

**South West HARP –  
Chronic Disease  
Management Program**

## Background:-

- ❖ South West Healthcare is the largest regional hospital West of Geelong
- ❖ Bypass issues // inappropriate admissions
- ❖ High Chronic Illness rates
- ❖ HARP money – confusion and unrealistic expectations
- ❖ Needed to clarify ASAP – DHS guidelines
- ❖ Areas tended to focus on specifics for their profession
- ❖ Major culture change – lack of understanding of issues

1. Initial Meeting with 40 different services where DHS guidelines were disseminated – large amount of discussion
2. Workshop – 35 services 18 agencies
  - ❖ Clarify Guidelines
  - ❖ Metro model presentation – extremely valuable
  - ❖ Workshop – local priorities and strategies

Individual meetings with agencies unable to attend workshop

Developed and distributed the draft plan

3. Feedback meeting around draft plan

Revision of final draft and distribution

- this provides the skeleton
- meet to go on the bones

**Vision:** To improve the care of people with chronic illnesses in the South West of Victoria through better co-ordinated and integrated health and community services.

**Aim:** To reduce avoidable emergency department presentations, hospital admissions and length of stays of the target group through the use of best practice principals, resulting in patient/client centred care and support.

## Target Areas

**Heart Failure:-** Left Ventricular dysfunction, Cor Pulmonale, Diastolic dysfunction, Valve dysfunction, Angina, Cardiomyopathy

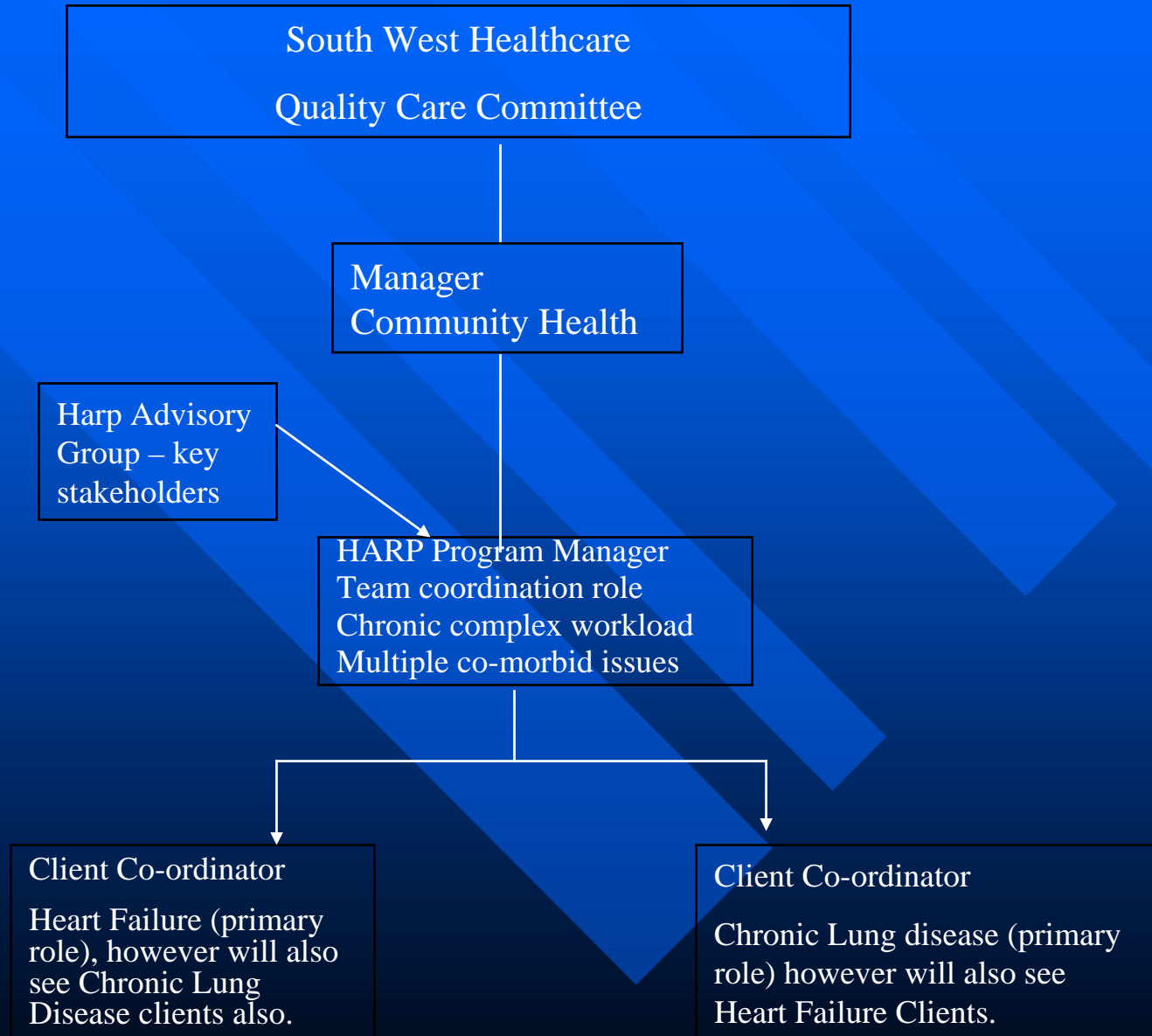
**Chronic Lung Disease:-** Chronic Obstructive Pulmonary Disease (COPD), Bronchiectasis, Pulmonary Fibrosis, Chronic Asthma, Restrictive Lung Disease

