

HARP Funded Projects 2002–2003

Name of Project	Project Objective	2002–2003 Funding	Project Contact Email and Phone
AUSTIN & REPATRIATION MEDICAL CENTRE (ARMC)			
Community Link Rapid Response Service	Establish a rapid response service for older people presenting to the ARMC ED, Banyule, Darebin or Eltham Community Health Centres or local GPs and implement case management strategies for each individual.	\$440,769	Allison Harle Allison.HARLE@armc.org.au 9496 5343
An Integrated Approach to Chronic Disease Management	Expand the existing ARMC Respiratory Outreach Service for patients with COPD, incorporate the management of CHF within the program and complement and expand the program through the integration and collaboration of community services.	\$404,191	
Improving Diabetes Care	Provide a patient-focussed care program for people living in the north-east region of Melbourne with diabetes who are at high risk of admission to hospital.	\$372,512	
BALLARAT HEALTH SERVICES			
Targeting Care Management Across the Continuum	Enhance the working partnership between Ballarat Health Services and primary care providers to improve health outcomes for people with COPD and CHF.	\$254,494	Dr Ian Graham IanG@bhs.grampianshealth.org.au 5320 4279
BARWON HEALTH			
Chronic and Complex Disease Assertive Case Management	Assist people with chronic or complex care needs who frequently use Barwon Health ED to live healthier lives, through case management involving all needed health and social strategies.	\$640,981	Anna Fletcher annaf@barwonhealth.org.au 5226 7573
BAYSIDE HEALTH			
Better Care for Older People Project	Provide a comprehensive community-based support program for older frail and chronically ill people focusing on cardiovascular and pulmonary disease, cancer, diabetes and mental illness.	\$1,526,890	Philip Cornish p.cornish@cgmc.org.au 9276 6708
BENDIGO HEALTH CARE GROUP			
Managing Respiratory Disease to Reduce Hospital Demand	Improve patient outcomes and reduce ED presentations through implementation of a respiratory disease management model that provides seamless care management across the continuum of care.	\$133,980	Dr John Ferguson Jferguso@bendigohealth.org.au 5454 7553
DIANELLA COMMUNITY HEALTH SERVICE			
A Community Approach to Paediatric Asthma Management	Improve health outcomes for children with asthma and their families who have been regular users of the Royal Children's Hospital.	\$289,250	Debra O'Connor debra.oconnor@dianella.org.au 8345 5678
DJERRIWARRH HEALTH SERVICES			
A Chronic Disease Approach to COPD, Asthma & Cardio Vascular Disease in the Outer West	Prevent admissions and readmissions to Western Health and Ballarat Health Services by introducing chronic disease self-management programs in Melbourne's outer western growth corridor.	\$104,315	Judy Gregurke judy@mchc.com.au 9747 0700
EASTERN HEALTH			
Primary Care Liaison Project	The Eastern Health GP Liaison Team will ensure effective communication and coordination around discharge planning, HITH admissions, HARP and HDM strategies.	\$235,880	Alina Tooley ahproject@knoxdiv.com.au 9720 2044
Rapid Outreach Response	Provide a multidisciplinary rapid assessment response to frail, older clients who have experienced a significant increase in dependency as a result of their medical status.	\$478,494	Moyra Kwan Moyra.Kwan@peterjames.org.au 9881 1875
