Department of Health

health

A whole-of-journey approach

A resource kit for health services that care for rural consumers who travel for health care

Victoria The Place To Be — A Victorian Government initiative

Health Issues Centre

A whole-of-journey approach

A resource kit for health services that care for rural consumers who travel for health care

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Preface

The idea for a resource kit of initiatives by health services working with rural consumers who travel for health care arose from discussions and collaboration between rural consumers, community advisory committee members and staff of rural and metropolitan public health services, transport providers, the Department of Health and the Health Issues Centre.

This kit is intended to inform, inspire and connect health services at all levels – primary, acute, rural, regional and city – in their efforts to provide care to rural consumers and their families who travel for health care.

A clear conclusion from the collaboration is that a whole-of-journey approach is necessary for consistent, coordinated and supportive care to rural consumers who have to travel. This means the journeys of rural consumers and their families need to be understood as a continuum from the moment their rural GP refers them away to specialist services in regional or metropolitan hospitals, through their experience as outpatients and inpatients, to their return home after treatment and use of local care and support.

To take a whole-of-journey approach, eight priority areas of policy and practice change and development have been identified.

The priority areas are:

1. identifying rural consumers at all points along the journey of health care, within and between health care services
2. developing rural GP practices – especially the practice managers or nurses – as the first point of information and coordination for rural consumers
3. placing key staff who can support, coordinate and advocate within and between health services in rural, regional and city hospitals
4. providing transport and accommodation information to consumers and health services
5. providing better transport and accommodation support and options
6. rethinking discharge as "transfer of care", including early planning with the consumer and carer as well as enabling better communication and coordination between treating and local health services
7. developing health-care initiatives that will reduce the need for rural consumers to travel
8. developing policies and coordination for a whole-of-journey approach by government at state and federal levels.

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- Country Health, South Australia
- Department of Transport
- General Practice Victoria
- Gippsland Rotary Centenary House Inc.
- Royal Victorian Eye and Ear Hospital
- Royal Women's Hospital
- St Vincent's Health
- South West Alliance of Rural Health
- Transport Connections, East Gippsland and Wellington Shire Councils
- Travellers Aid Australia
- Victorian Patient Transport Assistance Scheme
- Western District Health Service.

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- Sheryl McHugh, Let's Get Connected, Gippsland East Transport Connections
- Silvana Arcifa, Royal Women's Hospital
- Elena Wilson, Bendigo Health
- Cath Harmer, Department of Health.

The cartoons were drawn by Simon Kneebone.

The research and coordination of the resource kit were carried out by Jackie Mansourian, Senior Policy and Project Officer of the Health Issues Centre.

Introduction

This resource kit includes initiatives by health, transport and community services in most of the eight priorities. The initiatives are creative, flexible and responsive to the complexities of travel for health care experienced by rural consumers. They are dynamic and important developments.

About this kit

The kit is divided into eight sections, one for each of the priority areas.

Each section includes a brief explanation of the priority followed by one or more current initiatives that address and support rural consumers and families. Some sections do not have initiatives that illustrate the priority area. This may be for two reasons: because the developments of this whole-of-journey approach have identified gaps which need to be addressed, or because communication in the call for initiatives did not reach appropriate stakeholders.

The resource kit does not aim to cover the initiatives of all health care services or other organisations responding to the priorities of rural consumers. However, its examples may inform ongoing policy and service developments.

The cartoons on the front and back covers

The front cover depicts the experience of many rural consumers as they travel for health care. For many, their experiences are fragmented and inconsistent. The individual jigsaw pieces need to be pulled together into a whole. This will allow easier, more coordinated access for consumers as they travel for health care.

The image on the back cover depicts the experience as it could be: acknowledged, informed, supported, welcomed and accompanied when needed, from the time the rural consumer leaves home to travel for health care to their return after treatment.

Priority 1: Identifying rural consumers at all points along the journey of health care

The first priority is to consistently identify rural consumers who travel within and between health services.

Early identification of rural consumers who access distant health services will create greater awareness and a more coordinated response to patient needs.

Some methods for identifying rural consumers are:

- asking outpatients the question: "Will you have to travel more than 100 kilometres to reach this service?" when making an appointment
- placing a rural flag on patient files
- integrating rural identifiers into the Service Coordination Tools Template (or SCoTT) developed by the Department of Health for service coordination between primary and acute services
- placing maps of the patient's rural location over her or his bed or on a ward's patient board
- developing a "rural gold card" for rural consumers.

One example in this section is the outpatient alert system for country patients at the Royal Victorian Eye and Ear Hospital.

1.1 Outpatient alert system for country patients, Royal Victorian Eye and Ear Hospital

The Royal Victorian Eye and Ear Hospital has an alert system that includes specific alerts for particular population groups. These alert factors can influence the way services are delivered to patients. The targeted population groups include people with special language requirements, people with cultural and religious requirements, people with diabetes and people from country areas.

A process for identifying these targeted populations begins when the outpatient department receives a referral.

There are three opportunities for placing a rural alert on a new patient file:

- by the clerical staff who receive the referral and identify a rural address
- by the triage nurse who reviews the patient information and notes a rural location
- by clerical staff who ring the patient to finalise the appointment. At this point a rural alert can be placed if the patient raises any concerns about travel or if they ask for transport support.

The user-friendly system consists of a small yellow asterisk that comes up on the screen whenever the patient's file is opened. This means that services can be modified appropriately, either at the time of booking an appointment or when the patient attends the clinic. Staff can see that they are dealing with a country patient and can ask about transport and other patient needs, including fitting appointments around travel requirements.

At the clinic, clerical staff will again write on the appointment letter that the person is a country patient, alerting everyone else who will see the patient.

Consistent use of the alert system, including country patient alerts, requires ongoing communication with and training of all staff, particularly clerical staff. This is carried out by the Outpatient Bookings Manager.

Patients can be referred to the Transport and Accommodation Coordinator on request (see initiative 3.3).

Additional comments

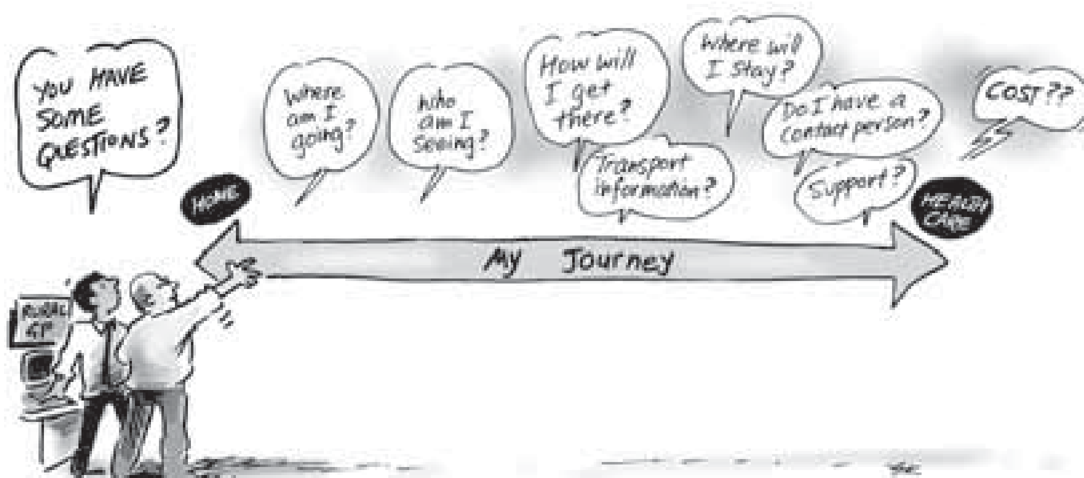
Rural patients appreciate being recognised as coming from the country, that they have travelled a long way and that the hospital is trying to respond to their needs and circumstances.