**Chronic & Complex:-** Multiple diseases including at least one Heart Failure and Chronic Lung Disease

\*Evidence based guidelines define the roles of all key stakeholders – agreement with all key stakeholders.

\*Target group specifics to be confirmed once Program Manager is employed.

# Proposed Structure



- ❖ All positions physically located in Community Health.
- ❖ All positions work in acute, rural hospitals, GP practices, community and the homes of clients as needed (including specialist and primary care settings).
- ❖ Co-ordinator positions are assertive roles that perform a co-ordinating role (no service provision).
- ❖ Program is Monday to Friday.
- ❖ The establishment of the program and its processes need to occur prior to accepting clients.

# Key Program Features

## 1. Delivery of Care

### 1.1 Single Point of Access

#### HARP team:

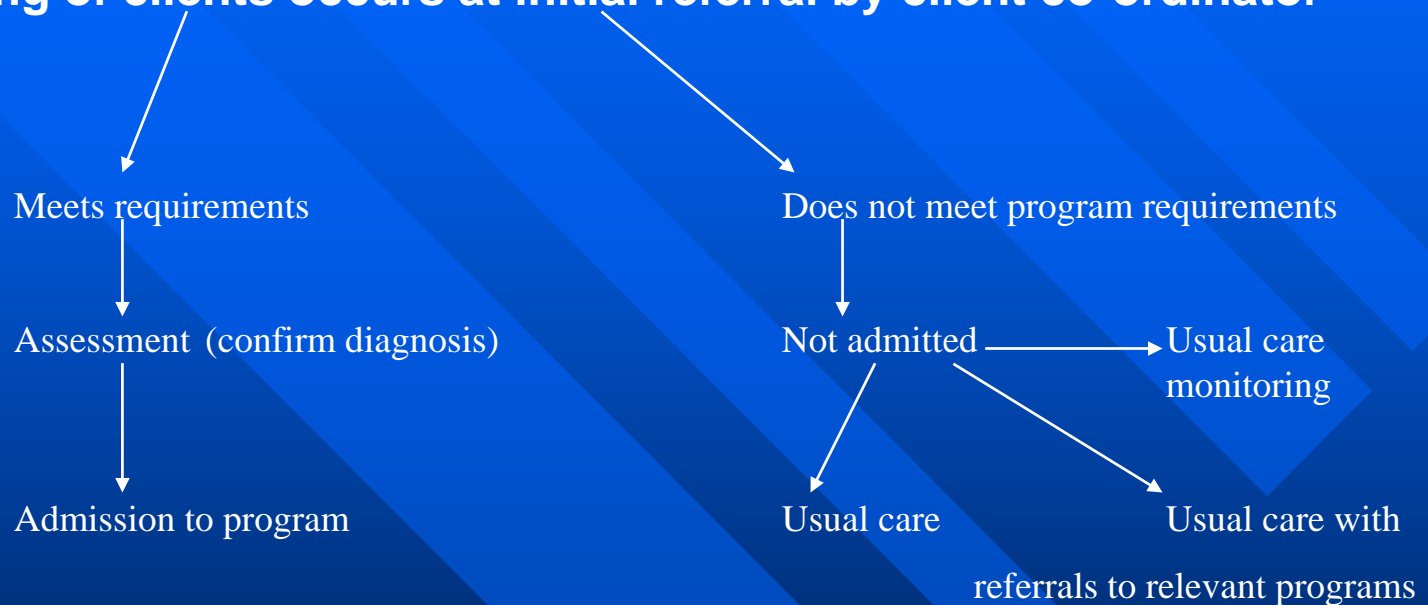
- ❖ **Based in Community Health with direct contact number.**
- ❖ Client Co-ordinators have individual contact numbers i.e. mobile phone/ pagers.
- ❖ Clients or health staff can contact Client Co-ordinators directly making it easy to access them.
- ❖ **Co-ordinators primary disease specific (i.e. Heart disease) but will also cover other co-ordinators and conditions (team approach) ie. Aim to balance workload between the coordinators.**
- ❖ Covering workloads and picking up other conditions if the need is greater elsewhere.