Client Focussed Integrated Disease Management	Establish an integrated disease management approach to the care and treatment of clients with COPD and CHF.	\$328,280	Penny Newsome penny.newsome@maroondah.org.au 9871 3340 Andrea McCance andrea.mccance@boxhill.org.au 9895 3439
Community Hospital Integrated Response Program (CHIRP)	Enhance the interface between ED and primary health care providers and ensure that clients are better managed in the community.	\$293,200	Evie Soldatos esoldatos@wchs.org.au 9890 2220
Complex Care for Older Patients	Improve outpatient support and care for older clients with complex medical conditions who are at risk of readmission and extended length of stay.	\$130,350	Dr Lee Hamley Lee.Hamley@boxhill.org.au 9859 3269
GOULBURN VALLEY HEALTH			
Rural Ambulatory Care and Evaluation (RACE) for Chronic/Complex Disease Management	Enhance the health status and well-being of people with complex and chronic disease, such as CHF, diabetes and COPD.	\$278,571	Brian Cole brian.cole@gvh.humehealth.org.au 5832 2737
LATROBE REGIONAL HOSPITAL (LRH)			
Prevention of Avoidable Emergency Presentations	Prevent or reduce the ED presentations to LRH of elderly people by connecting them to appropriate community and GP services.	\$350,953	Dr Peter Sloan psloan@lrh.com.au 5173 8351
MELBOURNE DIVISION OF GENERAL PRACTICE			
Diabetes Clinical Co-management in General Practice/the Community	Extend the role of the GP and the Credentialed Diabetes Nurse Educator in the management of people with diabetes and complex needs in the community.	\$623,701	Dr Ralph Audehm ralph@mdgp.com.au 9306 8921
MELBOURNE HEALTH			
Improved Community Management of People with COPD	Support patients with COPD and their carers by working with GPs and community health service providers to identify and assess people at risk of developing COPD.	\$303,270	Don Campbell Donald.Campbell@mh.org.au 9342 2176
An Integrated Model of Care: Severe Diabetes Related Foot Conditions	Improve the health and independence of people with severe diabetes-related foot conditions by providing specialist podiatry services, improving links with community services and improving training and support for community health service providers and GPs.	\$195,358	Peter Colman Peter.Colman@mh.org.au 9342 7428
Improved Capacity of ED to Meet the Needs of Mental Health Patients	Increase capacity in the ED by addressing the discharge block currently affecting acute psychiatric inpatient beds by providing step-down accommodation and clinical supervision for mental health inpatients.	\$508,872	Chris Gibbs Chris.Gibbs@mh.org.au 9342 8765
Improved Capacity of ED to Meet the Needs of Frequent ED Attenders with Psychosocial Needs	Provide more appropriate care to people with complex psychosocial needs who present to EDs, often associated with mental health and/or alcohol and drug problems, homelessness, social isolation and acute or chronic medical problems.	\$132,270	Chris Gibbs Chris.Gibbs@mh.org.au 9342 8765
A Community/Hospital Team Approach to Falls Prevention	Develop and implement an integrated model of falls risk management across the community and hospital sectors, targeting people who present to the Royal Melbourne Hospital ED due to a fall.	\$125,100	Caroline Brand Caroline.Brand@mh.org.au 9342 8772 Allan Mclean a.mclean@nari.unimelb.edu.au 9342 2224

