing a team culture, as a team is more likely to have all the essential ingredients to success than a few select individuals.

Being committed to using clinical assessment measures to quantify palliative care outcomes is challenging at first. It is confronting to those who don’t have a ‘quality improvement’ mind set. The fears of ‘not doing it well or right’ stop some from participating. Having a supportive learning culture where success and failures are opportunities to develop as a team assist individuals to overcome these fears. This takes time, commitment and flexibility from leaders, managers and colleagues to change the way they think about their work and each other.

Perspectives of a Community Advocate

Amanda Mitchell is the Health Development Coordinator, Aboriginal Health Council of SA and has been a long term member of the Patient Journey Initiative Steering Committee and strong community advocate for patient journey issues for Aboriginal people.

How I became interested in patient journey issues from my role with the Aboriginal Health Council SA?

I began work at the Aboriginal Health Council SA (AHCSA) as the Health Development Coordinator in late 2007 and was asked to be the Council’s representative on the Steering Committee. Being new to the Council and thinking about patient journey issues, I found the Steering Committee to be a really beneficial forum for me to learn and also to contribute issues from the Council’s perspective. As I grew into my role at the AHCSA and met with the AHCSA members (the Aboriginal Community Controlled Health Services,
including Aboriginal Health Workers) I heard their patient journey stories and concerns, and broadened my awareness of patient journey issues for Aboriginal people, especially from remote communities.

How I progressed the patient journey issues and advocated for change?

The way the meetings were structured meant that we had really good discussion on issues and you knew that what the group suggested was going to be acted on. This was because Karen Dixon was open to our ideas. We also had access to Executive staff from CHSA who were invited to the meetings to discuss issues with us. This was an important and supportive way for us to advocate for issues. I gained a lot of support for advocating for Aboriginal patient journey issues through the Steering Committee meetings.

We often send letters raising our concerns and ideas through our Chief Executive to the CEO of CHSA.

We are part of the SA Aboriginal Partnership. This is a forum where we can table issues for discussion. We have just signed our fourth agreement, and are about to revise and further develop an action plan for the next five years. I will make sure that I raise patient journey issues as part of that planning process, especially issues for Aboriginal people with renal problems and issues for people in rural and remote areas, and PATS.

What changed?

Most significantly for me, my understanding of patient journey issues and networks has grown from being on the committee. This has meant that I have become a better informed and more effective advocate about patient journey issues.

Being part of the Steering Committee meant

“Another success of the Steering Committee was preparation of the patient journey booklet for Aboriginal people.”

that patient journey issues were constantly on the agenda for CHSA and we had a forum to discuss these issues and problem solve as a group. This is in contrast to previously where we had to advocate on our own and try to bring issues to someone’s attention.

Most significantly for Aboriginal people were the establishment of the Aboriginal Patient Pathway Officers, which was an initiative that came out of the Patient Journey Initiative. I was on the reference group for this initiative which gave AHCSA an opportunity to represent and include the voice of our Sector throughout this process.

Another success of the Steering Committee was preparation of the patient journey booklet for Aboriginal people. This was a fantastic initiative to ensure Aboriginal people and people caring for them in their communities were better informed about patient journey issues, especially when they have to travel for health care.

What worked well?

The Steering Committee was a good forum to get feedback from other members. This helped to flesh out ideas and problem solve as a group. Initially, the membership was a mix of non-government, government and community representatives who were passionate and committed to improving aspects of the patient journey for country people. The people on the committee were united in their efforts to make a difference and improve patient journey issues for country people.

Through the Steering Committee we were able to advocate successfully for the appointment of
a PATS manager. This role was badly needed to drive changes to PATS that were long overdue.

Having Karen Dixon in the role of Patient Journey Coordinator worked extremely well. She had the leadership skills, passion and was a consistent person dealing with patient journey initiatives. Also, having Anne Johnson as independent chair for such a long time was great as she managed the meetings well and enabled us to have very productive discussions which were action oriented on outcomes.

The establishment of the Patient Liaison Network, which included metropolitan based Rural Liaison Nurses and country Patient Liaison Nurses and interested others, was fantastic.

What did not work so well?

There needed to be more Aboriginal people on the Steering Committee.

There always seemed to be different administrative and project staff attached to the patient journey initiative, and there were several changes with CHSA Executive and senior staff. This impacted on the consistency of the support provided to the initiative and to the Steering Committee.

In the later stages the membership became very unbalanced, with CHSA and SA Health staff dominating the membership.

What still needs to be done?

Accommodation and transport issues are still significant issues that need to be addressed, as are renal issues for rural and remote Aboriginal people.

There still needs to be a forum to bring people together to talk about patient journey issues and advise CHSA and SA Health. There are not enough avenues where these issues can be raised and addressed, especially for non-government organisations. AHCSA will still progress patient journey issues as an organisation, but it will be harder and take longer without this type of forum and commitment to community engagement from CHSA.

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“The establishment of the Patient Liaison Network, which included metropolitan based Rural Liaison Nurses and country Patient Liaison Nurses and interested others, was fantastic.”
Alternatives to Travelling to Access Health Services

Introduction

The Patient Journey Initiative was keen for alternative models of care to be introduced that reduced the need for country people to travel unnecessarily for health services, and to implement out of hospital strategies to reduce the need for people to frequently access local health services for preventable conditions. Innovative models of care are currently being implemented across CHSA and are providing really good alternatives for country people.

The two stories featured in this section are excellent examples of innovative models. Rural and Remote Mental Health Service (R&RMHS) of CHSA has been utilising telemedicine since 1994. This has proven to be a viable and affordable alternative model of care for country people with mental health issues and has reduced the need for them to travel to metropolitan health services to access mental health specialists.

The second story is by Tony Potts who works for Community Health at Mount Gambier and Districts Health Service. He utilises a case management approach as an alternative model of care to work with vulnerable clients with complex needs who are frequent users of the SA Ambulance Service (SAAS) and Emergency Departments (ED) for preventable conditions. This approach has been an effective community based out of hospital strategy.

Wayne Oldfield provides insights into his role as a rural health community advocate who has been a member of the Patient Journey Steering Committee since its inception. He also has strong links with his community and several key mental health forums and committees where he continues to advocate for the needs of country people, especially around patient journey issues.

Telemedicine in Country Health Services as a Way to Access Metropolitan Specialist Mental Health Services

Lee Martinez is the Director Operations Mental Health for CHSA, and Dr Ken Fielke is a Consultant Psychiatrist and Clinical Director Country Mental Health with CHSA.

What is this story about?

Mental health consumers living in country locations require various options to access metropolitan specialist mental health services, especially options which reduce the need for travel. Telemedicine via video or telephone conferencing is one option which enables country people to have local access to specialist mental health professionals from metropolitan health services.

Currently, Rural & Remote Mental Health Service (RRMHS) is located on the Glenside Campus and has a Distance Consultation Liaison Service consisting of the following:

- the Emergency Triage and Liaison Service (24 hour, seven day a week, crisis response telephone service 131465 number)
- Tele psych / video conferencing service
- Specialist mental health visiting service to rural and remote communities
- Aboriginal Mental Health Service
- Allied Health Seniors
- Older Persons Mental Health Service
Why were we doing it?