Contact

Outpatients Booking Manager, The Royal Victorian Eye and Ear Hospital

- Telephone: **03 9929 8666**

Priority 2: Developing rural GP practices as the first point of information and coordination



Rural GP practices are one of the key initial points for information for rural consumers when they are referred to specialist treatment at a distant location. The GP practice manager or practice nurse may be the most appropriate person to directly provide critical information about travel support, including transport and accommodation services and options.

Unfortunately no examples of the development of this role are included in this resource kit. However, there are anecdotal stories from consumers and rural GP Divisions of General Practice about such coordination taking place.

Responding to this priority will require further development of the role of practice managers and nurses as the starting point of information.

For rural GP practice managers and nurses to be effective as information providers to rural consumers, resources and information must be available and easily accessible to them – there is no suggestion that their role should include preparation of information. GP practice managers or nurses will need clear communication from and with health care, transport and community services so they can access travel support information relevant to their local area and the specialist or hospital consumers will be travelling to.

Priority 4, which concerns the development and coordination of travel support information including transport and accommodation, will provide useful resources for rural GP practice managers and nurses in their role of information support and coordination to rural consumers.

Priority 3: Placing staff who can inform, support, coordinate and advocate for rural consumers

It is important for rural consumers and their local health services to know that there is a key point of contact for them in their treating hospital.

In some hospitals in Victoria this position is integrated into social work positions. In other hospitals, dedicated positions provide transport or accommodation support. In South Australia, there are rural liaison nurse positions.

These points of contact can provide relevant information about travel support before rural consumers leave their home and while they are in hospital. This role can help coordinate care within and between health services, including taking travel into consideration when making appointments. They can also facilitate a transfer-of-care approach between the treating hospital and more localised health services who will continue the care once the rural consumer has returned home.

There are four Victorian examples of this type of position and one from Country Health South Australia that are relevant to this priority area.

3.1 Women's Social Support Services, Royal Women's Hospital, Melbourne

Women's Social Support Services (WSSS) provides information, counselling, support and advocacy to women and families who access care at the Royal Women's Hospital (RWH). This includes addressing their concerns about travel, expenses, the impact of current health issues on women and their families, and access to local health services.

When a woman arrives at RWH for assessment and admission, one of the standard questions asked is: “Have you travelled more than 100 kilometres?” If the answer is yes, information is automatically provided on three key areas:

- Victorian Patient Transport Assistance Scheme (VPTAS)
- Family Accommodation Service at RWH
- Social Work/social support services at RWH.

Women and their families may know about their travel options before leaving home if they have been informed by local health services such as GPs or community health centres. Or they may have researched the RWH website or directly contacted the social work department or general hospital number for information.

If a social worker works with the woman, they will ask about her family, her children, and whether she has other caring responsibilities. They will also identify local support networks including extended family, neighbours, churches and community services.

Discharge planning begins before admission. The Department of Health guidelines for discharge planning include four areas of special consideration such as whether people have had to travel and whether people have caring roles and responsibilities. WSSS uses different follow-up processes for women who travelled for their care and who need to access local services when discharged.

If a woman has had a baby and needs ongoing local care, WSSS will make appropriate referrals with her permission. These referrals can be to the rural hospital, the local Maternal and Child Health Nurse and other community and women’s services.

If a woman has had gynaecological care at RWH, her discharge is coordinated with local services including the Home and Community Care (HACC) program workers or her GP. If she identifies her GP as her local service, then it is an automatic procedure to communicate with her GP via the discharge summary.

Social workers will only continue to be involved if there are psychosocial issues in addition to medical and clinical issues. Even though rural consumers have an added complexity created by distance and travel requirements, psychosocial issues should still be identified for social work support including discharge referrals.

Additional comments

All women and families coming from rural areas should be informed about the availability of social work services in the health service they are travelling to. It is a key point of contact and information for rural consumers. However, if social work units in hospitals are to have an extended role in being a central point-of-call and information to rural consumers, they must be resourced appropriately.

Contact

Women can contact the WSSS (Social Work) directly or ask their doctor or nurse to make a referral.

- Contact the Intake Worker
- Telephone: **03 8345 3050** or **03 8345 2000**, pager **53081**
- Hours and days of service: Monday–Friday, 9 am–5 pm
- Website: **<www.thewomens.org.au>**. Search for Women's Social Support Services or social work.

3.2 Aboriginal Women's Health Business Unit, Royal Women's Hospital Melbourne

The Aboriginal Women's Health Business Unit (AWHBU) provides support and advocacy for Aboriginal and Torres Strait Islander women and their families who are patients of the hospital. Aboriginal women's support workers provide support and assistance for Aboriginal and Torres Strait Islander women, whether they are visiting the hospital for an appointment or being admitted. The AWHBU offers a comfortable space for women and their families to meet, make a cup of tea and relax if they need time away from the rest of the hospital.

The unit networks closely with all rural Aboriginal health services to provide a support service for families coming from the country for health care. Aboriginal Health Liaison Officers based in regional and rural hospitals also contact staff at the unit to coordinate the visits of country Aboriginal patients and their families.

Some of the support that the unit provides for country Aboriginal patients and their families includes:

- transport coordination: linking with Aboriginal health services in the country and city to discuss transport to Melbourne and back
- receiving and making appointments for patients from rural health services
- providing one-off material aid such as food vouchers and Safeway cards
- assisting with Centrelink if the family requests financial support

- advocating for other support services that can benefit the family while it is staying in Melbourne
- orienting families to the hospital and local area (shops, trams and buses, parks)
- connecting families to the Victorian Aboriginal Health Service, which provides general medical care and support to family members who are supporting a patient in the hospital
- attending appointments with a patient at their request.

Aboriginal women can contact the workers directly or be referred by their health workers.

Additional comments

Remember that when a city health service is supporting a rural Aboriginal patient it is not only supporting the patient but their whole family unit. Staff should clarify how many family members are coming with the patient as their supports. It is also important to contact the patient before admission to talk about her stay and what she and her family will need to bring when they come to hospital and Melbourne.

There are Aboriginal Health Liaison positions in many city and regional hospitals. The Autumn 2010 issue of the Health issues journal has an interview with Kim Galpin, an Aboriginal Health Liaison Officer at Horsham Base Hospital. He highlighted how important this role is for country Aboriginal people and their families who have to travel for health care:

“Aboriginal clients have told me that having Aboriginal workers in the hospitals both in the country and in Melbourne, as someone to turn to, has made a big difference to their experience of being away from home when they’re sick. Things like where to go to for a good feed, or where they’re going to stay, or how to get to the Victorian Aboriginal Health Service in Fitzroy. They’re all basic commonsense things, but it is daunting if you don’t know anyone who can explain those things in ways that you’ll understand.”

Contact

The Royal Women’s Hospital has two workers based at the Aboriginal Women’s Health Business Unit.

- Telephone: **03 8345 3047** or **03 8345 3048**, pager **2160**.
- Website: **<www.thewomens.org.au>**. Search for Aboriginal Women’s Health Business Unit.

3.3 Transport and Accommodation Coordinator, Royal Victorian Eye and Ear Hospital Melbourne

The Transport and Accommodation Coordinator position was created in 2002 to coordinate patient transport for outpatient clinic appointments and ward discharges for patients attending the Royal Victorian Eye and Ear Hospital in East Melbourne and its Broadmeadows and Lilydale spokes. The coordinator also assists with accommodation for country patients, relatives and carers.

The Transport and Accommodation Coordinator can help identify local community transport, including Red Cross volunteer transport, which may be available to support rural consumers to travel. If patients or their families are using public transport, the hospital can collaborate with transport providers, including Travellers Aid. It can also provide taxi vouchers from the station to the hospital and back on a case-by-case basis.