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NORTHERN DIVISION OF GENERAL PRACTICE			
Asthma Best Practice Model	Improve post-discharge asthma care and health outcomes for children and adults with asthma presenting to the Northern Hospital ED.	\$165,643	Phillip Bain phillip.bain@ndgp.org.au 9416 7689
NORTHERN HEALTH			
Northern Health Aged Care Outreach Service	Develop a multidisciplinary service model with community and residential care providers that will increase the capacity of the local health system to respond to the needs of older people with chronic or terminal illness.	\$651,249	Anne Fox anne.fox@nh.org.au 9261 3153
Chronic Obstructive Pulmonary Disease Project	Develop an ongoing, community health centre-based program to address the physiological and psychological needs of people with COPD.	\$48,946	Assoc Prof Bruce Jackson bruce.jackson@nh.org.au 9219 8000
After Hours Medical Services	Establish a separate after-hours primary care facility adjacent to the Northern Hospital ED. The new facility will be staffed by GPs who will assist the increasing number of Category 4 and 5 patients.	\$195,633	Dr Ian Carson ian.carson@nh.org.au 9219 8021
Aged Care Shared Care Model	Develop and pilot a shared care arrangement for elderly people, involving GPs, which will provide high quality community, inpatient and post-discharge care to older people to assist them to live as independently as possible.	\$396,012	Maree Cuddihy maree.cuddihy@nh.org.au 8345 5802
Diabetes Disease Management	Develop clearer and more streamlined referral and entry to diabetes care services at Broadmeadows Health Service for clients, GPs and other referrers, to create better pathways and deliver greater continuity of care.	\$255,489	Maree Cuddihy maree.cuddihy@nh.org.au 8345 5802
Bundoora Extended Care Centre GP Liaison Initiative	Enhance clinical practice and improve communication processes in relation to the needs of older people with complex needs by targeting the interfaces between GPs, sub-acute, hospital, residential care, ACAS and primary care settings.	\$159,166	Dr Michael Dorevitch michael.dorevitch@nh.org.au 9261 3100
PENINSULA HEALTH			
Self Managing CCF	Improve the quality of life for CCF patients admitted to hospital by involving them in a disease management program, employing a multidisciplinary interventional approach and interacting with community providers, including Primary Care Partnerships and Mornington Peninsula Division of General Practice.	\$253,820	Dr Peter Bradford Pbradford@phcn.vic.gov.au 9784 7687
Diabetes Disease Management Model	Develop a partnership approach between individual clients and health practitioners, to managing diabetes within the community. Diabetes educators will work with clients to develop and implement self-care plans.	\$179,000	Rob Macindoe Rmacindoe@phcn.vic.gov.au 9784 8145
Increased Coordination Between Psychiatric Services and Primary and Tertiary Services	Improve the health and welfare outcomes of patients with drug and alcohol and mental health issues by providing support in the acute environment and improving access to community-based treatment services.	\$400,960	John Wigan Jwigan@phcn.vic.gov.au 9784 7593
PLENTY VALLEY COMMUNITY HEALTH SERVICE			
Northern Alliance Suicide and Self Harm Prevention	Develop a coordinated system of care for adolescents and young adults who are experiencing mental health problems, self-harming behaviour or are abusing drugs and alcohol.	\$259,581	Gabrielle MacTiernan gabrielle.mactiernan@pvchs.org.au 9408 6333
ROYAL CHILDREN'S HOSPITAL			
Care Coordination Project for Children with Complex and Chronic Conditions	Expand a care coordination process for families whose children have complex and chronic conditions which result in frequent attendance at the Royal Children's Hospital.	\$80,428	Christine Minogue minogue@cryptic.rch.unimelb.edu.au 9345 5695
ROYAL DISTRICT NURSING SERVICE			
Reducing Medication Related Emergency Presentations and Admissions	Increase the use of the Domiciliary Medication Management Review with at-risk elderly clients (65+) in the Frankston Hospital catchment area.	\$86,965	Martin Wischer mwischer@rdns.com.au 9536 5225
ST VINCENT'S HEALTH			
Restoring Health: Joint Partnerships to Challenge Chronic Disease	Provide a coordinated self-management program for COPD, CHF and diabetes which ensures patient empowerment, optimal medical management, education, exercise and the support necessary to maintain wellbeing and manage chronic disease in the community.	\$790,599	Silvio Pontonio PONTONS@svhm.org.au 9288 2132
Holding it Together: Client Led Care in Mental Health, Drug and Alcohol and Homelessness	Provide a flexible response between the ED, inpatient and outpatient services and community agencies to assess the complex needs of patients who self-harm, have a history of drug and alcohol problems, homelessness and/or mental health conditions that are not within the scope of specialist mental health services.	\$557,160	
Treating the Elderly in the Right Place: Facilitating Appropriate Community Care	Establish an integrated system that has the capacity to provide comprehensive assessment and coordination of services from a centralised hub, including access to a suite of service options including acute, sub-acute and post-acute.	\$517,007	
Coach Program	Empower patients to recognise and effect change in their individual coronary risk factors through partnership with a health professional coach and their GP.	\$209,918	
SOUTHERN HEALTH			
Care in Context	Provide a range of interventions that identify and better manage complex conditions outside of acute settings, including earlier assessment, risk profiling, improved triage protocols, care coordination and a widely accessible, multi-agency care plan.	\$948,215	Peter Faulkner p.faulkner@southernhealth.org.au 9265 1351
Management of Chronic Respiratory Conditions	Improve quality of life of patients with chronic respiratory conditions, including improving the links between the acute hospital setting and GPs, community rehabilitation centres, community health centres and other community providers.	\$314,098	Dr Lakshmi Sumithran l.sumithran@southernhealth.org.au 9554 1155
WESTERN HEALTH			
Western Health Admission Risk Management System (WHARMS): Chronic Disease Management	Early identification, timely intervention and appropriate management of patients with chronic conditions such as CHF, COPD and asthma across the continuum of care.	\$591,063	Jon Evans Jon.Evans@wh.org.au 8345 0306

List of Acronyms

ACAS	Aged Care Assessment Service	ED	Emergency Department
CCF	Chronic Cardiac Failure	GP	General Practitioner
CHF	Chronic Heart Failure	HDM	Hospital Demand Management
COPD	Chronic Obstructive Pulmonary Disease	HITH	Hospital in the Home