People living in rural and remote areas of SA have limited access to specialist mental health professionals. This is due to geographical distances and the limited availability of specialist staff to travel to, or be located in, all rural and remote areas. The aim is to improve access and equity of outcome to specialist mental health services for consumers from rural and remote communities in country SA. This is through the Distance Consultation and Liaison Services. A new Mental Health Act (2009) for South Australia was released on 1 July 2010 which further enhances the importance of a sustainable telemedicine network across country SA. The SA Mental Health Act (2009) allows for medical examinations or examinations by a medical officer or authorised officer to occur over video conferencing.

This change will enable people in country SA to be managed closer to home and reduce the need to travel to Adelaide.

When did this work start?

Video conferencing first began in SA in 1994. Over the years it has gradually been built upon throughout the state. Country mental health has been involved in the Steering Committee since its inception, recognizing that key learning from the work of the RRMHS could be transferred to other clinical areas.

Where was this done?

The proof of concept was established with a site in Berri in 1994. In 1996 we received seed funding from the Commonwealth Government and there was an initial roll out of 67 machines across the state. There was a subsequent further roll out in 2003 of a further 30 machines to give a blanket coverage of SA. The hub site was the R&RMHS on the Glenside Campus.

What were we aiming to achieve?

To improve access for country people to specialist mental health services, and to increase the capacity of country health services and GP’s to care for people with mental health issues as close to home as possible.

The video conferencing network was never designed to replace face-to-face assessment and care, but has added value to the consultation liaison model that has been adopted to enhance the capacity for local health care providers to care for people in their own communities. Services include acute assessment, admission and discharge planning, specialised psychological services, cognitive behaviour therapy (CBT) and narrative therapy.

An additional benefit has been the up-skilling of staff in rural and remote communities, through remote supervision and mentoring. This has contributed to staff retention in these communities by decreasing feelings of isolation.

Who was involved?

Specialist mental health staff at R&RMHS, country health services and GPs.

What did we find?

There was a formal evaluation of the service conducted by the Commonwealth Government after the first three years of operation. There was overwhelming support by consumers, carers, and country based health care professionals for the service.
Video conferencing became extremely popular and was taken up extensively by clinicians in country areas. They drove the utilisation of, and demand for, the video conferencing and the 131465 telephone service. Feedback has been that nothing beats face-to-face consultation; however video conferencing does add value to the consultation and liaison model of practice, and makes specialist mental health services more accessible to people living in country locations, and is economically viable.

**What changed?**

More people with mental health issues living in country locations have access to specialist mental health professionals. There has been an increased awareness of mental health consumers’ needs and issues in country areas. The knowledge base about mental health issues has increased for many country GPs and clinicians working in country health services, which has lead to improvements in care provided. However, the need for building capacity of GPs and clinicians working in country locations is an ongoing process due to staff turnover.

**What worked well?**

The promotion and uptake of video conferencing equipment has worked well. It has provided a different model of practice for psychiatrists, and country based mental health clinicians and GPs. It is now being considered by other specialities.

GP and clinician support provided by the 131465 number has worked well, especially in a crisis situation.

With R&RMHS being the coordinating hub for the treatment and transfer of all country mental health consumers to metropolitan mental health services, all information is located in one place. We know the number of people in rural and metropolitan hospitals. We can use this information for service planning.

**What did not work so well?**

Video conferencing requires people to know how to use and maintain the equipment. In the early days when the equipment was introduced not enough work force training was implemented. In some locations the equipment was not utilised to its fullest capacity.

The implementation of the Mental Health Act (2009) has been a catalyst for improving the broadband capacity, and the implementation of up-to-date equipment, with appropriate workforce training and development.

**What can others learn from our work?**

We have developed considerable skill and expertise in conducting assessments via video conferencing for over 13 years and this can be shared with others. It does provide a way of building networks across rural and remote areas and linking people together for the benefit of mental health consumers.

There is a need to develop the skill of country staff to be confident in utilising the video conferencing equipment.

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Working with Vulnerable People with Complex Needs who Frequently Present to Mount Gambier and Districts Health Service Emergency Department

Tony Potts is the Care Coordination Facilitator and works in Community Health based at Mount Gambier and Districts Health Service.

What is this story about?

We initially participated in a pilot program to look at ways to reduce the number readmissions of people who were our most complex and vulnerable frequent presenters to the Emergency Department (ED) at Mount Gambier and Districts Health Service (MGDHS). After a year of participating in the pilot we were able to embed and extend the program to other client groups with complex needs and become a Foundation Site as part of the Better Care in the Community Program. This story will focus on the work I do with vulnerable clients with complex needs who frequently present to ED.

Why were we doing it?

The program was implemented to reduce presentation and readmission rates and occupied bed days for vulnerable clients with complex needs who were frequent users of the health service for preventable conditions. As many of these clients were also frequent users of South Australian Ambulance Service (SAAS) we anticipated that we may be able to reduce the preventable call outs to SAAS for this client group.

When did this work start?

We began participating as one of three pilot sites in March 2008. The other two pilot sites were Whyalla and Adelaide Hills. Each site took a different approach based on their issues. As I mentioned previously our approach was to focus on vulnerable clients with complex needs who frequently presented to ED and required many admissions to hospital per year. Community Health in Whyalla had a focus on clients with chronic respiratory problems and clients on the waiting list for hip and knee replacement. The Division of General Practice in the Adelaide Hills focused on referral pathways and electronic records.

In 2009 we became a Foundation Site and our focus extended in Mount Gambier to reduce preventable readmissions for clients who had cardiac conditions, endocrinology conditions (e.g. diabetes) and chronic respiratory conditions (e.g. asthma and chronic obstructive airways disease (COPD)). We also established a program in Millicent, which had a particular focus on reducing preventable readmissions in clients with asthma and COPD.

Where was this done?

Initially in Mount Gambier through Community Health, and since 2009 we extended the program to Millicent, which is about 50km from Mount Gambier and is part of the Lower South East Health Service Cluster.

What were we aiming to achieve?

To look at new models of community and hospital care that would improve clients’ health outcomes by gaining a greater understanding of clients’ needs and providing the support they needed to reduce preventable presentations and admissions to hospital. We were also aiming to reduce the number of unnecessary call outs to SAAS.

Who was involved?

Community Health Service, Lower South East Health Service at Mount Gambier took the
lead in the program. I was appointed as the Care Coordination Facilitator in March 2008. We established a Reference Group which had broad representation from Local GP’s, Community Health, ED, ward staff, discharge planning at MGDHS, the Division of General Practice for the Limestone Coast and SAAS.

What did we do?

Initially I met with a wide range of local service providers such as the larger pharmacies in Mount Gambier, nursing homes, hostels, all local GP clinics, Disability Services, Housing Trust, Police, hospital staff (Mount Gambier and Millicent), Community Health staff, SAAS, and Lambert Village (supported Residential Facility). I got a good feel for what they thought the issues were and started to develop strong networks with these services for the benefit of the clients. Later connections with Uniting Care Wesley, Anglicare, and other non-government organisations were made. These networks were essential for me to be effective in my role as a community liaison nurse.

