Establishing cross-agency service models in the rural and remote context: learnings for health reform

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Kristine Battye is the director of a small consultancy company that she established 10 years ago. During this time, Kristine has undertaken numerous projects in Queensland, NSW, the Northern Territory, Western Australia, and nationally. Much of the work that Kristine and her company do is in the areas of health service planning and service modelling, workforce planning, and program evaluation and review, generally within the rural, remote and Indigenous health context.

Over the last three years Kris has undertaken several projects to design and establish cross agency service models, as well as evaluate a cross sector model. These will be the focus of her presentation today.

Introduction

Health reform in Australia is focused on the establishment of Medicare Locals which will operate as regional integration and coordination platforms for primary health care linking to Local Hospital Networks. The health reform juggernaut is charging ahead with less than an 18 month timeframe for establishment of Medicare Locals across Australia. Medicare Locals will be new entities emerging from a diverse set of stakeholders and service providers from the public and private sectors and non-government organisations (NGOs). The establishment of these new entities, and the desired integrated health system will be challenging. While much of the focus and activity in health reform has been on negotiating state and commonwealth government agreements, policy development and boundary debate, the real challenge will be at the agency and provider level when we seek to blend differing organisational cultures, work practices, models of care, individual and organisational values, industrial conditions, remuneration processes and management practices.

Cross agency service models are a "taster" for the imminent health reforms. This paper seeks to highlight some of the lessons learned in developing and establishing cross agency models that could be considered as Medicare Locals are progressed.

Drivers

Cross agency service models are established for a raft of reasons and as such take on a variety of forms. In the context of health care and service delivery, the drivers for cross agency service models include clinical care coordination; better use of existing clinical, administrative and infrastructure resources; improving access to care and reducing barriers to service provision; improving the effectiveness of services; increasing workforce supply and skill sets, and/or addressing workforce recruitment and retention problems. These drivers may be stand alone but frequently operate in combination, particularly in rural and remote Australia.

Cross agency services are generally developed for a defined purpose by the partner organisations. Medicare Locals are being established with a broad remit including planning, coordination, service delivery, community engagement, and performance management functions.[1] Breaking down these broad functions into clearly defined, achievable and agreed objectives between existing agencies and providers is likely to be one of the first and defining tasks of a Medicare Local.

Partnerships underpin cross agency models

While this paper is not seeking to provide an academic discussion of partnerships there is the need to articulate the complexity of this concept as some form of partnership underpins cross agency service models (and Medicare Locals). Partnerships, cross agency approach, integrated services, inter-sectoral collaboration are some of the terms that are frequently applied when two or more organisations seek to establish a joint response to a specific issue. As such, the concept of "partnership" is difficult to define, with some commentators seeing partnerships as both a process and an outcome. A literature review undertaken by Griffith University explored the concepts of partnership and collaborative capacity and it is important to reflect on the complexity of these concepts within the mechanics of health system reform. The concept of partnerships can be viewed from three perspectives[2]:

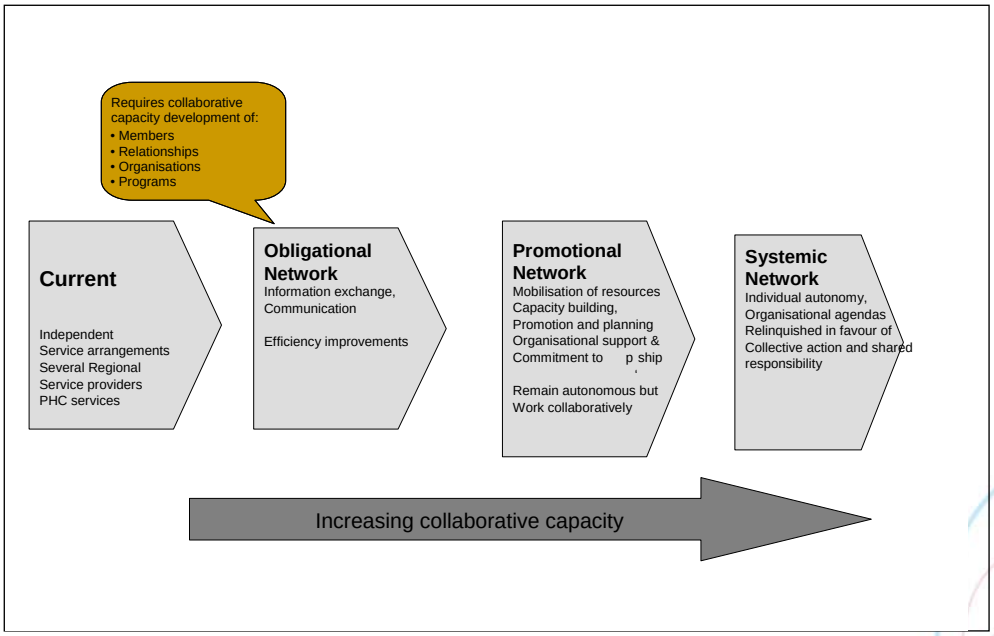
- As processes for improving services, making program delivery more efficient and increasing capacity by sharing and mobilising resources, reducing duplication, seeking joint funding, and sustaining effective use of resources
- Process to mobilise and engage stakeholders
- Vehicle for achieving other outcomes typically associated with effectiveness, efficiency and responsiveness of services.