Different rural areas have different transport services and options. Each has their own eligibility criteria and scope of provision. This means arranging local transport for patients is a complex task, but the hospital is committed to providing access and finding ways to help people use the service.

Transport information is available to outpatient clinics and is provided to patients before admission.

Many rural patients require accommodation for outpatient visits or for surgery. The hospital has a list of recommended accommodation providers that are nearby. These providers have been quality-assessed by the hospital.

Arranging transport and accommodation support

Patient transport support can be requested by the patient, their family, hospital staff or other service providers, such as GPs. The patient can ask for transport support when they make their appointment.

The hospital identifies patients who come from the country by noting their address. A rural alert is placed on patients' records on the computer database (see initiative 1.1). The alert enables rural patients' appointments to be fast-tracked, in recognition of the fact that they have travelled to the hospital or will have to travel back home. For example, if a patient has been brought by Red Cross volunteer transport, the Transport Coordinator will ensure that they are fast-tracked through the various clinics and appointments.

Eligibility criteria for access to the transport and accommodation support services include medical, financial or social considerations.

The Transport and Accommodation Officer also provides education sessions to all hospital staff to ensure that patients who need transport do not slip through the system. Eligibility criteria and transport support services and information are provided on the hospital intranet for use by all staff.

Outreach and information about transport and accommodation support is provided by other service providers such as GPs, case management services, nursing homes and hostels.

Additional comments

Having a central point for the management of patient transport enables the hospital to provide consistency and continuity in meeting the transport needs of country patients. Given the specialised nature of services provided by the hospital, transport assistance can be essential to ensure that patients reach the hospital and get the medical care they require. Some referrals made by medical staff have noted that unless patients get to their appointment they may go blind or suffer substantial hearing loss. Eliminating transport barriers has meant that many patients have been able to receive this care.

Contact

Ask for the Social Work Department or Transport and Accommodation Coordinator

- Telephone: **03 9929 8666**

3.4 Accommodation Liaison Officer, St Vincent's Hospital, Melbourne

St Vincent's created the unique position of Accommodation Liaison Officer in 2003. There were several objectives for the position:

- to ensure that patients and their carers are adequately assessed, enabling optimal and equitable access to appropriate accommodation information and services
- to ensure that St Vincent's resources are efficiently used by providing a service that helps patients who do not clinically require an inpatient bed to find and secure alternative accommodation
- to provide staff, patients and their carers with a central accommodation resource

- to ensure that out-of-pocket expenses for patients staying in external accommodation are kept to a minimum.

The target population includes clinically suitable patients and their families who live in rural, interstate and outer metropolitan areas and who have difficulty accessing health services due to travel distances. The Accommodation Liaison Officer role provides the target group with a contact person who has the resources to provide support and assistance.

The Accommodation Liaison Officer role is filled by a qualified social worker. They perform a modified psychosocial assessment on all referred patients and link them to the most appropriate accommodation provider. A clear plan of access to St Vincent's is established.

The strategies to achieve the objectives are:

- assess nearby accommodation providers, develop contacts and negotiate special hospital rates
- develop a list of suggested providers and update it each quarter based on consumer feedback (see initiative 4.5)
- respond to the needs of rural and interstate patients who require accommodation by finding them appropriate commercial accommodation near the hospital
- assess referrals for their suitability for external accommodation and link them with the most appropriate provider
- tell rural patients and their families about subsidy schemes that could reduce their travel and accommodation expenses.

The role of Accommodation Liaison Officer is well-established at St Vincent's and is used by all clinical units. Education has been a powerful tool in promoting awareness of services to clinicians and departments throughout the organisation.

When a referral is made, the Accommodation Liaison Officer contacts the patient. The officer then develops a plan based on the types of accommodation and the level of assistance required. Support varies from patient to patient: some require minimal support; others need maximal support. The officer can book preferred accommodation for patients and relatives if required. Regardless of who books or brokers the accommodation, the contract of service is between the accommodation provider and the client.

The Accommodation Liaison Officer provides information about the Victorian Patient Transport Assistance Scheme and other interstate schemes as appropriate. This clear, practical support is greatly appreciated by rural patients and relatives.

In 2009, 1240 nights of commercial accommodation were booked for patients and their relatives. Of these, 240 nights were booked solely for patients and 463 families were assisted with finding accommodation.

Additional comments

The Accommodation Liaison Officer's role is to ensure the efficient and appropriate use of hospital beds and that patients are cared for in the most clinically appropriate environment. People who do not clinically need to occupy a hospital or Medihotel bed are able to access hospital services while staying in the community. The Accommodation Liaison Officer enables patients who have to travel to access the health service, providing vital outcomes for the health service and its clients.

Contact

Accommodation Liaison Officer

- Telephone: **03 9288 2268**
- Website: **<www.svhm.org.au/visitors/Pages/Accommodation.aspx>**

3.5 Rural Liaison Nurses and Patient Liaison Positions, Patient Journey Initiative, Country Health South Australia

The following is an extract from a feature article by Karen Dixon – "Improving the patient journey for country South Australians" (Dixon 2010).

The Patient Journey Initiative leadership and focus within Country Health South Australia has provided a key contact, resource, and coordinating point for all health service providers (including many from interstate) for South Australian country patients.

Important achievements of the Patient Journey Initiative have been success in advocating on behalf of country consumers and health services to make sure changes to health services and health care are relevant to the needs of country people, especially in the areas of transport and accommodation. The initiative has successfully provided information about services available closer to where people live, and improving information exchange and coordination for those involved in supporting country patient journeys.

The Patient Journey Initiative has also:

- recognised existing and created new Rural Liaison and Patient Liaison Positions in rural and metropolitan hospitals
- created the Patient Liaison Network across the state to ensure better communication between health services and coordination of care
- improved transport and accommodation for country people who need to travel for health services
- improved health information on how country people can navigate the health system and strengthen their health literacy.

Rural Liaison Nurses and Patient Liaison Positions

These positions are integral in supporting country patient journeys. The aim was to establish Rural Liaison Nurse positions at all major metropolitan public hospitals, and to identify and further develop positions at all country health sites.

All major public hospitals within the Adelaide metropolitan area now have Rural Liaison Nurses or Patient Liaison contacts in place. There are currently 74 Patient Liaison nurses in country hospitals, as well as nurses and allied health staff in community health, health workers in Aboriginal Community Controlled Health Services, and practice nurses in rural general practices. Many of them are actively identifying and transferring patients back to country hospitals and communities, and supporting patients to access services closer to home.

Some of the country hospitals have established new Patient Liaison Nurse and Officer positions while others have identified a patient liaison contact from within existing staff. The role of Rural Liaison Nurses in metropolitan hospitals is vital to support country patient journeys. They do this by providing a key contact and coordinating point for country patients and health professionals, advocating on behalf of country consumers, and – in partnership with country patient liaison contacts – effectively transferring care, and, where appropriate, arranging alternatives to travelling.

Achievements of Rural Liaison Nurses and Patient Liaison Nurses

Some of their achievements are:

- introducing to all wards of a large metropolitan hospital a coloured magnetic map of South Australia, for easy identification of patients who are from a rural or remote area
- collectively developing a standard nursing and midwifery transfer form for use between country hospitals and other health units for easy identification of country patients, consistent transfer of information and to encourage liaison between service providers
- organising teleconferences for patients with difficulty travelling to access follow-up services or outpatient appointments
- arranging training for country health workers, thus enabling them to provide a greater range of health services for patients closer to home and allowing for the transfer of care from Adelaide-based services
- during times of peak events in Adelaide, communicating across metropolitan hospitals about the pressure on available accommodation and encouraging more appropriate scheduling of outpatient appointments
- identifying system issues and objectively recording these on the Advanced Incident Management System, allowing multiple sites throughout the patient journey to contribute to solutions
- Rural Liaison Nurses in metropolitan hospitals have reported that having patient liaison nurses at country hospitals works well by providing a key contact and transition point, resulting in stronger linkages, smoother transition and improved communication between points of care.

