HARP/ PRIMARY CARE INTEGRATION

HARP Background

Funded 2002, operational 2003

Program streams:

Chronic and complex case management

IDM – CHF, COPD,

Profile HARP Team

Multidisciplinary Team (16 EFT) incorporating:

Registered Nurses Division 1/3

Social Work

Psychologist

Physiotherapy

Occupational Therapy

Dietician

Clinical Analyst

Cardiologist (clinic) Pharmacist

and our *Volunteers*

Model of Care

- Client centred “assertive” case management based upon a self management framework
- Ulitilisation of Clinical Guidelines
- Link to large range community based supports based upon assessed needs
- Encourage appropriate use of GP, hospital and other services

- Client advocacy
- Multidisciplinary care plans
- Ongoing monitoring and review
- Management plans for maintenance
- Structured programs, community based clinics

Most importantly is the need for a flexible service response

Integration

- *Basically we were trying to fit a round peg into a square hole*

Issues, solutions and outcomes

What we found

A diversity of services funded under different policy parameters

Multiple entry and exit points

Lack of clarity around roles

Differences in philosophical approaches

Existing organizational change

Development of Multidisciplinary Care Framework

Key principles:

Assessment of need

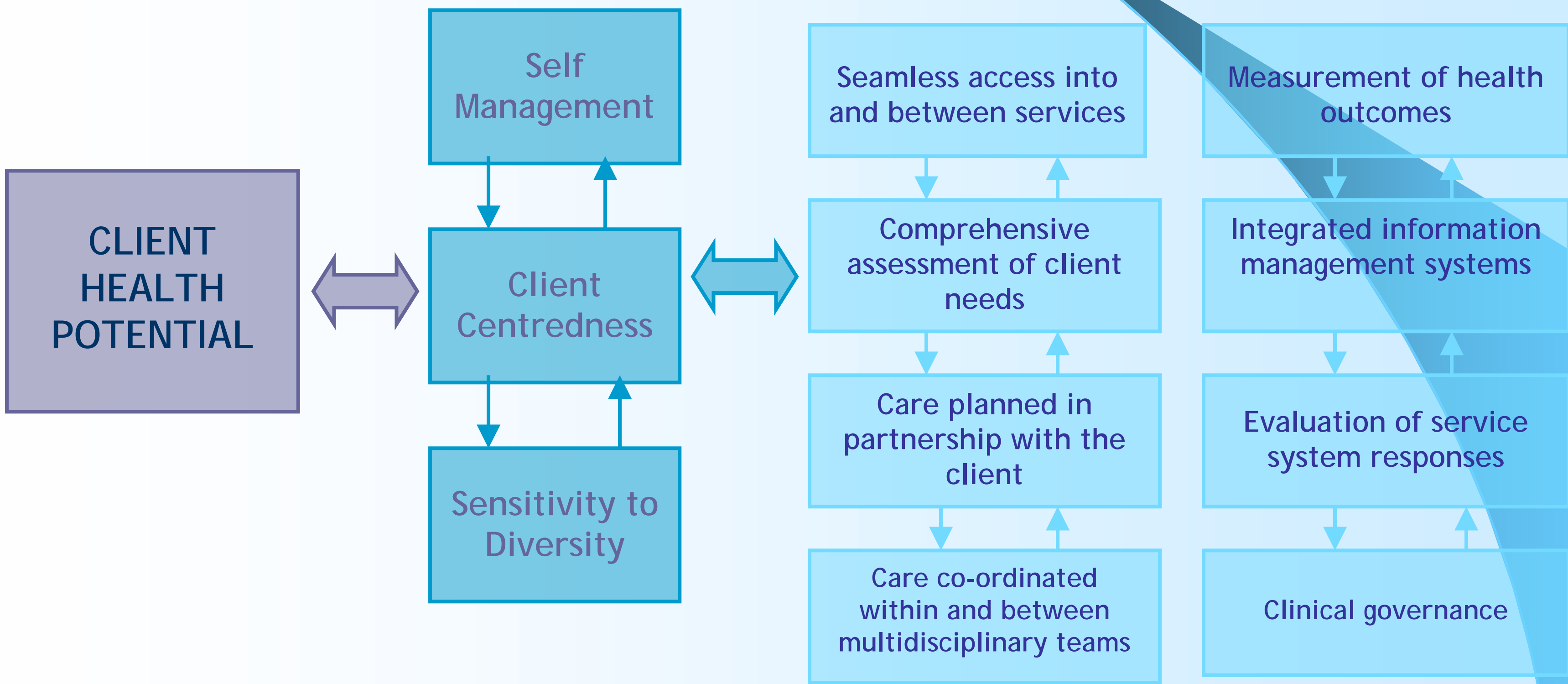
Key worker assigned

Care or treatment plan

Service intervention and follow-up according to outcomes of intervention

PARTNERS FOR HEALTH: OVERVIEW

HEALTH PROMOTING PRACTICE



MULTIDISCIPLINARY CARE

Barwon Health

Moving from…

The Greyhound Paradigm

"We'll do the driving for you"

