

Peninsula Complex Care Program

Integrating Disease Management

A “*Sea Change*” for
Peninsula Health



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Building a **Healthy Community**



Presentation Overview

1. Projects in operation prior to Complex Care
2. SWOT analysis
3. Process of integration and managing change
4. Results – successes and issues identified to date



A brief history...

- Peninsula Complex Care – HARP funded initially
- Program proposal included:
 - The integration of existing HARP funded projects at Peninsula Health
 - Implementation of service provision specific to clients with chronic conditions and/or complex needs



Peninsula Complex Care Program



PENINSULA HEALTH

Aims

- ◆ Improve client's quality of life
- ◆ Improve health outcomes for clients
- ◆ Improve the management of chronic conditions
- ◆ Provide a care coordination service in the community
- ◆ Facilitate integration of services for clients with complex needs
- ◆ Identify service gaps

Process

1. Client referred to Complex Care
2. Initial screening to ensure eligibility
3. Comprehensive assessment (usually in the client's home)
4. Client centred care planning (often in collaboration with GPs)
5. Care Coordination including provision of specific education and/or referral to other service providers

All Clients Receive

- ◆ Empowerment to increase their self-management skills
- ◆ Care planning directed at their own specific goals
- ◆ Advocacy – care coordinator able to attend GP appointments to facilitate completion of care plan
- ◆ Links to community health and other resources
- ◆ Specific information/education regarding their chronic disease
- ◆ Opportunity to attend either Health Self Management Course

HOURS: 0900 – 1700 Monday to Friday

CONTACT: Single point of entry for all streams

Phone: 9784 7353 Intake number: 0419 397 527

Diabetes

Eligibility:

Two or more presentations to Peninsula Health in the last 12 months with diabetes related illness; clients with difficulty managing diabetes-related complications.

Services:

- ◆ Comprehensive and holistic assessment
- ◆ Disease education and information
- ◆ Service coordination - assist with service engagement and referrals for general health needs
- ◆ Telephone monitoring and support



Chronic Heart Failure

Eligibility:

All risk of presentation to Peninsula Health with diagnosis related to chronic heart failure; evidence of a recent echocardiogram confirming CHF

Referrals:

Received from general practitioners, cardiologists and acute hospital staff

Services:

- ◆ Comprehensive and holistic assessment
- ◆ Multidisciplinary outpatient clinic
- ◆ 10 week heart failure rehabilitation (strong education focus)
- ◆ Heart failure maintenance group (seaside group post rehab)
- ◆ Service coordination - assist with service engagement and referrals for general health needs
- ◆ Telephone monitoring and support (including specialist Pharmacy review)



General Complex Needs

Eligibility:

Six or more presentations to Peninsula Health Emergency (Frankston or Rosebud) within the last 12 months.

Exclusion criteria:

Psychiatric case manager or living in residential care.

Services:

- ◆ Comprehensive and holistic assessment
- ◆ Service coordination - assist with service engagement and referrals for general health needs
- ◆ Telephone monitoring and support



Chronic Respiratory

Eligibility:

Six or more presentations to Peninsula Health Emergency (Frankston or Rosebud) within the last 12 months; diagnosis of a chronic respiratory illness.

Services:

- ◆ Comprehensive and holistic assessment
- ◆ Respiratory education and development of respiratory action plan (may include standing appointment with specialist)
- ◆ Service coordination - assist with service engagement and referrals for general health needs
- ◆ Telephone monitoring and support



Drug and Alcohol

Hospital Liaison

Presentations to Peninsula Emergency Department with primary or secondary diagnosis related to substance use issues

Services:

- ◆ Staff education
- ◆ Withdrawal management
- ◆ Harm minimisation strategies
- ◆ Family support
- ◆ Secondary consult for staff
- ◆ Review and renewal of patient policies for client management
- ◆ Referral to community based DSA services or Community Liaison

Community Liaison

Eligibility:

Six or more presentations to Peninsula Health Emergency (Frankston or Rosebud) within the last 12 months; diagnosis relating to substance use


Services:

- ◆ Comprehensive assessment
- ◆ Short term drug & alcohol care planning
- ◆ Assist with service engagement and referrals for general health needs
- ◆ Provision of secondary consultation to other general care coordinators



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Established HARP Projects



**Chronic
Heart
Failure**



Diabetes



**Drug &
Alcohol**

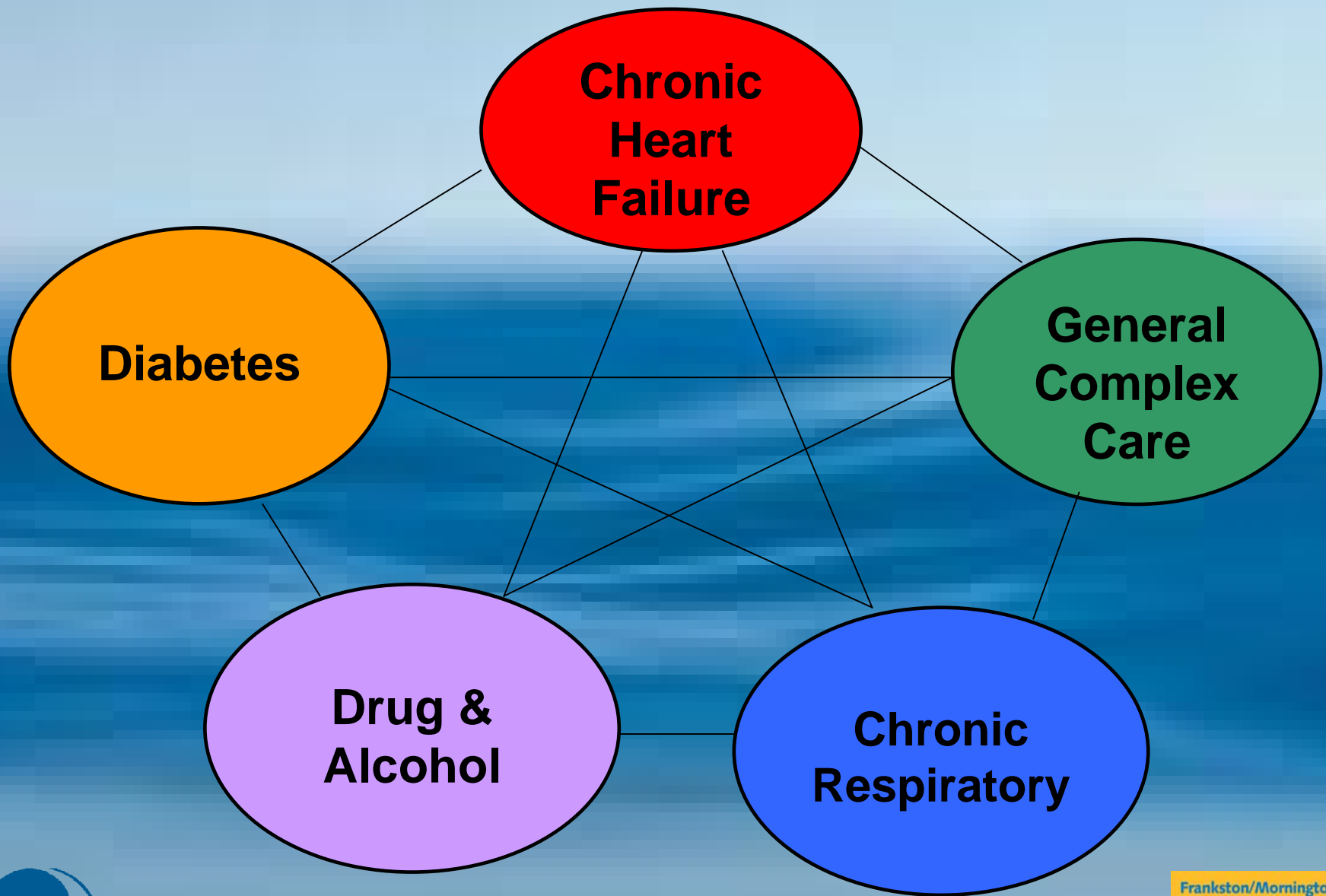


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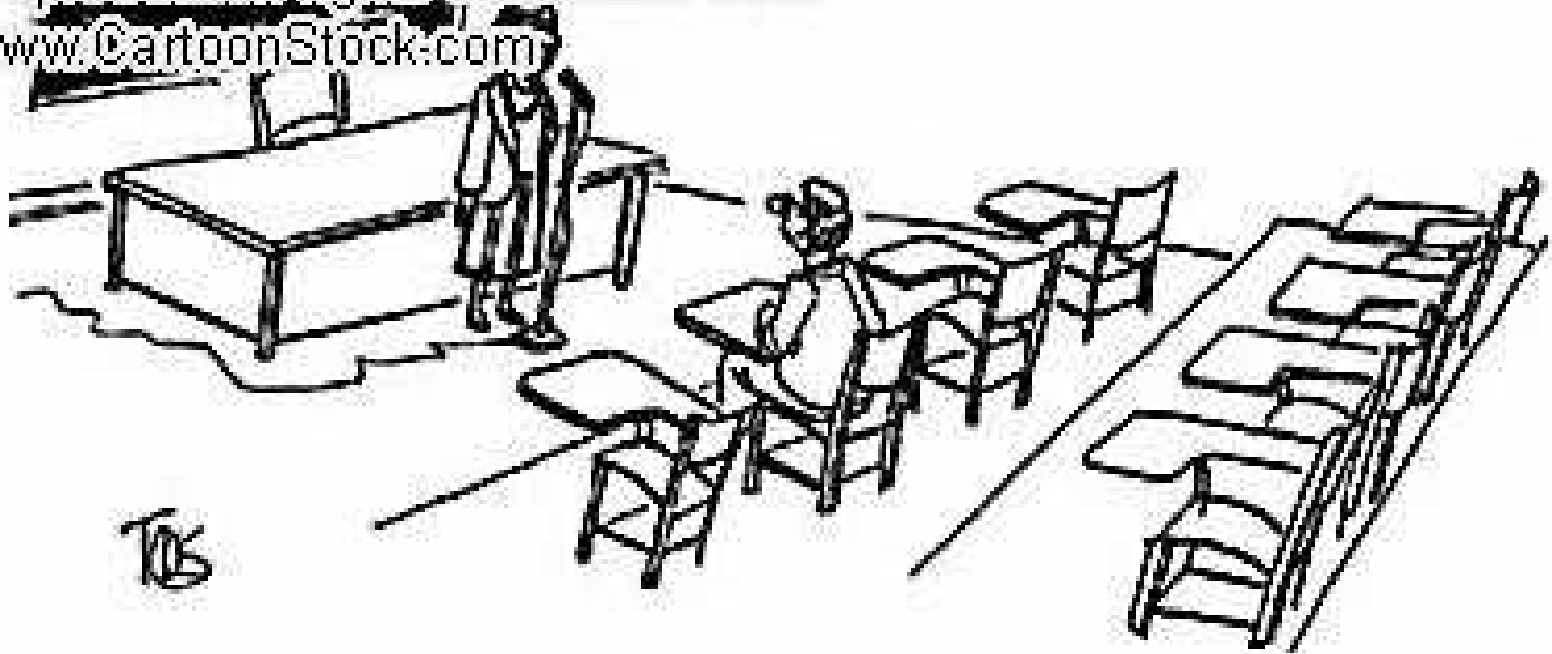
Service Integration

1. Diabetes Management
 2. Chronic Heart Failure Management
 3. Drug and Alcohol Hospital Liaison
- +
4. General Complex Care
 1. COPD Stream
 2. Frequent attenders (6+ presentations)
 3. Drug and Alcohol Community Liaison





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"Of course, the first rule of effective management is active participation."