Contact

For more information about the Country Health South Australia call the Adelaide office and ask for the Patient Liaison Network Coordinator.

- Telephone: **08 8226 6120**
- Website: **<www.countryhealthsa.sa.gov.au/Services PatientJourneyInitiative.aspx>**

Priority 4: Developing and providing transport and accommodation information

There are two connected issues regarding information about travel support for rural consumers and families who have to travel for health care:

- development of information by health services or other relevant services, including transport services or community organisations
- consistent provision of this information at key points along the consumer's journey for health care.

There is a need for the development of accessible, relevant and regularly updated web- and paper-based information about the transport, accommodation and health services available to consumers who travel for medical services. This information must be made available directly to consumers and be accessible to hospital and health service staff, social support agencies, emergency relief networks and at other service providers.

Information should be consistent at all stages of a patient's journey. It is important to identify the positions at health services that are responsible for providing this information and determining their roles and responsibilities. The provision of information is clearly linked to the roles identified in key priority areas 2 and 3.

This section includes five examples about the development of both transport information and accommodation information.

4.1 Let’s GET Connected Transport Assistance information brochures: East Gippsland and Wellington Shire Councils

The Transport Assistance Information brochures were developed because there was a lack of comprehensive printed transport information for people living in two Gippsland shires – East Gippsland and Wellington. Two brochures have been developed with information and contacts relevant to each shire and 10,000 copies are now in circulation.

The brochures are comprehensive and include information on:

- travel planning including contacts for Viclink, which provides information on public transport fares and timetables
- concessions such as the Victorian Seniors Card
- Victorian Patient Travel Assistance Scheme (VPTAS)
- Australian Red Cross Patient Transport
- Medical Transport Assistance including direct contacts at participating health services
- taxi subsidies
- V/Line customer service and how to provide feedback to public transport providers.

For the East Gippsland brochure, go to the website of the East Gippsland Shire Council **<www.egipps.vic.gov.au>** and search for East Gippsland Transport Assistance Brochure.

For the Wellington Shire Council’s brochure go to **<www.wellington.vic.gov.au>** and search for the Transport Connections Project page. There you will find a link to the Wellington Transport Assistance Brochure.

Additional comments

It is important that health services understand all aspects of travel planning, subsidies and transport support programs in order to better support rural consumers who travel to access their services.

Contact

Transport Connections Project Officer

- Telephone: **1300 366 244**
- Email: **enquiries@wellington.vic.gov.au**

4.2 South West Community Transport Program, Western District Health Service

The South West Community Transport Program's work fits both into this priority area and in provision of better transport options (priority area 5).

Focal point for information

The South West Community Transport Program began in 1999 and is a focal point for information about travel and access to health and other services for people in South West Victoria. The program is funded by Home and Community Care (HACC). It is primarily for older people and people with disabilities, but it has been able to extend its services to the broader community.

The program maintains an accurate database of information about local transport information, support programs and accommodation options for people travelling to Melbourne and other centres for medical treatment, and it assists service providers and consumers with complex transport arrangements.

The program regularly updates the South West Community Transport Directory with details for each town and the services available. It is available on the website.

Transport details and alternatives are developed for small towns in the region as brochures and on the website **<www.wdhs.net/swct>**.

Transport brokerage

The program provides brokerage for transport providers and individuals. Brokerage for service providers enables them to purchase minor capital items or undertake projects that contribute to the accessibility, safety and sustainability of the transport service they provide. Examples include the purchase of mobile phones and volunteer training. Some taxi services have received brokerage funding for lightweight wheelchairs to assist their passengers.

Brokerage for individuals is used for the direct supply of transport in situations where the only option is too expensive for the individual or they have an ongoing issue and require periodic support. Brokerage funding is used to purchase V/Line rail tickets, provide petrol cards for trips to Melbourne or other destinations, pay for taxi trips to the doctor for isolated residents, or to assist

homeless young people to return home. There is not enough funding to assist with ongoing transport costs but the brokerage funds can be used for short-term responses until a more sustainable transport option is developed.

Network of community transport

The program facilitates a network of community transport services. There are 27 community transport service providers in the region. Annual learning and development exchanges are organised for all community transport providers. Recently an interactive workshop held with network members focused on establishing the principles and processes relating to volunteer safety and risk management for managers of community transport volunteers.

Additional comments

Health services acknowledge that transport is an issue for many of their consumers but may feel that it is not their core business and that it is someone else's responsibility. Despite the fact transport is always cited as a barrier to accessing services, there are not many options when it comes to funding for this type of program. Western District Health Service saw the effect that restricted access to transport had on the health of residents in south west Victoria and it was able to find a program that was willing to fund the ongoing implementation of its community transport program.

Two factors in the establishment and implementation of the South West Community Transport Program have been ongoing funding and the development of a service model that is flexible and responds to the different transport issues in the region. As funding priorities within government have changed the service has modified its operations. The program's mobility management approach of South West Community Transport Program allows it to provide a service to the whole community, not just the HACC target group. This is the strength of the program.

Contact

Program Coordinator

- Telephone: **03 5551 8461**
- The South West Community Transport Directory and the transport information brochures relevant to small towns in the region are available at **<www.wdhs.net/swct>.**

4.3 Victorian Patient Transport Assistance Scheme

The Victorian Patient Transport Assistance Scheme (VPTAS) subsidises the travel and accommodation costs incurred by rural Victorians – and their escorts, if appropriate – who have no option but to travel a long distance to receive approved medical specialist services.

Information about VPTAS was developed in July 2010 in recognition of the fact that the awareness of VPTAS was relatively low across rural Victoria and that there were misunderstandings about the scheme among consumers and health services. Posters and brochures were distributed to rural and metropolitan health services, GP networks and other relevant agencies. Other information was provided through service and network newsletters, and organisations were encouraged to link to an updated VPTAS webpage to promote the scheme.

To ensure consistent provision of accurate information about eligibility for VPTAS and the claim process, a single statewide VPTAS toll-free contact number has been established. On this line, consumers, health services and other agencies can receive information and advice about how to apply for VPTAS from claims-handling staff.

There have been some notable changes to the administration and processing procedures of VPTAS since July 2009.

Contact

- Free call: **1300 737 073**
- Telephone: **03 5333 6040**
- VPTAS Office, PO Box 712, Ballarat Vic 3350. The VPTAS website includes information about the scheme, eligibility guidelines and all the VPTAS resources for download: **<www.health.vic.gov.au/ruralhealth/vptas/>**.
- Claim forms, posters and brochures can also be ordered via email from: **vptas@health.vic.gov.au**.

The VPTAS poster appears on the following page.

Victorian patient transport assistance scheme (VPTAS)

Do you live in rural Victoria and have no option but to travel a long distance to receive specialist medical services?

You may be eligible for assistance with your travel and accommodation costs if you need to travel:

- more than 100 kilometres one-way or
- 500 kilometres on average per week for a minimum of five consecutive weeks.

For more information pick up a brochure or claim form (available from most general practitioners and hospitals), follow the links on our website:

www.health.vic.gov.au/ruralhealth

or contact the Victorian VPTAS office.

Victorian VPTAS office
Phone: 5333 6040 or Freecall: 1300 737 073

A Victorian Government initiative

Victoria The Place To Be

4.4 Inner Melbourne hospital map and guide, Department of Transport with Transport Connections

The Inner Melbourne hospital map and guide is a pilot project developed to assist regional and rural Victorians when they travel to inner Melbourne for medical services.

The guide provides information to regional and rural Victorians on:

- public transport options to 14 public and private hospitals in inner Melbourne
- travel concessions and subsidies
- ticketing information
- Travellers Aid information and support services
- access and mobility information.