These various perspectives of partnerships need to be kept in mind when we seek to develop partnerships or cross agency models because they can exist across a continuum, with the simplest collaboration being an obligational network, transitioning to promotional networks and maturing to a systemic network or new entity (see Figure 1).[2,3]

Key features of these three types of collaborations are:

Obligational Network	• Focus on information exchange and communication • Largely dependent on personal relationships between individuals • Partner operations remain the same but become more efficient based on agreed exchange of ideas, services and goods for each other's benefit
Promotional Network	• Mobilisation of resources, capacity building, promotion and planning that increase organisational support and commitment to the partnership • Each member retains autonomy but begins the process of working collaboratively to address health issues
Systemic Network	• Ongoing collaboration results in the coalition becoming more complex and requiring resources that are independent of the membership contribution. • At this stage, individual autonomy and organisational agendas are relinquished in favour of collective, agreed action and shared responsibility.

Figure 1 Staged development of partnerships

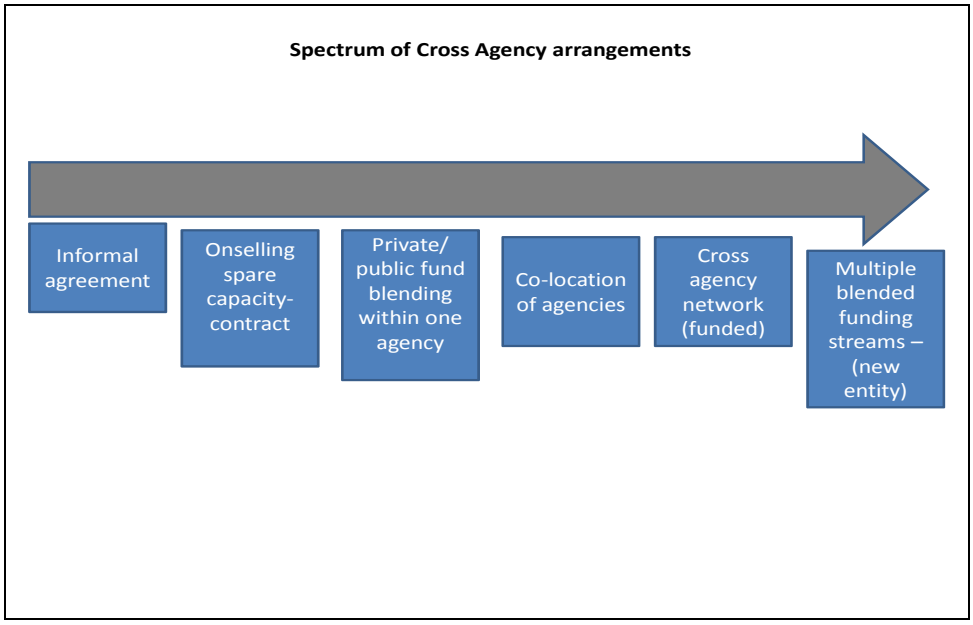


The literature tells us that it is essential to allow each of these stages to be operationalised and fostered if sustainable coalitions are to be achieved. i.e. these more complex partnerships take time to evolve.[2] Time to develop and nurture partnerships does not appear to be a luxury that Medicare Locals will have.