## 1.2 Referral & Screening

- ❖ Referral by phone with patient consent.
- ❖ Subsequent referrals out of HARP will be via e-referral/ paper using appropriate forms, eg. SCoTT tools.
- ❖ IT systems developed to flag 'HARP clients' on admission to Emergency at South West Healthcare.
- ❖ This will ensure automatic referral in electronic format and, admission to program (with consent if not already on program). (Systems with other South West Regional Emergency Departments will be developed over time and once demand is assessed).
- ❖ Ideally IT systems in Doctor's databases to populate their fields.
- ❖ **Needs to be advantages for the Doctors and opportunities exist with Medicare Chronic Illness funding (EPC items).**
- ❖ Admission to program can be done in any location by Client Coordinator.
- ❖ **Clients can self refer to the program.**

# 1.3 Screening

Screening of clients occurs at initial referral by client co-ordinator



- Screening done using validated tool
- Patients recruited with consent

## 1.4 Assessment

- ❖ **Assessment via electronic tool such as InterRai in mobile location. i.e. ED, Home.**

Note: Inter Rai (or substitute) aim to use a statewide tool if one is available.

- ❖ **All assessments and conditions verified with diagnosis by appropriate test** i.e. heart failure – Ecocardiogram, chest x-ray.
- ❖ People not meeting 'HARP admission' criteria not put on program and referred to necessary services (if required).
- ❖ Stratification of severity and complexity of the patient.
- ❖ Ongoing re-evaluation of client to ensure correct stratification.

A system whereby patients are not discharged but ranked by level of co-ordinator involvement is intended. This will be further clarified and developed by the Program co-ordinator.

## 1.5 Case Co-ordination

- ❖ System allows flexibility and responsiveness that puts the patient at the centre of care, and takes all co-morbid conditions into account.
- ❖ **Evidence based guidelines define the roles of key stakeholders.**
- ❖ **Agreement and endorsement of each professional groups scope of practice and the role they will perform as part of the evidence based guidelines.**

*Flexibility within this, that allows cultural and economic differences to be met.*

- ❖ Endorsed policies and procedures for relevant areas of the program
- ❖ Developed relationships with all relevant services and programs ensuring actual needs are met i.e. after hours consultations
- ❖ Use of IT to bridge distance barriers where appropriate i.e. home monitoring.
- ❖ **Client Co-ordinators work across acute and community without allegiances to either system.**
- ❖ Ongoing monitoring of clients (ie not discharged) and the impact evaluated.
- ❖ **Identification of service 'gaps' and strategies to address these gaps.**
- ❖ **Limited brokerage funding through the Program Coordinator to fill 'real' gaps.**

## 2. Training and Education

### Patient's/Clients Carers

Assess and stratify client ability/suitability for self-management:

- ❖ **Develop support structures for sustainable care for people who can't self manage including:**
  - \*Provide education and knowledge opportunities to increase abilities where possible.
  - \*People with multiple chronic illnesses and psychosocial issues are likely to need ongoing support
- ❖ **Develop individualised plans to build on skills of people who can self manage.**
  - \*\*\*Link to BHSM programs.
- ❖ Individual, client centred approach to each person and their education and training needs. -Especially important for Indigenous and Migrant communities.

### Carers

- ❖ **Define the role of carers in complex and chronic illness (varying between clients).**
- ❖ **Assess carer's knowledge and implement strategies to improve knowledge.**
- ❖ **Design relapse prevention strategies (updates).**

Note: Using existing evidence base material is intended.

### 3. Psychosocial Support

- ❖ All newly referred patients have a psychosocial component incorporated into assessment.
- ❖ Develop strong links with existing counselling and psychiatric services.
- ❖ Appropriate and timely referrals to specialised services where required.
- ❖ Upskilling and training of Client Co-ordinators to recognise symptoms of anxiety, depression etc.
- ❖ Education to carers to increase confidence and knowledge around chronic illness but also strategies to maintain their health and wellbeing (as per education / training section).
- ❖ Link to all services in the region including respite options for carers.
- ❖ Develop strategies to address isolation of clients (and carers) including referring people to activity programs to increase social connectedness.