The guide shows step-by-step how to get by public transport from Southern Cross station to any of the 14 hospitals. Each hospital is clearly highlighted on both a Melways-style map and a customised map of inner Melbourne.

The 14 hospitals are:

Public:

- Peter MacCallum Cancer Centre
- St Vincent's Hospital
- The Alfred Hospital
- The Royal Children's Hospital
- The Royal Dental Hospital of Melbourne
- The Royal Melbourne Hospital – City Campus
- The Royal Victorian Eye and Ear Hospital
- The Royal Women's Hospital

Private:

- Epworth Freemasons (Clarendon Street)
- Epworth Freemasons (Victoria Parade)
- Epworth Richmond
- Melbourne Private Hospital
- Mercy Private Hospital
- St Vincent's Private Hospital

Posters informing rural consumers about the guide will be distributed to rural and regional health services. About 50,000 copies of the guide will be printed and distributed to rural and remote GP services throughout Victoria.

A large-print, web-based A3 version of the map and guide is available to download and print and can be accessed at **<www.transport.vic.gov.au/maps>**.

The Inner Melbourne hospital map and guide can also be accessed though the regional Transport Connections Project Officers and Coordinators. Find out more about Transport Connections at **<www.dpcd.vic.gov.au/transport>**.

Contact for copies of the guide:

Information Victoria

- Telephone: **1300 366 356**

The poster of the Inner Melbourne hospital map and guide appears on the following page.

- Map is located under the "Transport in local areas" section of the opening web page of **<www.transport.vic.gov.au/maps>**.

Are you travelling to a Melbourne hospital on public transport?

Please ask here about the Inner Melbourne Hospital Map and Guide.

4.5 Accommodation guides by St Vincent's Hospital and the Royal Women's Hospital

Rural consumers and their families need information and guidance about accessible and appropriate accommodation options when they have to travel for health care. Some hospitals regularly update accomodation information for rural consumers on their hospital website.

Two examples are included below.

St Vincent's Hospital, Melbourne: Accommodation suggestions near St Vincent's

This guide offers more than 20 accommodation options near St Vincent's Hospital. Each option is described and its address, tariffs, facilities, distance from the hospital, public transport access, disability access and VPTAS subsidy availability are provided.

The guide is a resource provided to rural consumers by the St Vincent's Accommodation Liaison Officer (see initiative 3.4).

Contact

Accommodation Officer

- Telephone: **03 9288 2268**
- The information can be downloaded from: **<www.svhm.org.au/visitors/Documents/Accomm_Guide_Jan_2010.pdf>**

Royal Women's Hospital, Melbourne: Accommodation options near the Royal Women's Hospital

The Royal Women's Hospital provides a Family Accommodation Service for patients and their families who are from rural areas, or interstate, or who are experiencing a crisis (see initiative 5.2).

The Royal Women's Hospital has also produc*ed a guide: Accommodation options near the Royal Women's Hospital*, with information on more than 30 options, including: address, phone, tariffs, facilities distance from the hospital and public transport access details.

Contact

Family Accommodation Service Manager

- Telephone: **03 9344 2436**, pager **2436**
- Accommodation options near the Royal Women's Hospital can be downloaded from: **<www.thewomens.org.au/uploads/downloads/HealthProfessionals/CSD/FamilyAccom/Accommodation_referral_2009.pdf>**

Priority 5: Providing better transport and accommodation support and options

This priority area is about strengthening and diversifying transport and accommodation services and options for rural consumers.

Recommendations have been made elsewhere (Health Issues Centre 2009) about strengthening transport services and support.

The issues addressed here are:

- petrol and accommodation subsidies
- demand for community transport
- public transport for intra-regional travel and for travel to Melbourne
- transport support for rural consumers and families who are returning home after treatment in hospitals.

Three initiatives addressing these transport and accommodation issues are included in this section.

5.1 Travellers Aid Australia

Travellers Aid is a not-for-profit organisation that provides vital services and dignified outcomes to travellers in need, particularly for travellers with special requirements or in emergency situations.

Travellers Aid is committed to alleviating transport disadvantage and helping travellers at the point of need.

Travellers Aid acknowledges that many consumers from regional and rural Victoria experience severe transport disadvantages because there is insufficient transport available and because existing transport options do not always meet the needs of consumers. Many rural consumers already struggle with high medical costs and some cannot afford the fares on public transport to attend specialist appointments in regional centres or Melbourne.

Rural consumers who experience difficulties in paying for their tickets can receive financial assistance in getting to and from medical appointments. Assistance is usually provided in the form of V/Line vouchers.

Travellers Aid offers two other important services: Travellers Aid Access Service and Emergency Relief Assistance.

Travellers Aid Access Service is a unique Melbourne-based service offering friendly help and professional support workers to assist people with disabilities, older people with personal care needs, meal assistance and communication needs. This service is offered at Southern Cross and Flinders Street stations. It is free and no bookings are required.

Emergency Relief Assistance assists travellers who experience transport and social disadvantage or who are vulnerable and distressed. It provides travel-related emergency relief including V/Line fares to medical appointments. Emergency relief assistance can assist people who are not eligible for VPTAS or who cannot benefit from VPTAS because they do not have the funds upfront.

Referrals can be made by health services or by consumers themselves.

Case study 1:

Tracy and her two-year-old daughter were referred to Travellers Aid by a Melbourne hospital. They had to travel from Gippsland to Melbourne for a specialist appointment. The appointment became available at short notice and Tracy had not been able to put money aside for her fare. She was struggling financially as a single mother without income. Although she was eligible for the Victorian Patient Transport Assistance Scheme, she could not use it because she was not able to come up with the travel fare.

The Travellers Aid Emergency Relief program organised return tickets for Tracy and her daughter. The daughter was able to get to the appointment and receive her treatment.

Case study 2:

Jim has to travel from country Victoria to Melbourne for specialist treatment on a regular basis. Because of his medical condition he is not able to walk long distances.

Travellers Aid picks Jim and his wife up from the V/Line train and takes them to the taxi rank. On their way home, Travellers Aid collects them from the taxi rank and brings them to the lounge where they can wait comfortably until their train departs. Jim sometimes does not feel well after his treatment and he uses one of the bedrooms to have a rest; sometimes he also uses the shower facilities.

Services and contact

Travellers Aid City Village (head office), Level 3, 225 Bourke Street, Melbourne

- Open: Monday – Friday 9 am–5 pm
- Telephone: **03 9654 2600**
- Website: **<www.travellersaid.org.au>**

Travellers Aid Southern Cross Station (below Bourke Street Bridge, opposite the luggage hall)

- Open: 7 am–10 pm, 7 days a week
- Telephone: **03 9670 2072**
- Offers: Comfortable lounge and rest area amenities; fully accessible toilet with ceiling hoist, adult change table and baby change table; mobility equipment hire; internet; rest rooms for tired travellers; showers; the option to purchase basic hygiene products; a buggy service that can provide older people and people with a disability with safe transit through the station.

Travellers Aid Flinders Street Station (above platforms 9 and 10, inside ticketing area)

- Open: Sunday to Thursday 8 am–8 pm, Friday & Saturday 8 am–10 pm
- Telephone: **03 9610 2030**
- Offers: Comfortable lounge and rest area with great views and TV; mobility equipment hire; luggage storage; internet; fully accessible toilet with ceiling hoist and adult change table and baby change facilities.

5.2 Family Accommodation Service, Royal Women's Hospital, Melbourne

The Family Accommodation Service (FAS) was set up to accommodate women patients and their families who live too far away from the hospital and need to be close. Coordination of the accommodation and support for residents is provided by the FAS Manager.

Facilities

FAS provides 15 self-contained apartments for patients and their families who are from rural Victoria, interstate, or in crisis. The apartments are located at 141 Grattan Street, Carlton.