CHSA gave me a list of the top 50 clients who had the most frequent presentations to ED at MGDHS. From this list I could determine who came in, how often and the average length of stay. I encouraged ED and SAAS to gain consent from the clients for me to contact them and overtime I arranged to meet with these clients and offer a case management approach to their care. Through doing this I could gain an understanding of their situation, their needs and context, and what services could be utilised to reduce preventable calls to SAAS, presentations to ED and admissions to hospital.

The clients really appreciated the time I spent talking with, and listening to, them and it meant that they only had one person to speak with instead of multiple people. From knowing them as individuals, and their needs, I could then help them navigate the health and community services systems and speed up their journey due to referrals to the right services. Because I linked them to appropriate services, closed the feedback loop to all services involved in their care, and regularly called the clients to check how they were going, they were not able to fall through the cracks between services.

What did we find?

Once clients realised that I wasn’t there just to stop them coming to hospital, but I was there to spend time talking and listening to their stories, they usually became more receptive to this approach to coordination of their care.

Some clients, who had significant behavioural issues, resisted at first because I decreased their opportunities to play different service providers off against each other.

Some clients just needed someone to explain their illness using terminology they could understand, and repeat this often. Once they understood they were able to manage their care more effectively.

Often life issues were impacting on their health and their frequent presentations to ED, so I needed to look closely at what these were for every client.

Initially, through the data we received from CHSA, we thought the main group of people I would need to work with was in the 70 plus age group. However, in reality once we followed up with these people, talked with Aged Care Assessment Team (ACAT) assessors and Community Health staff we realised that they...
needed advocacy to ensure that their medical problems would be assessed and acted upon. Our main client group of frequent presenters for preventable and complex conditions to MGDHS is in the 40-60 year age group.

The clients I work with continuously changes as they become more effectively managed in the community, move, or die, and new people begin to present to ED on a frequent basis for preventable conditions.

**What changed?**

The majority of clients I have worked with use the community and health systems more efficiently now. They are linked into more appropriate services and get the supports they need. This has decreased their need to call SAAS and present to ED. For example, they may go to a GP instead of ED, may be having counseling which provides emotional and psychological support, or may go to community based programs, like the men’s shed, for social support.

We have been able to significantly reduce the ambulance call outs, presentations to ED and admission to hospital for most clients. For example, in 2008 one client we started working with had an average of 37 calls to SAAS each month, sometimes three or four calls in a night. This client had about 10 presentations to ED a month. We have been able to case manage her care and link her into a range of community supports and currently she may present to ED once a month, or mostly does not present at all. She is now seeing a cardiologist on a regular basis for symptom control.

Communication between the sectors improved significantly, especially SAAS who started making direct referrals to me for clients who frequently called them out for preventable conditions. SAAS have appreciated the benefits from this broader approach to managing complex clients through concentrated assessment and case management.

The range of clients we now see, and the programs we offer, has expanded since we became a Foundation Site for the Better Health in the Community Program. As I mentioned before this expanded to include complex cardiac clients and they now have a Cardiac Coordinator who can give close monitoring of their condition at home and we can now link them into cardiac specialists in Adelaide early as their condition begins to change. This in turn enables a more responsive treatment of their chronic heart failure.

**What worked well?**

Using case studies is a powerful way to describe our work, as people can see significant changes in client behaviours and outcomes. This is often hard to quantify in monetary terms.

Standarisation of forms and processes within CHSA as a result of the Patient Journey Initiative. We could see the real flow on effect to communication from this Patient Journey Initiative processes, as well as through the Better Care in the Community Program.

The Rural Liaison and Patient Liaison Nurse roles in metropolitan and country hospitals improved communication between services. Also the formation of the Patient Liaison Network greatly improved knowledge of what initiatives were going on around the state and provided opportunities for us to network and learn from each other.

Closing the feedback loop between health care providers worked well. This improved coordination and collaboration between the various providers. The relationship with ED and SAAS worked well. I was able to mentor staff and many have been able to understand the wider issues for clients with complex needs.
What did not work so well?

More work needs to be done to further engage the GPs. Their understanding of what is going on, and how they could better engage in the process, is patchy. So far engagement has been on a case by case basis.

As demand for our program has grown and we have extended our service, my administrative role has increased, impacting on the time able to be spent with clients.

What can others learn from our work?

Take time to listen to clients’ stories. Often the presenting medical problem is not necessarily what is causing the frequent call out to SAAS and/or presentations to ED.

Never knock back a good contact. Networking is critical to the success of a program like this to better meet the needs of complex and vulnerable clients.

You need to have a willingness to share knowledge and expertise. I find this best works through sharing my experiences using a case study approach as it is more meaningful for people.

You need to be visible to staff and talk with them about specific clients and provide feedback to staff that have referred clients. You need to take on a teaching role as staff turnover frequently and you need to continually invest in developing staff capacity to recognise clients that would benefit from being referred to our program.

Debriefing needs to be built in to a role like this due to the complexity of the clients that you work with on a day to day basis. A similar style to clinical supervision debriefing sessions that Social Workers do, would work well.

This Case Study Gives an Insight into the Way Tony Potts Works

The client is a 55 year old man with COPD, who is morbidly obese, a heavy alcohol drinker and has depression. He lives alone on a disability pension. When he was referred to the Better Care Program he was using the SAAS heavily (up to 10 callouts per month) often for non urgent matters.

He was presenting to ED one to two times per month, at times intoxicated. He structured his fortnight around his pension payment, buying and consuming alcohol for the first week or more, then sobering up to find that he didn’t have enough food or money to pay his essential bills. This in turn increased his stress and so the cycle continued. The SAAS callouts and ED presentations were a result of the impact of his lifestyle choices on his health.

When talking to the client, I discovered that he did not really enjoy his life as it was, and began to realise that he needed to restructure his fortnight to regain control over his life. He began by structuring his pay day to pay for food first. Centrepay was organised to pay his essential bills, and now he spends a reduced amount on alcohol. He joined the Men’s Shed, which also met on pay day and he became the valued kitchen/cuppas man. He also began attending Allied Health appointments to address his chronic health conditions. He reduced his weight from 200+ kg to 160 kg. His SAAS callouts were drastically reduced, and even though he still presents to ED occasionally, this has been greatly reduced. He is also now linked with several specialists for oversight and treatment of his chronic conditions. He visits a GP regularly, as well as Allied Health providers, including Podiatry and Dietetics. Feedback is provided between providers on a regular basis.

“All people have a story, and over time they will share the reasons for their lifestyle choices.”
I have learnt for this client that all people have a story, and over time they will share the reasons for their lifestyle choices. The rapport building component of my job is critical. My role has the flexibility and time to allow this process. The Rapid Intensive Brokerage Support Program (RIBS) providing flexible funding for local health services has been used to assist this client with equipment needs, including a recliner (for pressure area care for his feet). The Louisa Da Costa Foundation was also used to reduce his debts and, therefore, stress. I have also assisted him through the process with Anglicare to purchase a new washing machine.

Cost savings were brought home to me one day when I arrived at his home to see two ambulances and a fire service truck there to help lift him off the floor of his house. At 200+kg the risk to the client and staff was high. His weight loss and reduced alcohol intake has eliminated this risk and potential costs. This is in addition to the reduced ED presentations and SAAS callouts.