Spectrum of cross agency models

Cross agency service models operate across a broad spectrum (see Figure 2). A recent industry scoping activity undertaken as a component of a project to develop cross agency allied health workforce options identified models ranging from informal ad-hoc arrangements to support recruitment to a position, and on-selling spare capacity, through to integrated health care governance models working under Memorandum of Understandings (MoUs) or service agreements (cross agency network).[4] Less complex cross agency models or service arrangements would be classified as obligational networks, whereas co-location models and cross agency service networks are examples of promotional networks. Examples of a systemic networks (or new entity) were not identified by industry scoping. However, Medicare Locals are clearly examples of this.

Figure 2 Spectrum of cross agency models



Do cross agency service models work?

Given the current health system reform occurring across Australia at this point in time, this is an important question and one that does not have a clear or simple answer. Whilst there has been a lot of work undertaken to develop theoretical frameworks to understand partnerships, or to guide successful partnerships, there appears to be little evidence of benefits or outcomes.[5] This doesn't necessarily mean lack of benefit or outcome, but rather lack of evaluations to measure outcomes partly due to the challenge of attribution of causality in complex environments, as well as time required for measurable outcomes (e.g. health improvements or quality of life) to appear.

Realist evaluation is a recent trend in evaluation research that can be applied to complex interventions operating within an open system. A realist evaluation has an explanatory quest and seeks to ask "What works, for whom, in what circumstances, in what respects, and why?".[6]This approach is highly relevant to cross agency models because:

- The services are usually embedded in existing organisational structures and systems
- The services and service model is subject to the local community conditions, with varying access to primary, secondary and tertiary services
- There is likely to be varying preferences of clients, families and providers that may impact on uptake and utilisation of services
- They operate in an open system, such that changes in personnel, community attitude, and availability of other health and community services can impact on a program.

Realist evaluation stresses four key linked concepts for explaining and understanding programs:

- Mechanisms – describe what it is about programs and interventions that bring about effects
- Context – location, demographics, interpersonal and organisational conditions
- Outcome patterns – intended and unintended consequences of programs
- Configuration outcome – getting the right mix or combination of ingredients (inputs) to suit or meet the needs.

Therefore, given the complexity of cross agency service models, and various purposes for which they may have been established, we can't ask the simple question of "do they work" but rather what works, why and in what context?

Similarly, Medicare Locals will be operating in very different environments and contexts. The utilisation of a realist approach to a formative evaluation of the Medicare Locals would be a strategy to assist these new organisations shape their partnerships and develop and refine the necessary detail of the working model.

Developing cross agency services—what are we learning?

The main focus of this paper is to share learnings from our involvement in three different types of projects with a cross agency flavour. These include:

- The development and establishment of a cross agency drug and alcohol service
- A project to develop a toolkit to support the development of cross agency allied health workforce options
- An evaluation of a cross agency co-location model.

Murdi Paaki Drug and Alcohol Network

The Murdi Paaki Drug and Alcohol Network (MPDAN) is a cross agency service established to improve the response to drug and alcohol problems in western NSW.

The MPDAN is a partnership across five organisations:

- The Lyndon Community, an NGO service providing residential drug and alcohol rehabilitation services and outreach addiction specialist and counselling
- The Greater Western Area Health Service, Mental Health and Drug and Alcohol
- Maari Ma Health Aboriginal Corporation
- Bourke Aboriginal Health Service
- Walgett Aboriginal Medical Service.

The drivers for the establishment of the cross agency model:

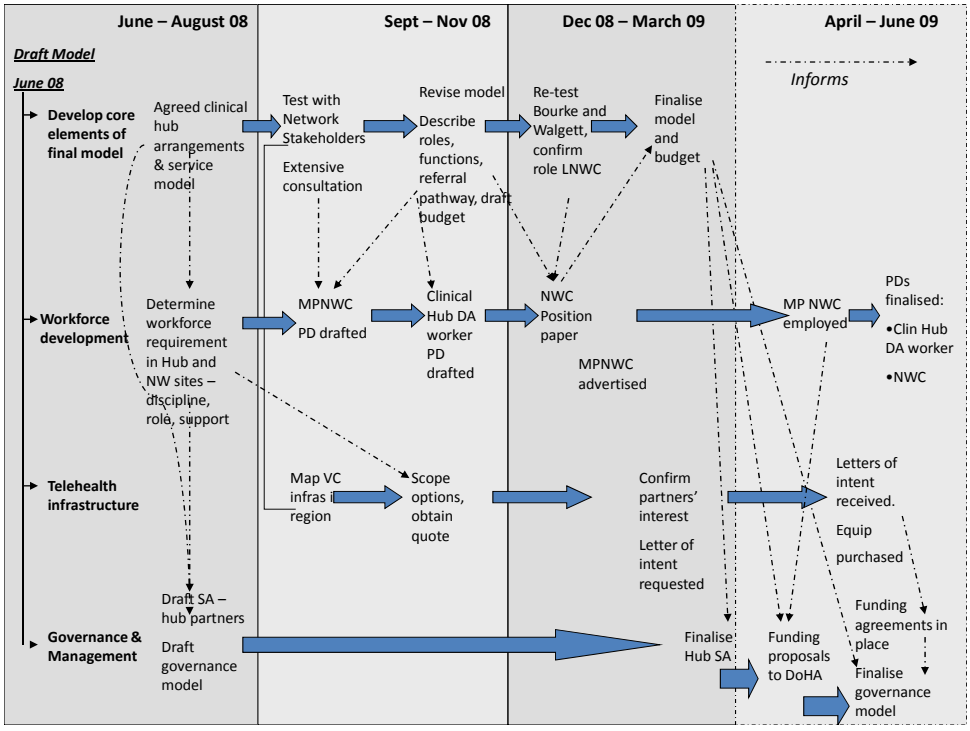
- COAG initiative to involve Aboriginal Community Working Parties, governments and service providers to work together in new ways to meet Aboriginal community needs
- Recognition that not one agency had the requisite skills and capacity to provide services to Aboriginal people across the region – hence increasing points of access, and improving technical and cultural skills of primary health care and specialist workers
- Seeking to establish a primary health care-led model of drug and alcohol service delivery, recognising that primary health care is the largest workforce "on the ground" in rural areas.

Over a 2-3 year period the partner organisations in conjunction with the Outback Division of General Practice worked together to develop:

- A social and emotional wellbeing (SEWB) framework outlining how care is organised across the community, primary, secondary and tertiary sectors, identifying the role and functions of the providers at each level
- A draft service delivery model, that was then further developed in detail over a 12 month period
- The workforce requirements and position descriptions for workers employed by the differing organisations
- Telehealth infrastructure to support the implementation of the model
- Governance structure.

The development of the SEWB framework and draft model was facilitated by KBC Pty Ltd. The finalisation of the model and establishment of the workforce needs, governance structure and funding agreements was a complex and iterative process (see Figure 3) over a 12 month period facilitated by the Centre for Rural and Remote Mental Health.[8]

Figure 3 Murdi Paaki Drug and Alcohol Network establishment phase: Process Map. [Source: CRRMH (2009)]



The MPDAN went "live" in July 2009, and a number of challenges and enablers have been identified in the establishment and early implementation of the model.[4,8] The key challenges relate to:

- Varying flexibility between agencies to change policies and operational processes
- Salary inequities between organisations
- Continually reforming the alliance and vision for the new way of working as new people are employed
- Maintaining consistency of processes across agencies

- Maintaining relationships between agencies
- Need for flexibility of role and way services are delivered in different settings
- Risk of competition between agencies as new funding streams become available
- Developing the detail of the operational policies of the new service and how these mesh with existing policies of partner organisations, agreed mechanisms for clinical information sharing, data collection and reporting.

The enablers to the establishment of the cross agency model:

- Long lead time to build relationships, develop and agree to model
- COAG sends the message that agencies need to work differently
- Resources for coordination and support at a program and management committee (governance) level
- Third party to work across agencies to develop agreed model, service agreements and governance structure.

Learnings for health reform

The key learnings for consideration as Medicare Locals are established:

- As mentioned earlier, the importance of time to build relationships and risk to disengagement of partners if the process is rushed
- Time and effort to develop a shared vision of what the partnership is to achieve
- Resources and independent party to work across agencies to develop agreement on how the agencies will collaborate, who will lead the collaboration
- Significant effort has to be put to the development of the detail to support implementation and operation of the new service model (policies and protocols, information sharing, data collection)
- Managing differing industrial awards and conditions will be an ongoing challenge while providers are employed by different organisations, but haven't come up with a solution to this.