Barwon Health

To…

The Hertz Paradigm

"We'll put you in the driving seat"

NCDS Workshop 2005

The Framework supports, through the Community Health :Assessment, Care and Evaluation Guidelines (CHACE)- *THE HOW TO*

Individual practice – self management, engagement, CALD

Services/Systems -

THESE REPRESENT

Access into and between services

Comprehensive access of consumer needs

Care planned in partnership with consumers

Care co-ordinated with & between interdisciplinary teams

Measurement of health outcomes

Integrated information systems

Evaluation of service system response

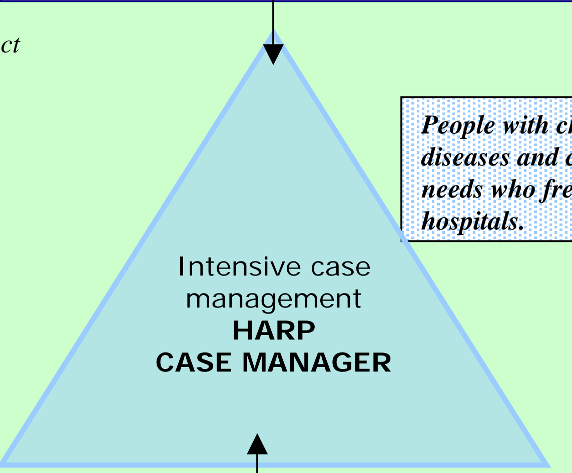
Clinical governance

BARWON HEALTH CHRONIC & COMPLEX CONDITIONS: INTEGRATED CHRONIC CARE MODEL

Referral from acute & sub-acute wards & Emergency Department

All levels of care reflect recognised Clinical Management Guidelines

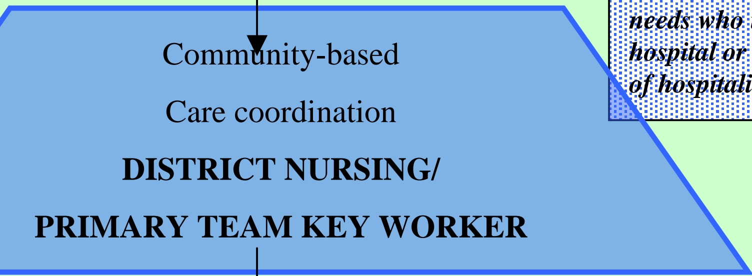
Common Processes across all levels of care:
- *Intake*
- *Assessment*
- *Care Planning*
- *Review*
- *Progress Record*
- *Care management*
- *Outcome measures*



Intensive case management
HARP
CASE MANAGER

People with chronic diseases and complex needs who frequently use hospitals.

INTENSIVE COMMUNITY CASE MANAGEMENT:
- Case management via identified Care Plan in collaboration with GP / medical / other plans of care.
- Clinical interventions to support plan of care
- Supported by condition specific focussed service activities
- Secondary consultation across all levels of care
- Transitional / co-Case Management between levels of care



Community-based

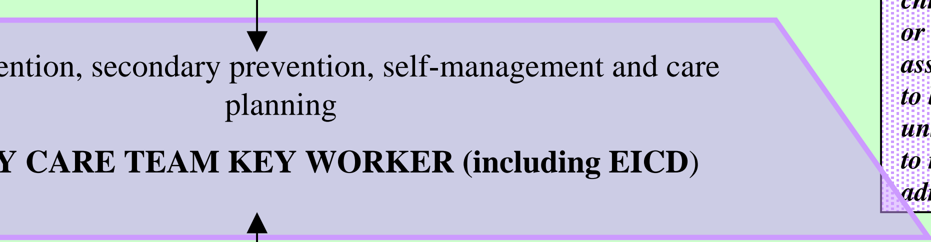
Care coordination

DISTRICT NURSING/

PRIMARY TEAM KEY WORKER

People with chronic diseases and complex needs who use hospital or are at risk of hospitalisation.