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**Perspectives of a Community Advocate**

Wayne Oldfield is a rural health community advocate who has been a member of the Patient Journey Initiative Steering Committee since its inception in October 2006 and is closely linked to his community and several key mental health forums and committees where he advocates for patient journey issues.

**How I became interested in patient journey issues, for example, from personal experience?**

I live in Wallaroo and have had a lot of experience with the health system as a consumer. This has made me very interested in health issues for country people. With regards to patient journey issues, I was aware of issues that many people in my community had. More specifically in 2006 I was talking to an older man who was having difficulty in accessing health services in Adelaide and should have been able to access local services for his condition. There also appeared to be lots of misconception within the community about what health services were available locally. I was at the One Country Health Region Conference in May 2006 and mentioned these issues to George Beltchev. Not long after he contacted me to see if I would be interested being on the Steering Committee as a community advocate. I have been a member of that committee from its inception.
How I progressed the patient journey issues and advocated for change?

I am very well connected with my community, and also sit on several committees where I am able to ‘join the dots’ for country health consumer patient journey issues. In addition to being on the Steering Committee I was on the Aboriginal Health Forum for CHSA and met monthly with George Beltchev to advise him on consumer issues. I am also on Monsignor Cappo’s Mental Health Consumer Advisory Group which advises the Social Inclusion Board. In addition, I am on the Mental Health Unit Consumer Reference Group and the local Division of General Practice Management Committee. On all of these committees I can bring up issues and be part of problem solving for how to address them. I can lobby locally through the Division of General Practice and the local cluster Director for CHSA, who I know well.

What changed?

Locally on the Yorke Peninsula we have been able to get the Health Bus running. We now have dialysis available at Maitland Hospital. Previously local people had to travel to Clare for dialysis. We now have chemotherapy able to be given at Wallaroo, rather than having to travel to Adelaide. These have been some of the changes we have been able to lobby for locally.

What worked well?

I am well connected to the community in which I live and I have good insight into diverse patient journey issues for country people, and I can bring these forward in different forums.

What did not work so well?

The health reform process is slow – Government wheels turn slowly, so I need to be very patient and not lose sight of what needs to be achieved.

What still needs to be done?

More services still need to be made available closer to where people live and the planning for these needs to continue to evolve. CHSA needs to use data about the reasons that country people need to travel for health services to plan what is feasible to be provided in country, and continue to look for different models of care to reduce the need to travel.

PATS is a complex area and significant changes need to be implemented to make it more consumer friendly.

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Supporting Country People to Move Back to Country SA when Clinically Appropriate

Introduction

Through the work of the Patient Liaison Nurses and Rural Liaison Nurses there has been an increased ability to facilitate country patients to return home, or to their local hospital, earlier than before the Patient Journey Initiative was introduced. Two stories in this section, the first from Barb Tyler, Port Pirie Hospital, and the second from Cate Owens, Flinders Medical Centre, that demonstrate how this process works and the amount of ‘behind the scenes’ work that is required to ensure a smooth transition process to enable country people to move back to country South Australia, when clinically appropriate. This often involves advocacy, effective communication and coordination, developing and maintaining networks, and creative problem solving.

For remote communities, distance is a huge barrier for people being able to access health services and return home, especially due to poorly developed public transport systems to assist people in their journey. Tanya Wolf from Ceduna Health Service describes the work they have been doing to develop an effective transport service to support Aboriginal people living in remote communities to access health services, and to move back to country afterwards. In addition, the building of a purpose built Step-down accommodation unit provides a model of accommodation and support that is an integral part of the patient journey for many people needing to access health services in or via Ceduna.

The final story for this section is by Judy Smith who has been a strong community advocate in her support to make senior clinicians more aware of the needs of country people to move back to country areas when clinically appropriate. This has mainly been through her work as Chair of the Rehabilitation Clinical Network and other high level committees.

The Role of the Patient Liaison Nurse in Coordinating Care to Enable Earlier Return of Country People to Port Pirie

Barb Tyler is the Clinical Liaison Nurse/HITH Coordinator, at Port Pirie Regional Health Service and has implemented a range of strategies to enable country people to be transferred back to Port Pirie from Adelaide hospitals when clinically appropriate.

What is this story about?

The Patient Journey Initiative, through the early focus it had on formalising and developing the Patient Nurse Liaison role and network, provided the opportunity for me to become proactive in bringing patients back to Port Pirie Hospital from metropolitan hospitals. Prior to this, in my role as Discharge Coordinator at Port Pirie Hospital, I had felt like a lone voice advocating for my country based clients and was frustrated at not knowing who to contact in metropolitan hospitals about client issues. I also had difficulties advocating on behalf of clients who needed more information and wanted to return to Port Pirie as soon as it was safely possible to be cared for closer to home. Formalising the role of the Patient Liaison Nurses and initiating the Patient Liaison Network empowered me to have a stronger voice for country clients. Working collectively has meant problems and solutions were shared.

Why were we doing it?

We were concerned about the misinformation and lack of knowledge of staff in metropolitan...
hospitals of the facilities we had in Port Pirie and the care options we could provide to clients on their return from metropolitan hospitals. Clients and their families wanted to come back to Port Pirie as soon as it was safely possible, and we really wanted to support them to do this. It seemed like a missed opportunity to not advocate on behalf of the clients and their families so that they could be cared for closer to home and be with their loved ones.

**When did this work start?**

I was involved from the beginning of the Patient Journey Initiative in late 2006 and became an active member of the Patient Liaison Network from its inception. I had been the Discharge Coordinator at Port Pirie Hospital since 2003 and in 2005 I also took on a combined role as the Hospital in the Home (HITH) Coordinator. Working on liaison issues became embedded in my role. It was recognised in my job description from 2006.

**Where was this done?**

Port Pirie Hospital.

**What were we aiming to achieve?**

There were four aspects of our aim.

1. To improve communication with country clients about patient journey issues and to improve coordination of care.
2. To be proactive in finding alternative care options to get people back to Port Pirie from metropolitan hospitals as early as safely possible.
3. To minimise the need for clients to go to Adelaide for assessments/outpatient appointments.
4. To challenge decisions that were not client focused for country clients.

**Who was involved?**

Initially it was just me in my role as the Clinical Liaison Nurse/HITH Coordinator. In 2008 I put forward a business case to use acute sector nursing hours to support additional patient liaison work at Port Pirie Hospital. Because of the importance of Patient Liaison roles in CHSA, through the Patient Journey Initiative, the business case was successful. We employed Deb Cliff and Dianne Champion as HITH Liaison nurses. Together we are now all actively involved in the movement of clients between services and discharge planning. This work is often provided to community clients as well as our hospital based clientele.

**What did we do?**

- We established expectations within metropolitan and country hospitals that country clients should return to their country area of origin as soon as possible.
- We developed guidelines for staff to share information with metropolitan nurses.
- We became proactive in supplying information to metropolitan nurses through phoning and faxing them on a regular basis for the purpose of improving coordination of care.
- We became proactive in making metropolitan nurses aware of safe care options and the supports available in our hospital and community health service to enable the earlier return of clients to Port Pirie.
- We became more proactive in advocating for return of clients to our health service.
- We worked with metropolitan nurses to problem solve issues that arose for clients, whether it involved acute care issues or outpatient issues. We certainly became...
more aware of client issues and were proactive in addressing these issues on the client’s behalf. As a result we became much more client focused as a health service, and as a health system

- We provided more information to clients so that they were aware of patient journey issues they may face, and to prepare them for discharge/transfer from metropolitan health services. It was good that several of the metropolitan health services and CHSA developed resources to support information needs of clients. We provided these booklets to clients about the relevant health service they were going to.