The accommodation comprises eight two-bedroom flats, three one-bedroom flats and four bed-sit flats.

The facilities provided include: a self-contained kitchen with a full-size fridge and stove; washing and drying facilities in two communal laundries; linen and towels; heating and fans in each room; television; free car parking is available on site; and there are telephones in each room for in-coming calls and calls within the hospital.

The first $100 is paid by residents of the Family Accommodation Service who do not have a health care card or pension card; subsequent costs are bulkbilled to VPTAS. Those who have a health care card or pension card directly bulkbill VPTAS with no additional costs.

Access

There are five ways in which women and their families are informed about or access FAS:

1. Clinic workers inform women outpatients and inpatients at the Royal Women's Hospital about the Family Accommodation Service. Patients or their worker can make a referral.
2. Referrals can be made by regional or rural workers such as Aboriginal Health Liaison officers.
3. Emergency and ward staff can refer a patient's family directly.
4. Referrals can be made via patient's personal networks.
5. The patient can do their own research, for example on the Royal Women's Hospital website.

FAS provides updated information about alternative, accessible accommodation options on the website.

Based on client feedback and a client survey in 2009, FAS is improving its information provision by raising its profile in outpatient clinics and birth suites and at regional health services. The aim is to ensure that patients are informed about the service prior to their first visit or on arrival. The role and support provided to women and their families by the Family Accommodation Service Manager is consistently highly valued by patients.

Case study: written feedback to FAS in 2009

"I was diagnosed with pre-eclampsia in Portland, Victoria, when I was just 25 weeks pregnant and was transferred to the Royal Women's Hospital in Melbourne, 420 kilometres away from home. It was a huge shock and as my fiancé and I don't have close family anywhere near Melbourne, we didn't know what to do and how to access accommodation. Fortunately, the hospital's social worker helped my fiancé to get into the family accommodation straight away. I felt so much safer having him close by to support me at this time.

"After being in hospital for ten days, our baby boy had to be delivered by caesarean section since my condition got too severe. He was born just 831 grams at 27 weeks. After giving birth, I had to stay in hospital for a further week and my fiancé kept staying in family accommodation. The circumstances were nearly too much to bear for both of us but at least we got to be together.

"When I was discharged, I moved to family accommodation as well and since it was close by, we managed to get to hospital and back by walking, which saved us well-needed funds. It took so much unnecessary pressure off of us! We could focus on the most important thing, our son.

"The accommodation we stayed in had other people in the same situation staying there, which worked like a free therapy every time we ran into each other. We made lifelong friends with many parents, since we were there for each other through the hard times, supporting each other as much as we could under the circumstances.

"The accommodation was our safe place through the worst and hardest times of our lives. We can never be thankful enough to have been able to stay there for 18 weeks. The premises was more than we could have asked for; the kitchen, for example, had basic necessities. Thanks to family accommodation we didn't get into huge debt and had a stable place to stay without any extra hassle. It became our home away from home and we will never forget it. We managed to deal with the mentally draining experience together as a family."

Contact

Family Accommodation Service Manager

- Telephone: **03 9349 1629** or **0409 011 382**
- The Royal Women's Family Accommodation Service guide can be downloaded from the Royal Women's Hospital website **<www.thewomens.org.au>** Search for Family Accommodation Service.

5.3 Gippsland Rotary Centenary House

Gippsland Rotary Centenary House is a community-based not-for-profit accommodation facility for patients and their families who will be attending the Gippsland Cancer Care Centre at Latrobe Regional Hospital or undergoing other treatment for long-term degenerative diseases. It has an emphasis on the families of very sick children.

This project was initiated by various Gippsland Rotary Clubs to mark the centenary of Rotary and has attracted broad community support and representation throughout Gippsland. Funds have been raised through community fundraising, applications to philanthropic trusts, sponsorship and donations in kind. Latrobe City Council assisted Centenary House by acquiring

a two-hectare site on Valley Drive, Traralgon, on the northern boundary of the Latrobe Regional Hospital. This is being leased to Gippsland Rotary Centenary House for 25 years at a peppercorn rental.

Gippsland had lacked cancer treatment facilities and patients and their families had to spend extended periods in Melbourne undergoing treatment. This caused major disruption to their families and accommodation for family carers was an expense that many could not afford. As a result many seriously ill patients opted to undergo more radical and intrusive treatment; sadly some even opted to forgo any treatment rather than face the family stress of long and expensive stays in Melbourne.

A major new treatment centre for cancer was opened at Latrobe Regional Hospital in 2006. Starting in 2003 the Gippsland Rotary Clubs prioritised the development of accommodation services for patients and their families who had to travel to the new centre. Centenary House opened in early September 2006.

Centenary House is run by a voluntary Committee of Management. It comprises representatives from Rotary, the Gippsland community and businesses, and user groups. This is a project by the community, for the community and has generated enormous community goodwill in the accommodation centre's catchment area.

Centenary House has had a good relationship with Latrobe Regional Hospital from the beginning but it remains an autonomous organisation. There is no hospital representative on the committee.

Facilities

The philosophy of Gippsland Rotary Centenary House is to provide affordable, comfortable, supportive and secure accommodation for patients and their families so that the stress of travelling and treatment is minimised.

Centenary House is within walking distance of Latrobe Regional Hospital. It is easy for families to visit seriously ill patients and take a short break back at the accommodation facility. The facility offers comfortable accommodation and also provides a supportive environment within easy reach of the hospital.

The facility comprises six large motel-style ensuite units, two disability access self-contained units, a communal kitchen with two work stations, a communal dining and lounge, a quiet room for family consultation and privacy, a library, a secure playground and a courtyard.

The facility is operated by a full-time paid manager who is supported by a team of volunteers. They provide services including after-hours security and access, cleaning, servicing rooms, administrative support, driving guests and general garden and building maintenance.

Access

There is an average 98 per cent occupancy from Monday to Friday. Many referrals come from social workers at Latrobe Regional Hospital; other guests are referred by their doctor, family or local networks.

Centenary House advertises its services through hospitals, medical clinics, local community groups and the local media.

There is an informal waiting list. If guests are unable to be accommodated, they are referred to the Latrobe Hospital's social workers who provide suggestions for alternative accommodation.

Case study

Joe is an 80-year-old man from Port Welshpool who had to have six weeks of radiotherapy for a brain tumour. He was unable to drive during his treatment. Because he was only travelling 80 kilometres for treatment, he could not access the accommodation allowance from VPTAS. He stayed at Centenary House for a cost of $30 per night, making it affordable for him. He also had the support from staff and volunteers to drive him to get food or to and from Latrobe Regional Hospital for treatment. Joe lives alone and he found the company he had at Centenary House very important in keeping his spirits high during his treatment. On returning home he found that he missed the support of other guests. As they had swapped contact details he continued to contact the other guests for support after returning home.

Contact

Centenary House Manager

- Telephone: **03 5171 1600** or **0448 550 260**
- Email: **carol@centenaryhouse.org.au**
- Website: **<www.centenaryhouse.org.au>**

Priority 6: Rethinking discharge as ‘transfer of care’

Returning home from hospital has its own complexities for rural consumers and their families. Often they are left with unanswered questions such as how they will get home, what medication and services they will need, and whether their local GP and other appropriate local services have been informed. Many are unclear about what they should be doing and whom they should be contacting for their ongoing care after returning home.

The concept and language of “transfer of care” is more appropriate than “discharge”. It implies an ongoing responsibility by the treating hospital for a safe and supported journey by rural consumers when they return home. It implies communication and relationships with appropriate local rural services.