Pathways to cross agency rural allied health workforce options: improving access to care

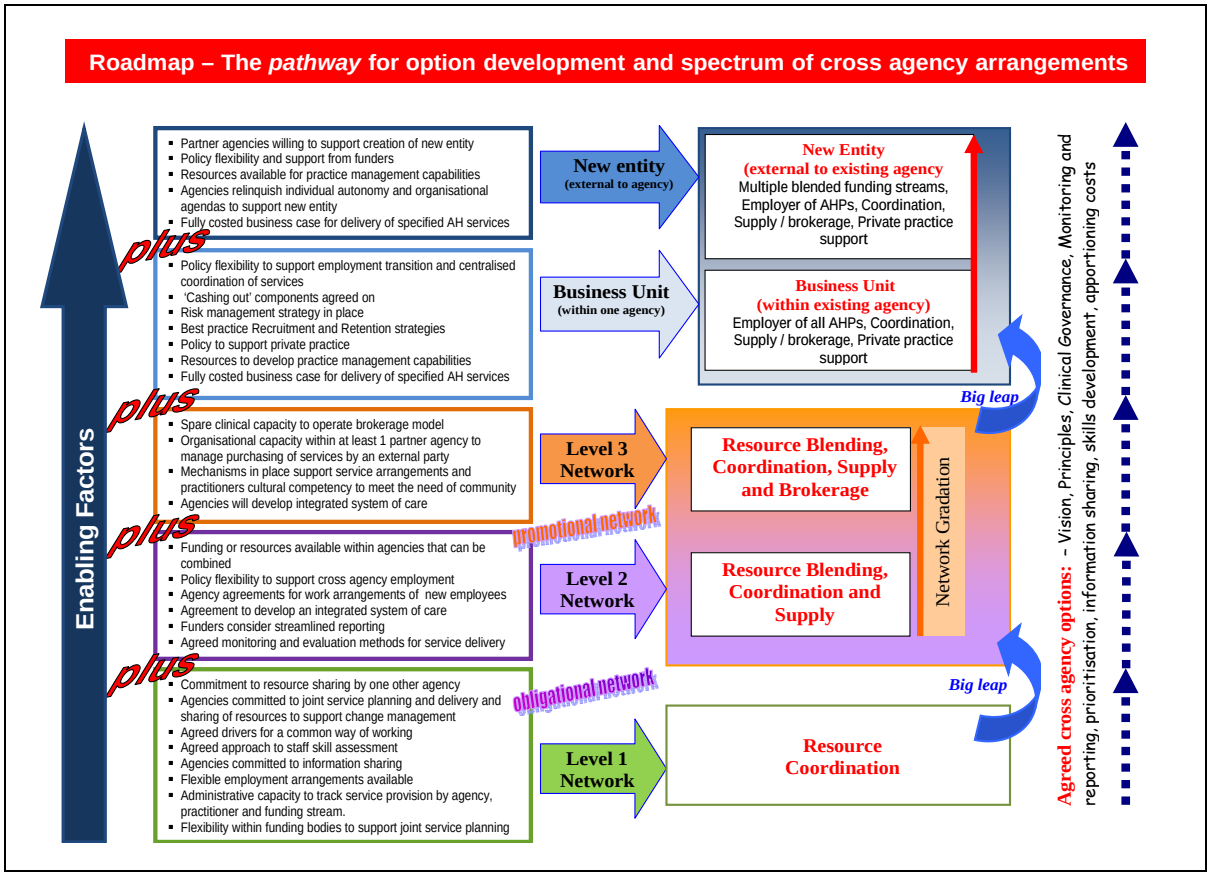
In 2010, the Clinical Education and Training Institute, Rural Division, NSW Health, commissioned a project to explore the development of options for integrated cross agency allied health services, and develop a toolkit to assist managers of health services tailor cross agency service arrangements to local conditions and context.

Drawing on industry knowledge and experiences, research, and policy, the project identified[4]:

- Five broad cross agency arrangements to support allied health workforce options with increasingly complex functions. The simplest arrangement supported the coordination of resources (services); transitioning to resource coordination and allied health purchasing and brokerage to increase supply; through to a new entity established through fund blending, cashing out and pooling allied health positions and providing practice support functions to increase workforce supply.
- Enabling factors required to progress the development and implementation of each option and assess the readiness and capacity of the partner organisations to pursue a cross agency option. As the presence of enabling factors increase the establishment of more complex cross agency arrangements is possible.