- We utilised video conferencing more, and increased the number of clients having video conferencing with metropolitan specialists.

What did we find?

The Patient Journey Initiative gave us the authority to challenge practices in both country and metropolitan health services and raise the importance of meeting the needs of country clients. We realised that when we worked together (metropolitan and country) for a common purpose we had the power to make a huge difference for country clients. Through the Patient Journey Initiative we could push for individualised care, especially for clients who had special needs. We also found that long held beliefs and barriers to making changes were easier to address when we were client focused and worked together. We were able to get recognition for the special needs of country based clients. This increased our confidence to continue to advocate to make a difference.

“\textit{The client satisfaction is overwhelmingly higher, as they are very keen to be reunited with family and friends.}”

“\textit{We found that many more clients returned to our hospital earlier than before. We also raised awareness that many country clients were opting not to have follow up care in Adelaide because of the challenges they faced with transport, cost and limited support with frailty issues.”}

We found that many more clients returned to our hospital earlier than before. We also raised awareness that many country clients were opting not to have follow up care in Adelaide because of the challenges they faced with transport, cost and limited support with frailty issues. Consequently health service staff here are now taking a more active role in ensuring clients can access vital after hospital care. The client satisfaction is overwhelmingly higher, as they are very keen to be reunited with family and friends.

What changed?

We now have really good relationships with many nurses in metropolitan and other country health services. We work together as much as possible with the client’s needs central to our decision making. I am certainly not a lone voice any more.

We have been able to assist many clients with earlier return to Port Pirie to be cared for locally. Over time we have been able to reorient our health service and develop the skills of our nursing staff to be able to provide different care options in response to the needs of clients.

We challenged the need for orthopaedic clients to go back to Adelaide for a six week check at the RAH at one of our Patient Liaison Network forums. Often the clients were uncomfortable having to travel to Adelaide and back. The appointments were only for a few minutes while
their X-Rays were checked by the consultant. The RAH orthopaedic nurse coordinated the change at the RAH and now through negotiation with metropolitan orthopaedic consultants the clients have their X-Rays done locally at six weeks, and we send the X-Rays through to the consultant to be reviewed. If they have any concerns then the client goes to Adelaide to see them. We have had very few clients who need to make the trip to Adelaide now.

We were able to negotiate with some metropolitan health services to have outpatient appointment times between 11am and 3pm, and have multiple appointments coordinated so clients could make use of the passenger transport service to get them to Adelaide and back on the same day, and reduce the need for multiple trips.

I think of how helpless I felt five years ago and how now I feel so empowered to really make a difference to the lives of many country clients. It is unbelievable what a difference the focus on patient journey issues has made. The Patient Journey Initiative has opened my eyes to the problems shared by many country based clients struggling to access health care and it supported me to find individualised solutions. I feel I have been a part of instilling change and improvements for country clients.

What worked well?

- CHSA making patient journey issues a focus and creating the networking opportunities for country and metropolitan nurses to become more client focused.
- Formalising the liaison work by embedding it into current nursing roles has given this vital work both legitimacy and valuable recognition.

“The Patient Journey Initiative has opened my eyes to the problems shared by many country based clients struggling to access health care and it supported me to find individualised solutions.”
• Shared enthusiasm and shared problem solving between metropolitan and country health services.

• Realisation that together we can change the health system to be more client-focused. This was very empowering.

• Recognition that ‘invisible work’ such as coordinating care and communicating with others does have advantages for the country clients and the health system.

• The networking opened my eyes to opportunities for country clients. I became more knowledgeable and savvy through networking.

What did not work so well?

Initially we had no additional funding to accompany the additional duties on top of our existing workload. It was hard in the beginning. However, this changed as new practices became embedded in job descriptions and it was funded in the acute care area.

There is still more that could be achieved if more resources were put into this area so we could expand. There is still a lot more to do to make more services available closer to home for country clients.

What can others learn from our work?

• Value your importance in the lives of country clients and your ability to make a positive change.

• Knowledge is valuable and useful.

• Networking is valuable and useful.

• Background work, or ‘invisible work’, needed to coordinate care and communicate, is really important in providing seamless care for clients.

These Case Studies give an insight into the way Barb Tyler works

An elderly pensioner was treated for cardiovascular problems in hospital and was booked for an angiogram in Adelaide. The appointment date was not known at the time of discharge. He lived alone with no family support. He was unable to drive himself to Adelaide or use public transport because of recurring angina. When the date was confirmed he approached his local GP for advice, but was told they do not arrange transport or accommodation. Also, his GP was reluctant to authorise ambulance transport, even though he had ambulance cover. Chatting over the fence, he told a neighbour that he was considering cancelling the procedure. The neighbour recalled the help he received from me with his follow up arrangements when he left hospital. His neighbour recommended that he contact me. I negotiated for him to access return ambulance transport from his home. I also contacted the Rural Liaison Nurse at the metropolitan based hospital, where the procedure was booked, and found out about a supported accommodation option that was free for him. The procedure then went ahead successfully.
We had an elderly female client who had lived for many years in a caravan with her husband, despite severe disability and chronic illness. Whilst at the RAH for a life threatening infection she was told that follow up care (six weeks of IV antibiotic infusions three times a day) could not be provided at her caravan and that her care needs were such that she could no longer be supported by health workers at her home. Nursing home placement was advised.

I investigated the support she currently had through our Home Nurse and Domiciliary Care services and found that they were well able to continue care due to their established strategies developed to cope with the cramped home site. I successfully negotiated with the RAH Rural Liaison Nurse so that the client could be returned to Port Pirie Hospital whilst we organised home administration of the IV antibiotics. Her home care provision was reviewed and modified to ensure safe care delivery could continue in the caravan. This lady had been on the verge of signing herself out of the RAH and forgoing vital treatment prior to my intervention. She successfully returned to her caravan to complete her treatment.

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**The Development of the Rural Liaison Nurse Role at Flinders Medical Centre**

Cate Owens established the Rural Liaison Nurse at Flinders Medical Centre (FMC) for 18 months and implemented key strategies to enable easy identification of country patients.

What is this story about?

This story is about the development of the Rural Liaison Nurse role at FMC. In the first half of 2008 a Project Officer was employed to undertake a scoping study to see what the issues were for country patients at FMC. During this scoping study it was identified that on an average day country patients make up about 10-15% of inpatient numbers at FMC. These patients are primarily from four catchment areas – Victor Harbor, Alexandrina council area, Mount Gambier and Wattle Range; although there were some patients from other areas as well. A key finding was that country patients had a longer length of stay than metropolitan patients with the same diagnosis.

I was employed in late 2008 and worked to continue the work to understand the issue for country patients at FMC, and to establish the Rural Liaison Nurse role. I worked in this role for 18 months.
Why were we doing it?

