

# Mainstreaming HARP



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# Hospital Admission Risk Program

## A Community Perspective

*In my experience, this is the first hospital admission reduction program that is driven by the needs and requirements of the client. The outcome is a program that is developing a model for the continuity of client care that bridges service gaps and eliminates boundaries. The benefits to the community and health sectors are also exciting.*

Manager  
Community Health Service

# Implementation of HARP

- Governance arrangements
  - HARP Reference Group
- Establishment of a knowledge base
  - Implementation of about 90 projects
  - HARP background paper
  - 7 HARP working parties
  - Independent evaluation
- Investment
  - Approximately \$150m over 4 years

# Key Achievements of HARP

- Reduction in hospital utilisation
- Ambulatory models of care tested
- Integration of acute and community based services
- Effective engagement of GPs to support continuity of patient care
- Better patient management systems identified

# Creating a symphony



# Mainstreaming HARP

- Motivations
- Enablers and challenges
- Governance



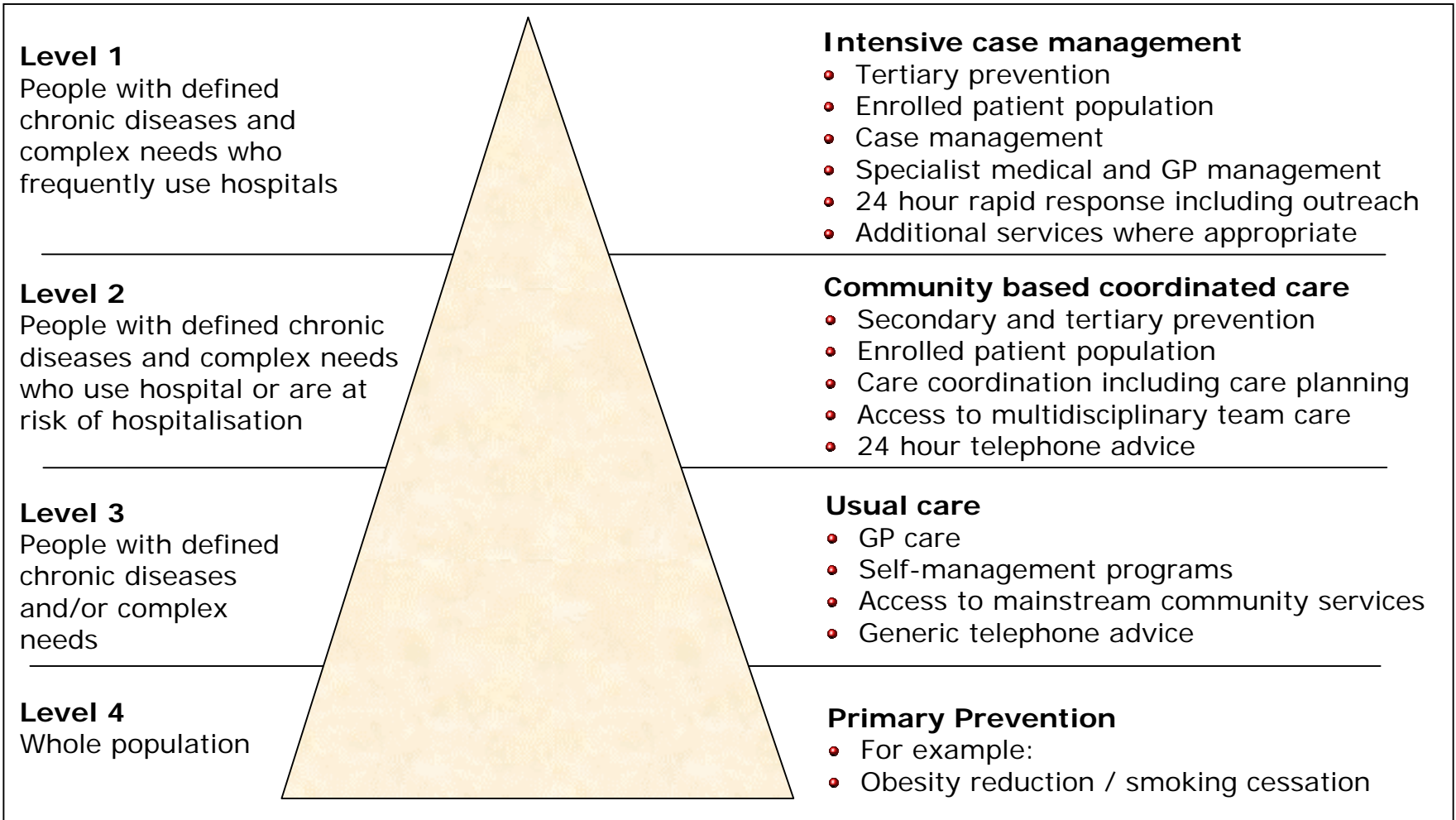
# Motivations for mainstreaming



# Project clusters

Chronic and Complex Care Program	\$34.1 m
Diabetes	\$4.3 m
Respecting Patient Choices	\$0.8 m
Remote Patient Monitoring	\$0.4 m
ED Care Coordination	\$5.2 m
Mental Health Initiatives in EDs	\$2.0 m
General Practice Liaison Officers	\$1.7 m

# Chronic Disease Management



# Client case study – Mrs Mc

- 65 year old woman with severe COPD, CHF, osteoporosis, cataracts
- 4 admissions in 12 months
- Not attending GP or Outpatients
- General assessment undertaken by care facilitator
- Client educated about disease and a care plan developed in consultation with GP and principal carer (daughter)
- Encouraged to visit GP, medication review undertaken by care facilitator and GP
- Client accepted Community Aged Care Package and now attends GP regularly and uses action plan

# Enablers and challenges

## Enablers:

- Local Alliances
- Workforce
- Funding
- Technology
- Evidence
- Change management

## Challenges:

- Change of focus
- Organisational culture

# Governance

- Victorian Chronic and Complex Care Program Reference Group
- Local Alliances
- Fund holding and management
- Performance Management System

# Local Alliances

- Shared vision
- Purpose and objectives
- Roles and responsibilities
- Partnering structures and processes
- Resource allocation arrangements
- Performance monitoring and review processes
- Communication and consultation processes
- Risk management
- Quality management

# Priority action areas

- Develop effective governance framework
- Communicate a shared vision
- Align planning processes
- Develop performance management systems
- Facilitate change
- Learn from and disseminate results

# Conclusion

- Victorian government will continue to work with the sector to:
  - Improve health outcomes for people with chronic and complex care needs
  - Promote more effective use of hospital and community resources