COMMUNITY BASED CARE COORDINATION:
- Care co-ordinated through Key Worker via identified Care Plan in collaboration with GP / medical / other plans of care.
- Multidisciplinary clinical interventions to support Care Plan across all levels of care
- Transitional / co-Case Management between levels of care



Early intervention, secondary prevention, self-management and care planning

PRIMARY CARE TEAM KEY WORKER (including EICD)

People with chronic disease or complex needs assessed as likely to become unstable leading to risk of hospital admission

USUAL CARE:
- Identified Community Health entry point
- Assessment, care planning & interventions co-ordinated by Key Worker in collaboration with GP / other plans of care
- Individual and group-based service interventions
- Condition-specific and ‘generic’ clinical service actives (smoking cessation, nutrition, physical activity, managing anxiety & depression)

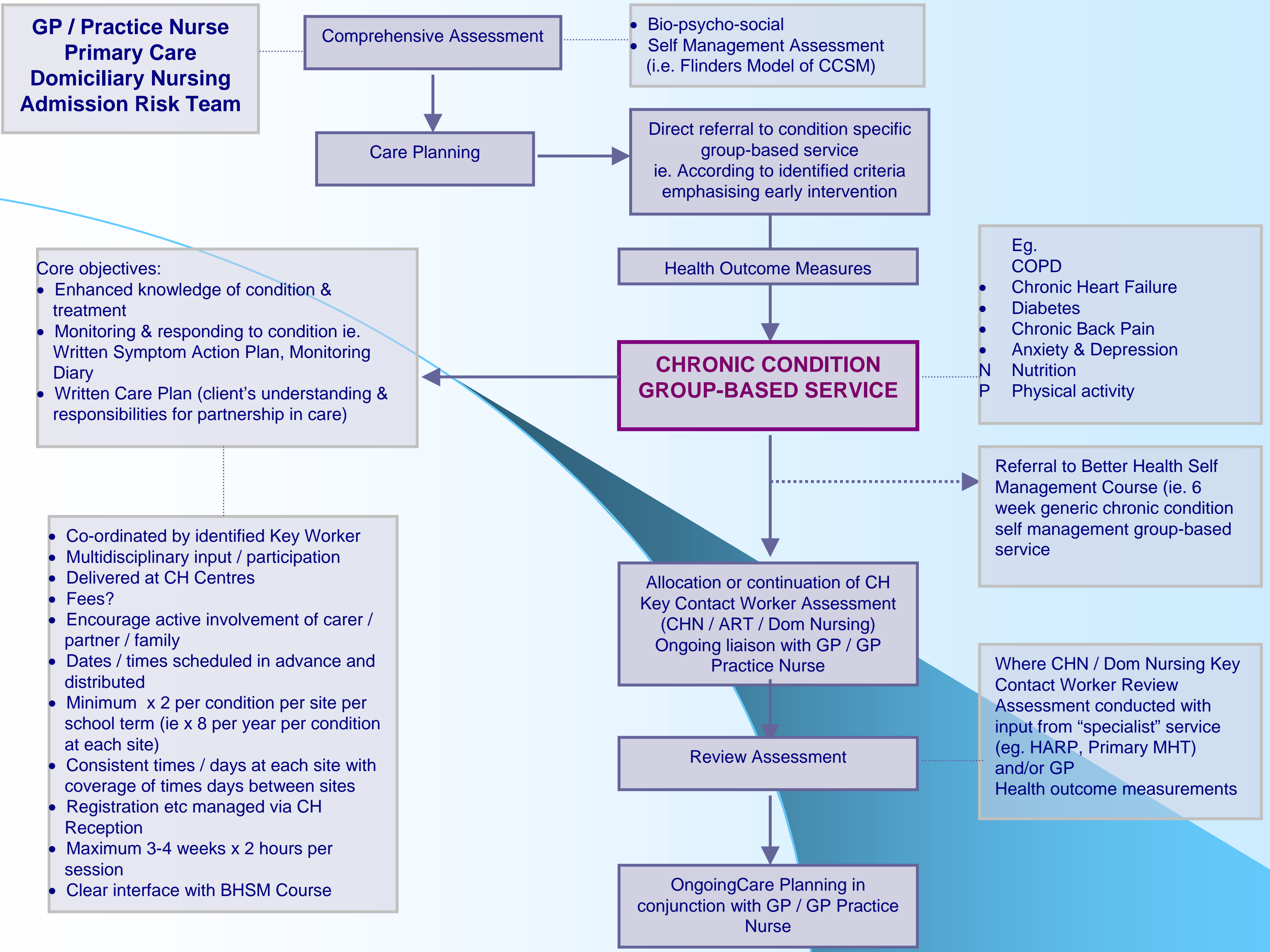
Referral from GP, self/family & community agencies