To reduce the length of stay for country patients, where appropriate. We needed to understand the barriers for country people accessing metropolitan health services so that we could put processes and systems in place to meet their needs. We also wanted to establish a single contact point for country hospitals to establish collaborative partnerships with FMC, and undertake joint problem solving to reduce the barriers for transition of care back to country areas.

When did this work start?

The initial Project Officer was appointed in early 2008 to undertake the scoping study. I was appointed at the end of 2008 and was in this position until mid 2010. The first six months was dedicated to identifying and understanding the issues, developing relationships with country hospitals and developing supportive networks with other Rural Liaison Nurses in metropolitan hospitals and Patient Liaison Nurses in country hospitals. During this time I also trialled some initiatives. The next 12 months was about embedding practices across FMC and then into Repatriation General Hospital and Noarlunga Hospital, which were the other hospitals that were part of the Southern Adelaide Health Service at the time.

Where was this done?

Flinders Medical Centre.

What were we aiming to achieve?

To reduce length of stay for people from country areas and enable a smooth transition back to their communities, either to their local hospital or home with appropriate community supports. We were also aiming to understand the barriers and issues faced by country people accessing our hospital, and put in place sustainable processes and systems.
Supporting Country People to Move Back to Country SA when Clinically Appropriate

Who was involved?
I was in the role of Rural Liaison Nurse at FMC.

What did we do?
I had a background in Lean Thinking and redesigning care, so it was very clear to me that I needed to understand the problem before I did anything. So the first thing I did was focus on identifying where the work was and what the problems were. For example, I needed to identify who the country patients were and where they came from. I also needed to make country patients visible to the staff caring for them. I needed to understand the country settings where the country patients were being transferred to, and I needed to share knowledge about who the country patients were and what resources were available to assist staff in the transition of care process.

I visited most major country health services to meet staff and see what services and facilities they had so I could understand their capacity to take patients back to their hospitals, and also what community and allied health supports were available. This enabled me to develop good relationships with these country health services, and be well informed when I was advocating for transition planning. I also spent time with Genevieve at the RAH and learnt about what processes and systems were in place there.

With regards to making country patients visible to staff, I implemented two key strategies to make country patients more visible on the patient IT system and on the wards. Initially through the patient IT system at FMC I was able to identify who the country patients were, but this access was not available to staff on the wards. Through negotiation with the IT staff I was able to make that information available to the Clinical Services Coordinators on the wards, so they could easily identify the country patients in their wards. Each ward has a patient board which lists all patients admitted on that ward at that time. A colour coding system was in place at FMC to identify patients who were at risk (for example, coloured dot for risk of falling).

This system seemed to work well, so I organised the printing of fluorescent pink magnets, which had a map of South Australia on it. This was used to indicate on the patient boards who were country patients. Initially, I trialled this on two wards where most of the patients were admitted to. For the first two weeks I would go around to the wards every day and place the pink magnets next to country patients’ names on the patient board. This was to make my work visible, and also to make the country patients more visible to other health professionals who were part of the care team involved in transition of care planning.

After two weeks I stopped doing it myself and supported ward staff to do the identification and placement of the pink magnets next to country patients’ names. This worked well, and there was great uptake by clinicians. This was then rolled out to all other wards. Once country patients were visible, staff were quick to pick up that they needed to consider a range of issues for transition planning, such as what practitioners and services were available in their local area and what needed to be put in place to support these patients. I developed resource folders for the staff to assist them in this process. I also included a map of South Australia in the resource folder, because I found that many of the FMC staff were from other states and overseas countries and did not have a good appreciation of the geographical locations and distances. I spent a lot of time talking to staff about the needs of country patients.

I also developed a special booklet for country patients, and their families, coming to FMC and Adelaide for care. Initially, I had 3,000 copies printed and I took them with me on my country hospital visits and distributed them that way. That addressed the needs of the country patients having unplanned admissions, as the country hospital staff gave the patients
and their families the booklet before they were transferred to FMC. However, it didn’t meet the needs of country people who had planned admissions through metropolitan specialists. We had the booklet put into an electronic format onto the website so that they had access prior to admission. The booklet also had my contact details in it so that people could contact me if they had any questions.

What did we find?

The visits I made to the country hospitals were invaluable in enabling me to understand the capacity of each hospital and how we could work together. The staff there were extremely welcoming and generous and absolutely wanted to bend over backwards to enable patients to come back to their hospital to be cared for locally. The visits were the first step in building really good relationships between FMC and the country hospitals.

Once country patients were identified at FMC, staff were quick to pull together and work through discharge needs for country people, especially allied health staff planning for rehabilitation. In the beginning they regularly consulted me about the needs of all country patients being discharged, but over time they only consulted me about the more complex patients. This was because their knowledge, confidence and skills began to increase and they were less reliant on my input for the majority of country patients being discharged back to country. Country patients and their families really appreciated the information booklet and it helped them plan for their admission to FMC and relocation to Adelaide for that admission.

What changed?

We successfully decreased the length of stay of most country patients by, on average, one day, so that the length of stay for country patients compared to metropolitan patients with the same diagnosis were comparable. This was a big change from previous practice at FMC.

I was able to separate fact from fiction about the needs of country patients and the capacity of country hospitals to care for patients with particular needs.

We were able to recognise what was needed for country patients and who needed to be contacted in their local area to support successful transition of care.

Many country people contacted me prior to admission to discuss issues, as I was listed in the booklet as a key contact person. Also switchboard new to put country people making inquiries about their hospital stay through to me. If I wasn’t able to answer their queries I was able to triage the calls and direct them to the most appropriate area.

What worked well?

Putting the processes and systems in place for clinicians to identify and transition care to country hospitals worked well. The identification of country patients through the IT system, and also visually on the patient board in each ward worked really well. Once country people became visible, staff knew that they had to consider additional things to assist people to transition to country hospitals or to home with community supports.

The resource folder for staff worked really well in supporting them to transition care. It was an important resource to assist in developing staff capacity to work more effectively with country patients. Placing a map of SA in the resource folder was important. It was surprising the number of staff who didn’t know the names
of towns and the distances required to travel to them.

The booklet for country patients and families worked really well. This contained important information so they could prepare for their time at FMC and in Adelaide. It answered a lot of their queries and assisted in reducing their anxiety about travelling for health care.

My visits to country hospitals were invaluable as it enabled me to develop relationships with country hospital staff, and also learn about their capacity to care for different types of patients in their facilities.

Having the contact with other Rural Liaison Nurses and the Patient Liaison Network was fantastic. Being part of the network enabled me to meet with like minded people who I could learn from, and share information and problem solve with. We were also able to identify what issues were site specific and what problems were system wide, which meant that we had the knowledge to begin to address issues at a system level.

**What did not work so well?**

Having limited funding was an issue. After I had been in the position for 12 months I was asked to take on the same role at Noarlunga Health Service and the Repatriation General Hospital. This spread the role too thin and reduced the effectiveness of the role to meet the needs of so many country patients.

The Repatriation General Hospital has about 30% of its patients coming from country areas and they really needed a dedicated Rural Liaison Nurse to meet the needs of their country patients, but this didn’t happen.

