15 March 2015

Alfred Health

HealthLinks Chronic Care Strategy

AlfredHealth

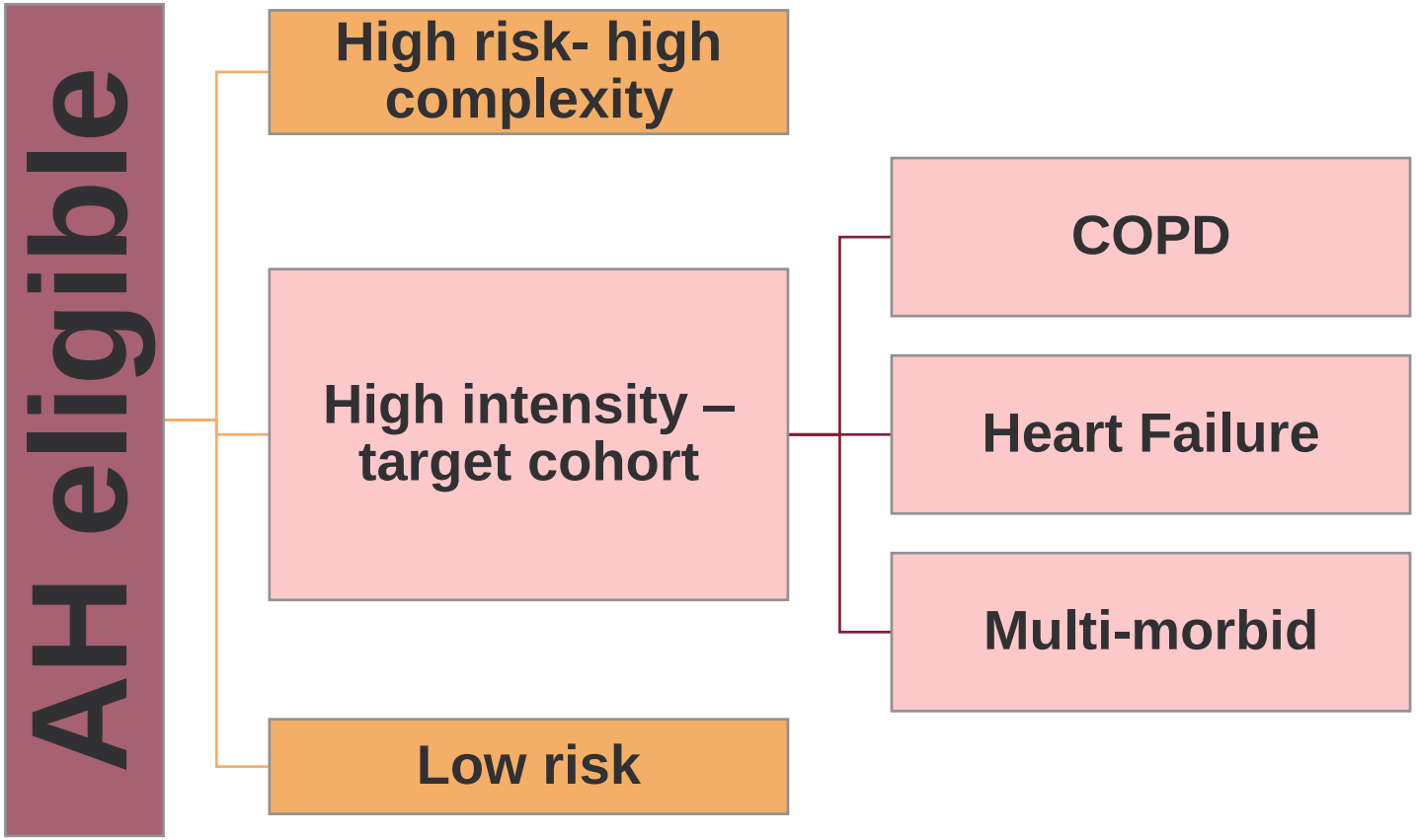
theAlfred

Caulfield HOSPITAL

Sandringham HOSPITAL

MSHC MELBOURNE SEXUAL HEALTH CENTRE

Alfred Health Intervention HLCC cohorts



1st Intervention Group - Chronic respiratory Disease

200 patients with COPD in eligible pool - aim for 15% reduction in predicted avoidable hospital attendance:

- Develop pathways to enable rapid access to non acute services
- Earlier management of deterioration
- Proactive prevention of avoidable hospital attendance through:
  - ✓ Bolstering the HARP/HIP approach
  - ✓ Proactive involvement of GP
  - ✓ Specialist Medical review
  - ✓ Partner with community based services/primary care

- NB: Intervention groups are COPD and Heart Failure and subsequently Multi Morbid within eligible cohort
- Concurrent HARP redesign

Model of care

Principles:

- Build upon existing work
- Develop the initiative gradually and adjust as we learn(PDSA)
- Create pathways between services for right care, at right time, in right place

The initiative:

- COPD and Heart failure cohort - use of care bundles to drive evidence base care
- Bundle mandates referral to HARP
- HARP redesign occurring simultaneously
  - Person centred teams - 'bespoke' – team wraps around the person rather than person "fitting into a team".