Some key considerations and features of a “transfer of care” model include:

- early planning with the rural consumer and their family
- holistic assessment including an understanding of what support mechanisms are available locally
- communication that is linked back to the locally based care services, including the GP, rural hospital, community health service, allied health workers, post-acute care coordinators or other appropriate health services
- travel support that matches the health needs and financial circumstances of rural consumers and which is coordinated with local transport service providers
- medication availability from the treating hospital, which takes into consideration travel and local access difficulties and unavailability
- using accessible language and providing culturally appropriate information and support to rural consumers and their families about self-care.

One initiative involving transfer of care is included in this section.

6.1 *Building blocks for discharge communication and resources*, General Practice Victoria and General Practice Liaison Units

Ensuring effective, clear discharge communication between hospitals and GPs has been an issue for many years. General Practice Victoria (GPV) developed a position statement on discharge communication in 2009 that says:

“It is absolutely fundamental to patient care and safety that GPs receive a legible discharge summary within 24–48 hours of patient discharge for all patients, except those on chemotherapy or dialysis where multiple treatments are required.”

In Victoria, discharge summaries are regarded as essential for continuity of care and patient safety, yet there is no specific state or national legislative or regulatory requirement for discharge summaries. Within hospitals, there does exist a policy focus on discharge planning but not on discharge communication. Part of GPV's role is to raise the profile of discharge communication and promote improvements through the General Practice Liaison program.

GPV and General Practice Liaison units based at public hospitals have formed a working party that aims to improve hospitals' discharge communication. The working party has developed a framework and resource for improving safe referral home. It is called *Building blocks for discharge communication*.

The framework has 10 strategies. Its building blocks are:

1. Medical staff in hospitals recognise the value of the GP role.
2. The hospital has a discharge policy that values the GP role.
3. The hospital has a strategy for implementing its discharge policy.
4. It is the patient's decision to nominate which GP will provide their continuing care.
5. A patient's nominated GP's name is on their hospital file.
6. The hospital has accurate contact details for GPs at the ward level.
7. The hospital has a mechanism for notifying a patient's GP of their admission.
8. Hospital staff understand that providing a safe referral home is part of their job.
9. Hospital staff have access to tools that generate a legible and useful summary.
10. Hospital staff have access to meaningful data on their unit's discharge performance rate.

It is a web-based resource found on the General Practice Victoria website: **<www.gpv.org.au>** click on "Programs", then "GP Hospital Communications" and "Discharge Communications".

An example of a public hospital initiative that embodies these building blocks is the Royal Children's Hospital Discharge Summary webpage and 10 steps to a good discharge summary **<www.rch.org.au>** and search under "10 steps discharge".

Additional comments

The main difficulty is that many public health services do not have a communication target for discharge summaries or any means of monitoring their discharge success rate. General practice liaison officers are working with their hospitals to identify leaders who will introduce communication targets and monitor performance.

Contact

General practice liaison officer Program Consultant at General Practice Victoria

- Telephone: **03 9341 5220**
- Email: **j.measday@gpv.org.au**

Priority 7: Reducing the need for rural consumers to travel

This priority area considers the importance of developing more health care initiatives and services in rural communities, reducing the need for travel – particularly for specialised health care. This is part of the whole-of-journey approach because it could reduce the distance travelled for health care or even the need to travel at all.

This priority area may be covered by some reforms being considered and introduced as part of the national reform agenda for health and health care in Australia.

It is worth noting that two of the three examples included here involve relationships and initiatives between Melbourne and regional health services.

7.1 Specialist Speech Pathology and Nutrition Care Mentoring for Cancer Professionals in Regional Victoria, St Vincent's Hospital, Melbourne

The Specialist Speech Pathology and Nutrition Care Mentoring for Cancer Professionals in Regional Victoria project was an initiative of the speech pathology and nutrition departments at St Vincent's Hospital. It was funded by Cancer Australia.

This project was developed in response to the ongoing clinical needs of head and neck cancer patients living in regional Victoria who were travelling back to St Vincent's after surgery for ongoing care. Either such specialised care was unavailable in their region due to lack of specialist skills and experience or patients perceived a lack of local specialised care and decided to travel where they had established relations with various clinicians.

The project had three objectives:

- to improve access for head and neck cancer patients to skilled allied-health professionals in their regional health services
- to reduce the number of outpatient visits to Melbourne by rural consumers
- to improve the clinical skills of, and confidence in, speech pathologists and dieticians working in regional and rural Victoria in the area of head and neck cancer management.

The key activities were:

- regional training workshops conducted by St Vincent's staff at three partner regional health services: Goulburn Valley Health, Ballarat Health Service and Bairnsdale Regional Health Service
- funding shadowing-visits to St Vincent's by regional and rural speech pathologists
- ongoing clinical mentoring between St Vincent's staff and regional and rural speech pathologists in the area of head and neck cancer
- developing a discharge tool for all transfers of care of head and neck cancer patients from St Vincent's to regional health services.

The initial project was funded from May 2006 to December 2007. However, St Vincent's Hospital staff continue to offer mentoring and shadowing opportunities for regional speech pathologists. The discharge tools developed for this project continue to be used.

Project achievements

- Regional training workshops: 57 regional health professionals – mainly speech pathologists and dieticians – attended the workshops conducted by St Vincent's staff. Thirteen patients also participated, which was essential for hands-on clinical training of the clinical participants and for building patient confidence in regional services.
- Mentoring: The project further developed and formalised the informal mentoring relationships that previously existed between St Vincent's Hospital speech pathologists and several regional speech pathology departments. The availability of a mentor on the telephone or via email has provided regional clinicians with support almost on-call. It has affirmed their confidence and ability in managing this specialist caseload.
- Discharge tool: This provides regional clinicians with extensive information about a patient's acute journey and recommendations for their ongoing care. It provides and prepares regional clinicians for the issues that will confront them when the patient is transferred to their care.

Outcomes

For regional allied-health professionals outcomes have included improved confidence and practical knowledge in managing head and neck cancer patients in the areas of swallowing, communication, tracheostomy management, radiotherapy issues, and enteral feeding.

All patients living in the targeted regions now receive their ongoing care for head and neck cancer locally, reducing their need for travel. Patient confidence in local allied-health professionals has increased.

Additional comments

It is important that such initiatives be centred on patient care. A well-planned and implemented project can sometimes lose focus unless someone keeps asking: "What's in it for patients?"

Relationships are important. St Vincent's Hospital staff have built on existing relationships with regional health services and facilitated relationships between regional health services and local patients.

It is important to have executive and management support for such initiatives.

Contact

Chief Speech Pathologist, St Vincent's Hospital

- Telephone: **03 9288 3846**
- Email: **sue.wilson@svhm.org.au**

7.2 Virtual Ophthalmology Support

Virtual Opthalmology Support is a collaboration between South West Alliance of Rural Health and the Royal Victorian Eye and Ear Hospital. South West Alliance of Rural Health has a broader project – the Virtual Services Project (VISP) – that involves providing health services to rural and remote communities by using remote-access technology. The Virtual Opthalmology Support is part of the VISP.

The objective of Virtual Ophthalmology Support is to provide virtual services – such as advice and support from the Eye and Ear Hospital, Melbourne – to four regional public acute hospitals in south-west Victoria. These regional hospitals are South West Healthcare (Warrnambool), Western District Health Services (Hamilton), Portland and District Health and Colac Area Health. This initiative enables the four regional hospitals and the Royal Victorian Eye and Ear Hospital to remotely treat clients with complex or specialist issues.

The key activities included:

- establishing a high-speed network connection to the Royal Victorian Eye and Ear Hospital via the existing South West Alliance of Rural Health high-speed converged network

- upgrading specialist eye equipment at the participating rural health services. The integration of internet-based video-conferencing and specialised slit-lamp software enables the remote specialist to directly see the eye of the patient on their workstation
- establishing protocols between the Royal Victorian Eye and Ear Hospital and South West Alliance of Rural Health hospitals that enable the provision of a remote service at all hours, every day
- integrating Virtual Ophthalmology Support into the roles of existing specialist staff at the emergency departments of the four participating regional hospitals
- training at the four regional health services. The training included nursing and medical staff in each emergency department. It was segmented into the use of the slit lamp and sharing of the slit-lamp outputs with a remote clinician.