Also after 18 months, even though the work was being really effective in reducing length of stay for country patients, and improving their transition to country hospitals and home with community supports, the position was rolled in with the Palliative Care Liaison role. The person in this role has many competing demands on their time, so their role is spread pretty thin.

The engagement of some of the medical staff was limited and very challenging at times. Several medical staff appeared resistant to transfer country patients back to country services earlier than in the past.

**Storyteller’s details**

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**Supporting Country People to Move Back to Country SA when Clinically Appropriate**

“**My visits to country hospitals were invaluable as it enabled me to develop relationships with country hospital staff, and also learn about their capacity to care for different types of patients in their facilities.**”

**What can others learn from our work?**

- **Identification of country patients and making them visible is vital. Both at a hospital level and on the wards.**
- **It is important to put processes and systems in place to sustain staff practices, rather than relying on sustainability being personality driven, and by one person.**
- **The creation of networks around you for support and to learn from others is vital. This also enables opportunities for creative problem solving and identification of strategic issues that need to be addressed (site specific and across the health system).**
Effective Accommodation and Transport Strategies Based in Ceduna to Improve Access to Health Services and Safe Return to Country for Aboriginal People

Tanya Wolf is the Clinical Services Coordinator, Ceduna District Health Services.

What is the story about?

In an effort to ensure Aboriginal people were supported appropriately in their journey to and from hospital, Ceduna District Health Services identified and developed a strategy which would not only address issues around temporary accommodation and clinical support but also the need for a secure transport system to and from the Step-down accommodation.

A purpose built Step-down accommodation unit, situated on campus with the hospital, medical practice and community health buildings is able to house up to ten Aboriginal people and is staffed 24 hours. It is integral in meeting the demands for accommodation and further transport services.

Why were we doing it?

Our drive was to improve the health outcomes for Aboriginal people. Experience taught us that many Aboriginal people were reluctant to stay in hospital any longer than necessary and effectively became homeless after being discharged from hospital, waiting to return to country. There were notable incidents of people living rough within the town area and on the perimeters. These living conditions compromised their health and made it difficult to support the required follow up treatments. The Step-down unit was an important way to address this problem.

Step-down has been well received and usage has increased. However, it became evident that there remained a lack of transport services which would assist Aboriginal people to return to country after their medical treatment had concluded.

Extremely limited transport options existed for clients travelling to and from Ceduna and other Community Controlled Health Services. Additionally, these limited services existed to and from Ceduna and Port Augusta with no public transport system available to and from Port Lincoln. It was clear that a considerable gap existed in the patient journey.

When did this work start?

Following on from the purpose built Step-down in 2007, Ceduna District Health Services staff assisted with patient transport, using hospital cars. After consultation with the PHISC in 2010, a bus, with wheelchair access, was purchased to meet the growing demand for patient transport.

Where was this done?

Ceduna and Port Augusta, who were experiencing similar transport issues with
their Step-down unit, worked closely with COAG funding bodies to address the gap. The outcome being that both health services were allocated additional funding and a small bus.

**What were we aiming to achieve?**

To provide culturally appropriate and safe accommodation to Aboriginal people who were discharged from hospital and who required minimal support. To provide accommodation to neighbouring communities whose people required further medical care prior to their return to country. Ceduna District Health Services envisaged the Step-down unit as the hub, and the transport service as the spokes in getting people to the health service and home to country.

**Who was involved?**

Executive staff of the Ceduna District Health Services, including myself, and Karen Dixon, Coordinator Patient Journey in consultation with Aboriginal communities.

**What did we do?**

We met face to face with Elders, Community members and Health Workers at Yalata and liaised with the Oak Valley community to ensure we had captured their needs and their views on how we could assist in making the patient journey easier. We asked how we could best coordinate services between the communities and Ceduna and maintain accessibility for all concerned.

The opportunity arose for me to attend a forum with representatives from country and metropolitan health services to explain how the patient journey could be improved. This gave metropolitan health services a better understanding of what happened once clients were discharged from their services and opened discussion as to how Ceduna District Health Services and metropolitan health services could best assist with the difficulties clients experienced. There was a clear purpose to make the patient journey as least traumatic as possible.

The set up of the transport system would enable Ceduna District Health Services to facilitate coordinated travel on behalf of clients needing to attend appointments in Port Lincoln, Port Augusta and Ceduna, and then back home to country. However, the demand was greater than could be provided by accessing hospital cars and the team addressed the need to secure funds to purchase a small bus.

Once the bus had been procured, further coordination was required to coordinate travel arrangement with other health facilities. Our intent was to stream line appointments allowing Aboriginal people to attend their varied appointments in the one trip, and then return to the Step-down unit until they were able to return home to country. Often this means negotiating with health staff in Yalata to meet half way, allowing patients to travel home, and providing opportunity for people requiring access to Step-down or other health services in Ceduna to travel from Yalata. Oak Valley community members requiring health services are able to travel to Yalata as their half way point. It became evident that ongoing communication and coordination was required to ensure the success of the patient journey.

**What did we find?**

Aboriginal people are receiving timely access to health services and are better cared for whilst staying in Ceduna. They travel to and from home safely and are away from their communities for the minimal period possible.

Figures show the continuing demand for the Step-down service. In May 2011 we provided 74 Aboriginal people with transport assistance.
We have an average of 84 people stay in the Step-down unit each month.

Distances between communities on the Eyre Peninsula are significant and travel is exacerbated by high fuel costs. It is a 960 kilometre round trip from Ceduna to Port Augusta, 800 kilometres to and from Port Lincoln and a 400 kilometre return journey between Yalata and Ceduna. Coordination and communication is challenging at times.

**What worked well?**

Our relationship with PATS is vital to the sustainability of the bus service. Funding was limited to the purchase of the bus with no allowance for fuel. We have had to negotiate with PATS to utilise fuel cards for patients requiring access to services outside their communities. We have also had to negotiate with PATS in regard to what services are authorised. Our PATS claim forms can now be signed by Radiographers.

Having a 24 hour staffed Step-down unit has meant ongoing support for Aboriginal people while in Ceduna and has reduced the number of people living rough while waiting to return to country.

Collaborating with Port Augusta Health Service to obtain funding for transport for our Step-down units has given the opportunity to support and learn from each other.

The model works well for Aboriginal communities and has allowed us to expand the scope of our services to include working with Midwives to support pregnant women in surrounding communities to access services in Ceduna, ensuring appropriate ante-natal care.

**What did not work so well?**

Continued funding for the transport service remains a challenge. The original allocation on funds was to purchase a bus; we need to look at alternative ways to cover costs of fuel and vehicle maintenance.

Referral patterns are still inconsistent from the Aboriginal Patient Pathway Officers (APPOs). There are a number of clients who turn up unexpectedly with the possibility of no vacancies.

**What can others learn from our work?**

- It is vital that the ground work with Aboriginal communities is done well. It is important to identify what they see as a need and how that need can be provided.
- Have a vision of what is possible and be committed to achieving this.
- Work collaboratively with others wherever possible and you will achieve more.
- Clear communication across all levels so at to ensure the success of a culturally appropriate service.
- Change can be slow, but be persistent in maintaining your vision and work steadily toward it.