Primary Prevention - Integrated Health Promotion - Whole of population
COMMUNITY HEALTH INTEGRATED HEALTH PROMOTION PLAN

Areas of Integrated Service Provision include

- Diabetes and Respiratory health management
- Structured utilisation of clinical guidelines and pathways
- Client focused outcome measurement
- District nursing mentoring project
- Self management in clinical practice strategy
- Mental Health First Aid

- Move to common database to be shared across Community and Mental Health
- Provision of in-service training to GP Practice Nurses in relation to Heart Failure and Chronic Obstructive Airways Disease
- Self Help in Anxiety and Depression Group Facilitation
- Development of joint care plans between Mental Health, Drug Treatment Services, District Nursing
- HARP/ Primary Care/ Diabetes Referral Service Project
- DIV 2 Project


GP / Practice Nurse
Primary Care
Domiciliary Nursing
Admission Risk Team
Comprehensive Assessment
Bio-psycho-social
Self Management Assessment (i.e. Flinders Model of CCSM)
Care Planning
Direct referral to condition specific group-based service
ie. According to identified criteria emphasising early intervention
Health Outcome Measures
CHRONIC CONDITION GROUP-BASED SERVICE
Eg.
COPD
Chronic Heart Failure
Diabetes
Chronic Back Pain
Anxiety & Depression
Nutrition
Physical activity
Core objectives:
Enhanced knowledge of condition & treatment
Monitoring & responding to condition ie. Written Symptom Action Plan, Monitoring Diary
Written Care Plan (client's understanding & responsibilities for partnership in care)
Co-ordinated by identified Key Worker
Multidisciplinary input / participation
Delivered at CH Centres
Fees?
Encourage active involvement of carer / partner / family
Dates / times scheduled in advance and distributed
Minimum x 2 per condition per site per school term (ie x 8 per year per condition at each site)
Consistent times / days at each site with coverage of times days between sites
Registration etc managed via CH Reception
Maximum 3-4 weeks x 2 hours per session
Clear interface with BHSM Course
Referral to Better Health Self Management Course (ie. 6 week generic chronic condition self management group-based service
Allocation or continuation of CH Key Contact Worker Assessment (CHN / ART / Dom Nursing)
Ongoing liaison with GP / GP Practice Nurse
Review Assessment
Where CHN / Dom Nursing Key Contact Worker Review
Assessment conducted with input from "specialist" service (eg. HARP, Primary MHT) and/or GP
Health outcome measurements
OngoingCare Planning in conjunction with GP / GP Practice Nurse

From: KATHLEEN DOOLE
Sent: Tuesday, 21 February 2006 4:41 PM
To: ANDREA LEONARD; KERRIE SMITH; MAREE DERTIEN
Cc: MARK LEE
Subject: SHADES - HARP/Primary Care (inc EICD) Integrated Response

For your comments. If this represents a basis for moving forward there may not be a need to meet as planned tomorrow.

The following is a proposed integrated HARP / Primary Care (inc EICD) response to implementation of SHADES (Self Help Anxiety & Depression Service):

Initial course to be delivered from Corio co-facilitated by Darryl Behnane (EICD Social Worker) and Simone Armistead (HARP). First course to commence as soon as possible after March school holidays.
Proposed Action: Darryl to contact Simone directly to negotiate dates & time.
Proposed Action: Darryl to arrange booking for Corio Community Room

Clients to be drawn from EICD & HARP client base.
Proposed Action: Darryl to lead client identification
Proposed Action: Kerrie & Andrea to clarify applicability of CH Fees Policy to clients from across service areas

Negotiate support from MindLinx to conduct pre-course screening interviews in conjunction with Darryl for initial course
Proposed Action: Kerrie to contact MindLinx

Darryl to observe a pre-course screening interview with MindLinx
Proposed Action: Darryl to contact MindLinx to arrange

Non-clinical support processes to be managed via Corio reception
Proposed Action: Kerrie to communicate through appropriate channels(?)

Possibly for another course to be delivered via ?Belmont under similar arrangement.
Proposed Action: Kerrie to communicate with Andrea to clarify

Commitment to co-facilitation by HARP staff (Barb Howard & Simone Armistead) available as an interim arrangement only while further Primary Care staff complete facilitator training during 2006.
Proposed Action: Ongoing discussions between Andrea & Kerrie to confirm capacity

Arrangements for nominated Primary Care staff to participate in facilitator training at earliest opportunity.
Proposed Action: Kerrie

For review and report back to EICD Reference Group after commencement and then completion of initial course at Corio.
Proposed Action: Kath to agenda at EICD Reference Group at relevant time.