Outcomes

- connection to the Royal Victorian Eye and Ear Hospital using remote access technology (such as video-conferencing and image transfer) to receive virtual advice and support
- timely access to expert advice for health professionals working in regional agencies and for access to additional support during emergency situations
- minimised the need for travel and maximised the efficiency of health services provision by enabling the expert review of patients through the use of real-time slit-lamp images.

Benefits

Consumers have directly benefitted by having timely, local access to health advice and intervention from specialist services. Rural consumers can avoid worrying about accessing specialists and having to make complex travel arrangements for their health care. Time and travel expenses are being saved for consumers, their families, health services and government.

Additional demographic benefits could accrue in relation to improvement in community confidence, which aids in the retention of people within regional communities.

South West Alliance of Rural Health

South West Alliance of Rural Health has a history of innovation and change. The Virtual Services Project (VISP) is one of its key initiatives. VISP is part of the Business Support and Innovation Unit of Western District Health Services, which is a member of the alliance.

South West Alliance of Rural Health feels that initiatives based on virtual services offer hope for regional Australia, particularly in relation to the difficulty of obtaining high quality specialist staff and local clinical support. The alliance is sure that there will be an increasing uptake of virtual services that rely on identified pools of clinical specialists. However, incentives to provide virtual services seem to be highly correlated with client demand (through emergency or hardship), rather than provider costs.

Additional comments

The concept of virtual services such as virtual ophthalmology is well-supported by the chief executive officers and clinical staff of hospitals involved. Clinical and non-clinical staff need to see the benefit for their practice and their organisation before they will readily accept and adapt to virtual services.

There are huge practical challenges involved in adding innovative practices to established services. Technical support must be readily available when things go wrong in the use of the virtual service technology.

The lesson for virtual services and their development is that the challenge lies in business re-engineering and not just in achieving technological success. The difficulties of achieving change in a clinical environment relate to organisational culture, which is risk averse and litigation sensitive.

The South West Alliance for Rural Health's virtual services model is sustainable, scalable and transferable to all regions within Victoria.

Contact

Projects Coordinator, Business Support and Innovation, Western District Health Service:

- Telephone: **03 5551 8030**
- Email: **katherine.cooper@wdhs.net**

7.3 Transition Care Program, regional outreach services, Bendigo Health

The Transition Care Program provides short-term support and active management for older people at the interface between acute or sub-acute and residential aged care sectors. The program targets older people at the conclusion of a hospital episode who require more time and support in a non-hospital environment. The program offers them the opportunity to

complete their restorative process, optimise their functional capacity and finalise and access their longer-term care arrangements. The length of stay in the Transition Care Program is up to 12 weeks.

The regional outreach initiative was developed by Bendigo Health to provide access to Transition Care Program services for people living in regional centres and rural communities outside Bendigo.

The services provide residential and community-based low-level rehabilitation services in local health services. This has increased the range of services and the number of care pathways available to older people on discharge from hospital. The initiative is funded by the Victorian Department of Health and the Commonwealth Government.

Bendigo Health's Transition Care Program commenced in March 2007. The regional outreach Transition Care Program services were set up at the Echuca Regional Health, Swan Hill District Health and Maryborough District Health services in 2008 and expanded to Kyabram District Health Service in 2009.

Enablers

- An initial workshop – with representation from executives, allied health and community services from Bendigo Health and invited regional health services – was essential to discuss the model and process of implemention.
- An ongoing Transition Care Program Reference Group was established with members from participating regional health services, Bendigo Health, Aged Care Assessment Service and the Department of Health.
- An action plan was developed for implemtation based on processes of continuous review. Lessons from the first outreach service informed implementation of other outreach services.
- Regular site visits are made by the Bendigo Health Transition Care Program Manager to the regional health services to support and guide implementation.
- Transition Care Program coordinator positions and working parties were established at all participating health services.
- There is ongoing support from health service executives.
- In-service training is undertaken with staff of referring services and residential facilities to increase their understanding of the Transition Care Program.

Outcomes

- The program successfully provided care to older people in their own community, allowing them more time to recover and make long-term care arrangements. There have been many cases in which premature admission to residential care has been avoided.
- Older people are able to stay near their local support networks.
- Low-level rehabilitation services are now available locally.
- The program has reduced the need to transfer patients from other regional and rural health services to Bendigo Hospital inpatient rehabilitation.
- People are able to be transferred back to their local area for ongoing care following surgery and or medical care at a major health service.
- There is access to geriatrician consultancy for Transition Care Program clients with an expanded role for the regional Aged Care Assessment Service geriatrician.

Additional comments

It is important to communicate and build relationships with participating health services from the beginning. Workshops prior to establishing Transition Care Programs at regional health services need input from all relevant staff and services. The ongoing support by the Bendigo Health Transition Care Program manager to coordinators and other staff in outreach services is necessary to sustain commitment and coordination.

Case study

There have been several occasions when an older person has been assessed as requiring placement in residential care when in hospital. For example, one person was discharged to a regional Transition Care Program residential service which then explored long-term care options. Following the intervention of allied health, nursing support and case management staff the person has sufficiently improved function to return home.

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Priority 8: Policies and programs for a whole-of-journey approach

The many initiatives from various health, transport and community services in the seven key priorities detailed above have been developed in direct response to the needs of rural consumers and families. Health services have recognised gaps at service and system levels.

Some health services have used their resources in creative ways to respond to the needs of rural consumers who have to travel for health care, including the creation of specific positions and services. Others have recognised that it is more cost-effective to respond to the priorities of rural consumers outside the hospitals. And others have worked to strengthen communication and coordination between city, regional and rural services to better support rural consumers at different points in their journey.

The priorities of rural consumers who travel for health care are not centred only on transport, but transport is often where the discussion and the action gets stuck. Affordable and accessible transport options, adequate transport support and consistent provision of transport information to rural consumers are all essential. However, transport is only one of the priorities that need to be coordinated and acted on for a whole-of-journey approach.

The whole-of-journey approach requires a policy framework. It also requires coordinating roles within government health departments.

Additional comments

Travel for health care will never be eradicated. There is an increasing focus by government on providing services closer to rural consumers and using virtual services technology to improve communication. This is essential, but it will be a medium- to long-term process and people living in remote parts of Victoria will still need to travel to their regional services for specialist care. When rural consumers and their families do need to travel for health care, a whole-of-journey approach addresses the complexity of this experience in a coordinated, consistent and supportive ways. Policies that address and implement this approach and coordination from government at the state and federal levels are vital.

Conclusion

It is important to reiterate that the whole-of-journey approach with rural consumers who travel for health care integrates eight priority areas. These priorities require changes at various levels in the health system:

- in government policy
- at rural GP services
- at public and primary health services in rural areas, regional centres and in Melbourne
- in transport and accommodation services.

Eighteen initiatives have been documented in this resource kit. They show what can be done when the complex experiences and journeys of rural consumers and their families who have travelled for health care are integrated into policy and service provision.

These initiatives have been included to inform and inspire commitment and change with and for rural consumers. They do not include everything that has and is taking place.

We encourage readers to contact those who have been working to develop these initiatives. Each contact is open to sharing their insights and experience.

It is important to end this resource kit with a vision of what a coordinated and supportive health care journey could be like for rural consumers. The cartoon that completes this resource kit captures the welcomed, acknowledged, accompanied, clear and uncomplicated whole-of-journey experience of diverse rural consumers. Initiatives like those in this kit are important contributions towards achieving this vision. More initiatives are needed.

We hope you have been inspired.

References

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