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Frankston/Mornington Peninsula



Primary Care Partnership

SWOT Analysis

STRENGTHS

- Commitment from executive level
- Funding and resources
- Acknowledgement of action research
- Needs analysis outlining current demands
- Staff familiar with organisation and client cohort
- Staff trained in self-management philosophy



Maximising the strengths

- Regular meetings with executive to inform of progress
 - HARP Steering Committee
 - Complex Care Program Management Committee
- Funding allocated to the procurement of experienced professionals and adequate resources
- All staff trained and reviewed in Flinders Self Management Tools



SWOT Analysis

WEAKNESSES

- Duplication of documentation
- Lack of systems integration
- Physical location (lack of space)
- Inefficient IT systems

Addressing the weaknesses

- Developed standard client documentation
- Integrated all data capturing systems
- Secured appropriate site as a base for all staff
- Developed new database
- Staff trialling e-referral systems

PENINSULA HEALTH



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SWOT Analysis

OPPORTUNITIES

- Integration with community health
- Disseminating the self-management philosophy
- Changing viewpoint of current health care services
- Team formation
- Further develop links with tertiary institutions



Exploiting the opportunities

- Providing client services in conjunction with community health
- Communication plan developed and implemented
- Close links established ED (RAD) and psychiatric services
- Staff trained in Better Health Self-Management

SWOT Analysis

THREATS

- Feasibility of ongoing funding
 - Job security
- Resistance to change
 - Inter-organisational
 - Individual
- Acquiring suitably trained staff given general lack of human resources in health care



Eliminating the threats

- Medical records – systematic procedure developed
- Ongoing funding secured
- Strong links with new CH funding
- Consultative process
- Communication plan
- Focus on the patient/client



Service Integration

- One on one meetings with current staff
- Familiarisation with current policy directions
- Team planning sessions
- Shared resource room

Service Integration - difficulties

- Redefining existing services
- Developing new service/team model that will be sustainable
- Organisational wide impact of service change

Service Integration - successes

- Single point of entry/referral
- Majority of team now co-located
- Standard documentation and evaluation processes implemented
- Generic program guidelines developed

TEAMS DON'T JUST
HAPPEN –
They require
conscious, skilled,
creation



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Primary Care Partnership

Results to Date - Diabetes

- Bearing Point Report
- Currently investigating a new model of care incorporating potential systems review
- Impact on the acute sector:
 - Reduced ED presentations
 - Reduced inpatient separations
 - Reduced number of bed days
 - Reduced length of stay
 - Small reduction in HbA1C levels (not significant)



Results to Date – Chronic Heart Failure

- Bearing Point Report
- Cardiac Failure Rehabilitation Evaluations
- Impact on acute sector:
 - Reduced ED presentations
 - Reduced inpatient admissions
 - Reduced number of bed days
 - Average LOS over the project:
 - » State: 5.02 – 5.50
 - » PH: 5.39 – 5.34



Results to Date – Drug & Alcohol

- Bearing Point Report
- Currently looking at model expansion
- Impact on acute sector:
 - Reduced number of bed days
 - Reduced LOS

Results To Date Complex Care (n=68)

Reductions in:

- ED Presentations: 36%
- Inpatient Admissions: 51%
- Bed Days used: 63%
- Length Of Stay: 32%



Program Successes

- Better Health Self-Management Courses
- Regular newsletter
- Comprehensive orientation program
- Risk Assessment Tool
- “Open Day” November 2004

Issues currently being addressed

- Co-location on the Southern Peninsula
- Organisational-wide education sessions
- Data management
- Ongoing evaluation management