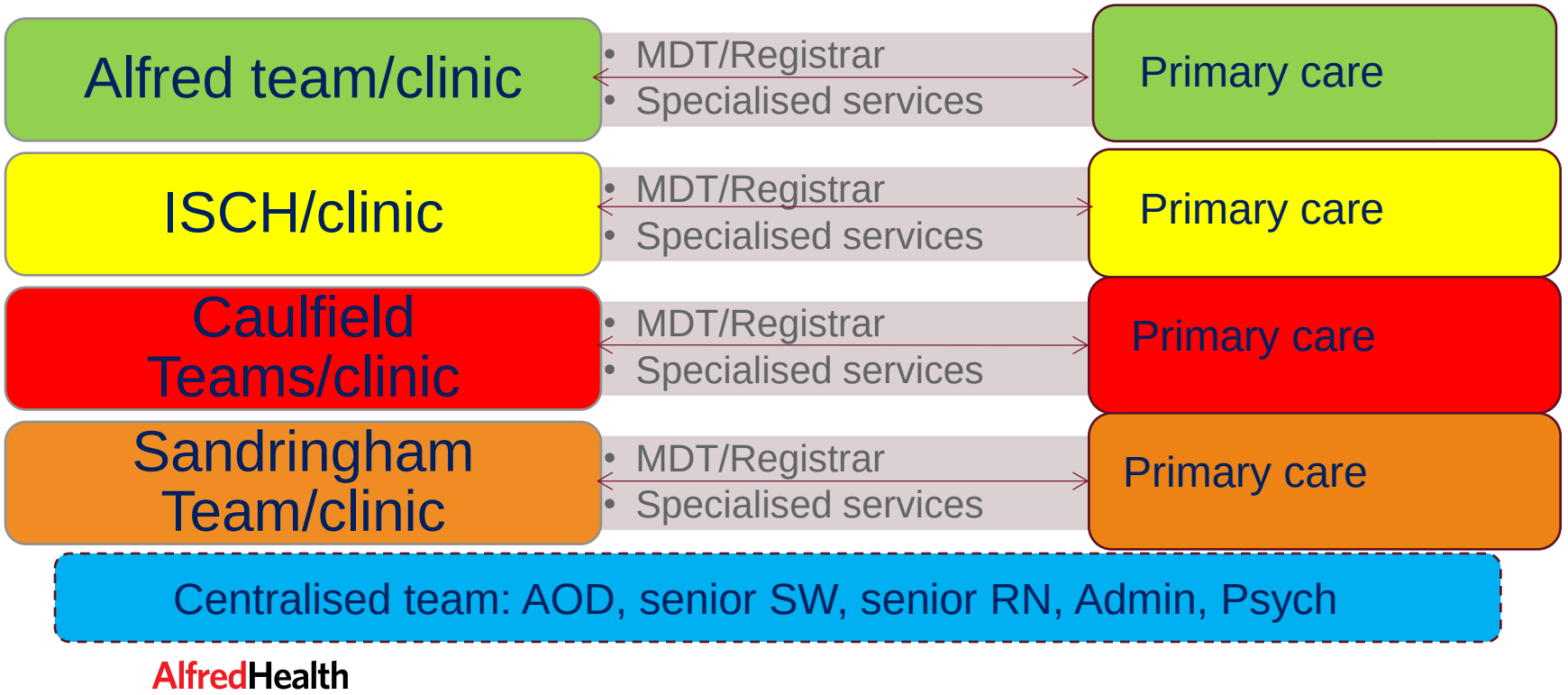
Model of care

HLCC/HARP intervention:

- 72 post discharge phone call
- Comprehensive assessment
- Structured disease specific rehab programs;
- Home or clinic based model with integration into GP chronic disease mgt. care plan
- All clients are linked to one of 4 site based teams
- HLCC Consultant & HLCC registrar
- Rapid response clinical out-reach
- Patient pathways to sub-acute services
- Integrated approach to delivering Community based services

HealthLinks – HARP model

- 4 site based teams each linked to a General Medicine clinic
- Centralised team of specialised clinicians (resource for all HARP)
- HLCC Consultant and Registrar
- Book end model with care delivered along continuum from Primary Care to Acute



Challenges and Opportunities

Identifying eligible and enrolled cohort

- Integrating the DHHS algorithm into hospital data base to rapidly identify eligible patients
- Manual process of client detection through health records system

Opportunities

- Opportunity to strategize about how to deliver care differently across program areas
- Strengthening clinical support for vulnerable client cohorts in the community
- Opportunity to partner with clients and stakeholders in the development of services
- Strengthening engagement with Primary Care
- Foundational work for further development
- Enhances quality of care integration across the continuum