## 4. Role of General Practitioners

- ❖ **GP involvement is critical when further developing the project including sitting on the advisory committee.**
- ❖ GP communication maximised without excessive time demands on the GP ie. IT solutions.
- ❖ Client Co-ordinators have regular GP liaison role.
- ❖ **Client Co-ordinators work closely with GP practices and GP practice nurses ensuring efficiencies.**
- ❖ **Client Co-ordinators can provide a lot of the information required by GP's for care plans.** If this can populate their field via IT would work better.
- ❖ Ensure an easy referral process into the program for GP's ie. phone.
- ❖ Participation and regular input from specialist is crucial.
- ❖ Needs to be a “business incentive” for GP's involvement and this may come through EPC items.
- ❖ GP's need access to HARP data and this could be managed by the Program Manager.

## 5. Leadership and Management

- ❖ **HARP Advisory committee to be developed.**
- ❖ Terms of reference developed.
- ❖ Act as an advisory committee for program.
- ❖ Regular reports to relevant agencies, communities and boards to ensure accountability and outcomes are being achieved.
- ❖ Program policies and procedures developed including evidence based best practise guidelines with defined role (an agreement) of key stakeholders.
- ❖ Evaluation process with agreed KPI's and outcomes.
- ❖ Collaborate with universities where possible to guide evaluations.
- ❖ South West Healthcare has ultimate accountability for the program.

## 6. Human Resources

- ❖ All positions advertised as Allied Health or Nursing Division 1.
- ❖ **Interdisciplinary positions.**
- ❖ Generic skill sets will be important, including medical model and social model's of health.
- ❖ Specialist skills (i.e. Physiotherapy) will be used by the program if required but this is not the core role of the Client Co-ordinators and will not be the focus of recruitment.
- ❖ Comprehensive clinical knowledge of target conditions is required.
- ❖ Line accountability will be to Manager Community Health through the Program Manager. Other areas remain accountable within existing structures.
- ❖ Positions will be advertised statewide as well as locally.
- ❖ **Client Co-ordinators will work across all service systems and require knowledge of these.**
- ❖ Although primarily targeting one area, all HARP staff will have clients from other target groups.
- ❖ Program Manager will provide regular reports to the HARP steering group.
- ❖ **Not Case Management but case coordination, there is a distinct difference.**
- ❖ Staff are expected to regularly update their knowledge through education.
- ❖ **Alliances with other HARP programs are important to ensure peer support.**

# Staff Training and Education in all sectors

- ❖ Training across the region focusing on self-management principals, which creates a standardised baseline. i.e. The Better Health Self Management program as developed by the Arthritis Foundation.
- ❖ **Regionally available education around:**
  - o Progression of chronic diseases and best practice
  - o Increased knowledge of the other health services and what they deliver
  - o Change management
  - o Team development
  - o Diversity and cultural knowledge development
  - o Aim for philosophy of self management be embedded into organisational practices
- ❖ Staff training is crucial to the program working. Organised placements in existing HARP programs would build rapport and skill base.

## 7. Information Management

- ❖ Database that is used across the system with custom built areas to meet the needs of HARP. Talks to all systems including PMI.
- ❖ IT 'flags' need to identify people on the program (or people likely to be on the program) who are presenting to Emergency.
- ❖ Data to be collated & presented as per requirements of steering group & DHS.

Likely Data requirements include:

- ❖ Assessment data.
- ❖ Pre & Post program data i.e. cardiac rehabilitation / pulmonary rehabilitation
- ❖ Intervention data
  - o Working with clients
  - o Where
  - o How many times
  - o Status
- ❖ Underlying causes data – Why did the person have an acute episode? eg. no transport to GP.
- ❖ Brokered services.

## **8. Safe Practice and Environment**

- ❖ Risk Management Plan to be developed for HARP and incorporated into policies and procedures.
- ❖ Staff education around Risk Management Plan and policy manual including relevant procedures.
- ❖ Meet all OH&S requirements as per South West Healthcare requirements.

## **9. Quality Improvement**

- ❖ Plan to be developed in conjunction with organisational processes and reporting requirements.
- ❖ Participate in South West Healthcare ACHS EQUIP Accreditation program.

## **10. Change Management and Relationships**

- ❖ A key role of the Program Coordinator will be to implement change management processes and have commitment from all service providers to implement evidence based guidelines and to determine their role within this.

# 11. Budget

To be finalised.



## 12. Next Steps

- ❖ Revisit draft plan.
- ❖ Program Manager advertised – appoint by 15 December 2005.
- ❖ Submit plan to DHS and receive sign-off prior to implementation.
- ❖ Program Manager to finalise plan and facilitate any additional feedback from last draft including consultation with all key stakeholders.
- ❖ Program Manager to get agreement on use of evidence based guidelines, put all process and practices into place (ie screening of assessment tools, design evaluation, IT infrastructure etc)
- ❖ Begin implementation of the plan including advertising and appointing program co-ordinators.
- ❖ Program begins accepting clients in March - May 2006.