**Storyteller’s details**

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“*It is vital that the ground work with Aboriginal communities is done well. It is important to identify what they see as a need and how that need can be provided.*”
Perspectives of a Community Advocate

Judy Smith was the Chair of the Rehabilitation Clinical Network and the Director of Nursing, RDNS and has been a strong advocate for strategies to improve earlier return to country areas when clinically appropriate.

How I became interested in patient journey issues?

I have a strong consumer focus in my approach to health service management and service delivery and I had an opportunity to become an advocate for supporting people to move back to country SA when clinically appropriate through two influential committees. I was on the Clinical Senate and heard terrible stories of patient journey’s that had gone wrong and was able to raise questions to look at system issues from the country client’s perspective. For four years I was the Chair of the Rehabilitation Clinical Network. It was in this role that I became aware of the difficulties faced by country people after they have had a stroke or brain injury and needed rehabilitation. I feel that I had a significant influence in advocating for better support for country people to move back to country when clinically appropriate.

How I progressed the patient journey issues and advocated for change?

I became a ‘broken record’ and would say ‘hold on what is this going to be like for the country patient’ and ‘what is this going to look like from the client perspective’. I was like this at every forum. I would also personalise issues to get clinicians and others to take a step back and think about what it would be like for them in that situation and what they would like to occur. Early on in my role as Chair of the Rehabilitation Clinical Network I took several clinicians involved in rehabilitation on a road trip to country areas to meet staff, look at rehabilitation facilities, understand funding for rehabilitation services in country areas, and become aware of the expertise of the clinicians in the country areas. This enabled the senior clinicians, who are very influential in statewide rehabilitation services, to gain a depth of understanding that they would never have been able to gain from not visiting the country areas. It also enabled relationships to be developed and networking to occur on an ongoing basis.

What changed?

Senior clinicians who have been involved in the Rehabilitation Clinical Network can now see what the situation is like for people living and working in country areas.

As a result of this insight there was an acknowledgement that statewide services have a responsibility to develop services across the state, not just in metropolitan services. This isn’t just a country problem; it is a whole of health system problem that is able to be solved through collaboration between metropolitan and country health professionals and services working together for joint problem solving.

We have been able to organise training for clinicians in Whyalla and Mount Gambier which are the health services where we are developing rehabilitation capacity in the country at the moment.

What worked well?

Visits to country areas opened the senior clinicians’ eyes. It also helped to develop

“Some clinicians struggle to understand the consumer perspective and it was difficult to get them to look at things differently.”
relationships between key metropolitan and country health services and clinical staff. It also helped develop champions of the senior clinicians so that they can speak up for country clients and health services at the many forums that they attend.

I think the fact that I had a strong consumer focus made a difference in my role as Chair of the Rehabilitation Clinical Network as I was in an influential position to encourage the members of that committee to see things through a different perspective.

What did not work so well?

Some clinicians struggle to understand the consumer perspective and it was difficult to get them to look at things differently.

What still needs to be done?

Need to embed patient journey issues for country clients into the whole system, so it doesn't rely on individuals advocating for better supports. As new clinical staff and health service managers are appointed, there is the risk of losing what ground has been gained if the consumer perspective and strategies to support country patients is not embedded. This work will need to continue to be strengthened as new pressures emerge in the health system.

Storyteller’s details

Judy Smith
Previous Chair
Rehabilitation Clinical Network
Past Director of Nursing
RDNS
Adj Prof Belinda Moyes

Afterword

I am delighted to be providing this ‘afterword’ to the Patient Journey Storybook and to highlight the importance of consumer and community engagement as we continue to build forward and further develop Country Health SA Local Health Network as an organisation that works respectfully and collaboratively.

The Patient Journey Initiative has been an excellent example of a project that resonated with country communities and has resulted in significant improvements for country people accessing health services.

Storytelling is a powerful mechanism to share the experience of consumers and health service providers. The stories captured within this publication are testament to the passion and commitment of country people and are a celebration of some of the achievements of the Patient Journey Initiative.

Whilst this chapter may be closing, the book is not yet finished. The work to support access to services for country people is important and ongoing. The developments and improvements implemented through the Patient Journey Initiative have been embedded into day to day business for Country Health SA Local Health Network. Work in this area will continue although I am sure there will be future challenges to address. I know that there are passionate consumers and community advocates who will continue to monitor the progress of Country Health SA Local Health Network in this regard.

“Whilst this chapter may be closing, the book is not yet finished. The work to support access to services for country people is important and ongoing.”

“Achieving improved access also means embracing new ways of working including the expansion of telehealth services.”

An integrated health system requires collaborative partnership models in order to be functional and this is fundamental to improving access to services for people from country South Australia, whether it be partnering with our metropolitan colleagues, private service providers, or the non government sector. Equally important is how we continue to develop local health services so that more people can access services closer to home.

As we move into a new era with National Health Reform it will be important for Country Health SA Local Health Network to develop links with Medicare Locals to ensure a seamless integrated system is achieved for consumers and to continue to address service gaps and any breakdowns in service integration and coordination that may occur.
High quality, safe services are fundamental and this requires services to be provided in the most appropriate setting. Achieving improved access also means embracing new ways of working including the expansion of telehealth services.

The Patient Journey Initiative has been a good example of consumer and community engagement in practice. Country Health SA Local Health Network has implemented a new integrated governance framework and this continues to be fine tuned as a work in progress. Country Health SA Local Health Network should be unable to separate efforts to improve the patient experience from efforts to improve quality and safety; the two are integrated and mutually reinforcing.

A feature of the governance framework is customer and stakeholder participation. The integrated governance framework aims to actively engage with staff, consumers, communities and other stakeholders to ensure that an evidence informed strategic approach to planning, development, decision making and action is taken. It is intended that the engagement of consumers, community and stakeholders occurs across the governance structure. There is much still to be done to achieve this but I am committed to ensuring that the governance framework provides the mechanism to achieve effective consumer and community engagement.

A first step in the implementation of the new governance framework for Country Health SA Local Health Network was to revisit the vision and mission of the organisation with the following being agreed:

**Vision**

- Country Health SA Local Health Network is proud to be transforming health care and actively delivering health benefit so that rural and remote South Australians live healthy lives.

**Mission**

- Supporting rural and remote South Australians to be healthy.

- Country Health SA Local Health Network is committed to partnering with individuals, communities and staff to deliver high quality, high value health care that enhances the lived experience of rural and remote South Australians and their carers and families.

- Country Health SA Local Health Network is committed to enhancing the satisfaction and promoting the talent of its workforce.

Congratulations to all those involved with the Storybook and the Steering Committee who continued to challenge Country Health SA Local Health Network to focus on patient centred care through a collaborative partnership model. I look forward to the next chapter as we embed consumer and community engagement mechanisms within the strategic governance framework for Country Health SA Local Health Network.

ADJ Prof Belinda Moyes
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Country Health SA Local Health Network Inc.
Acknowledgements

Patient Journey Story Book

Health Consumers Alliance of South Australia Inc. 2011
ISBN: 978-1-74243-319-6

Editorial: Health Consumers Alliance SA and Country Health SA Local Health Network

Funded by: Country Health SA Local Health Network

Written & Compiled by: Dr Anne Johnson

Design & Printing by: Eureka Printing 08 8356 1122

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