Figure 4 describes the enabling factors required to support the development and implementation of the cross agency workforce options.

Figure 4 **Roadmap to progress the development of cross agency allied health workforce options[4]. (Source: R. Cheney, 2010)**



Within the Network models, enablers fall into broad categories relating to:

- A shared vision and commitment to resource sharing
- Mechanisms for joint planning, information sharing, assessment of staff skills and competencies, developing integrated systems of care,
- Flexible policy to support employment
- Change management capacity and processes.

However, as the business unit and new entity options are progressed, enablers relate to availability or capacity to establish:

- Employment transition processes
- Mechanisms for costing and cashing out positions
- Business and practice management capacity.

Across the five options, "key ingredients" were identified to design the cross agency options. These included:

- Governance – corporate and clinical
- Service planning mechanism
- Model of care

- Monitoring and reporting
- Development of agreed policies relating to:
  - Prioritisation of clients
  - Information sharing
  - Skills development, assessment and support
  - Communication (clinicians, clients, community)
  - Professional indemnity
  - Travel and accommodation (particularly relevant for rural and remote services).

A health service integration framework recently developed to guide cross sector activity and health system reform identified twelve core elements.[9] Our bottom up approach to cross agency allied health workforce design aligns with the health service integration framework.

Co-location models

There are numerous examples of co-location models in the health and community services sector such as the NSW Health Ones, GP Superclinics, Early Childhood Centres, the Safe Families program (NSW). Cross agency service models, particularly where co-location is involved, bring together staff from several organisations under one roof. The staff bring their experience of the formal and informal organising characteristics of their own organisation - or the 'personality' of their organisations. According to Weber (1947), staff are a product of their organisation[10] – yet the assumption in much of the health reforms that seek to build cross agency service models is that by putting members of different organisations together under one roof, they will *automatically* give up the undesirable 'personality' characteristics of their organisation (that at least partially drove the collaborative approach in the first place) and go on to create the skeleton of a *new* organisation with *new* and *more desirable* organising characteristics. However, a long tradition of sociological and psychological research suggests that the emergence of this *new* approach will not happen automatically, and if it does happen will take considerable time and effort. For example drawing on social psychological research, it is evident from research on intergroup relations and intergroup contact that bringing together opposing groups can improve relations as long as the contact is prolonged, purposeful, supported by the bureaucracy, ensures equal status of the groups and is focused on shared goals.[11,12]

Our involvement in the evaluation of co-location models found serious impediments to operation when:

- There has been a policy directive for establishment of a complex model without the necessary assessment of the local service agency environment to determine readiness
- There is an absence of a change management process to support the new way of working within the co-located cross agency service
- There isn't a clearly defined go-to person or manager of the cross agency team
- Ideological and philosophical differences between providers continue and are not resolved or a common ground found
- Different organisational policies and protocols continue rather than a "cross-agency" policy
- Different information systems continue without capacity to share information.

Many of these may appear as low level issues. However, as is often the case, it is the detail that needs to be addressed to enable the big picture ideas to fly.

Conclusion

While cross agency service models offer significant potential to improve access, effectiveness and efficiency of health and community services they are challenging models to establish and maintain. We have sought to

synthesise common themes emerging from a number of cross agency projects in which we have recently played a role. They offer salient warnings and risks to be managed as health reform progresses through the establishment of Medicare Locals. Those for particular consideration include:

- Adequacy of time and process to develop relationships between agencies, identify common and agreed drivers for collaborative work, assess readiness and capacity for collaboration, develop a shared vision, and an agreed model or process to achieve the vision
- The establishment of cross agency service models are complex and iterative processes and funders must allow sufficient time and resourcing to facilitate development
- Funders, policy makers and management need to provide the policy environment, skills and necessary resources to support local agencies to develop the detail to operationalise a cross agency model
- A formative evaluation strategy using realist methodologies to support the implementation of cross agency models offer a mechanism for identifying the effective features of the model, contextual issues that help or hinder implementation, and identify and trouble shoot blockages
- Much effort goes into the development of models and partnerships, but mechanisms to monitor and maintain the partnership are also required.

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Acknowledgments

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