

Better Living Better Health

MODEL OF CARE

The Hospital Admission Risk Program / Chronic Disease Management in the Southern Health catchment has been re-named Better Living Better Health

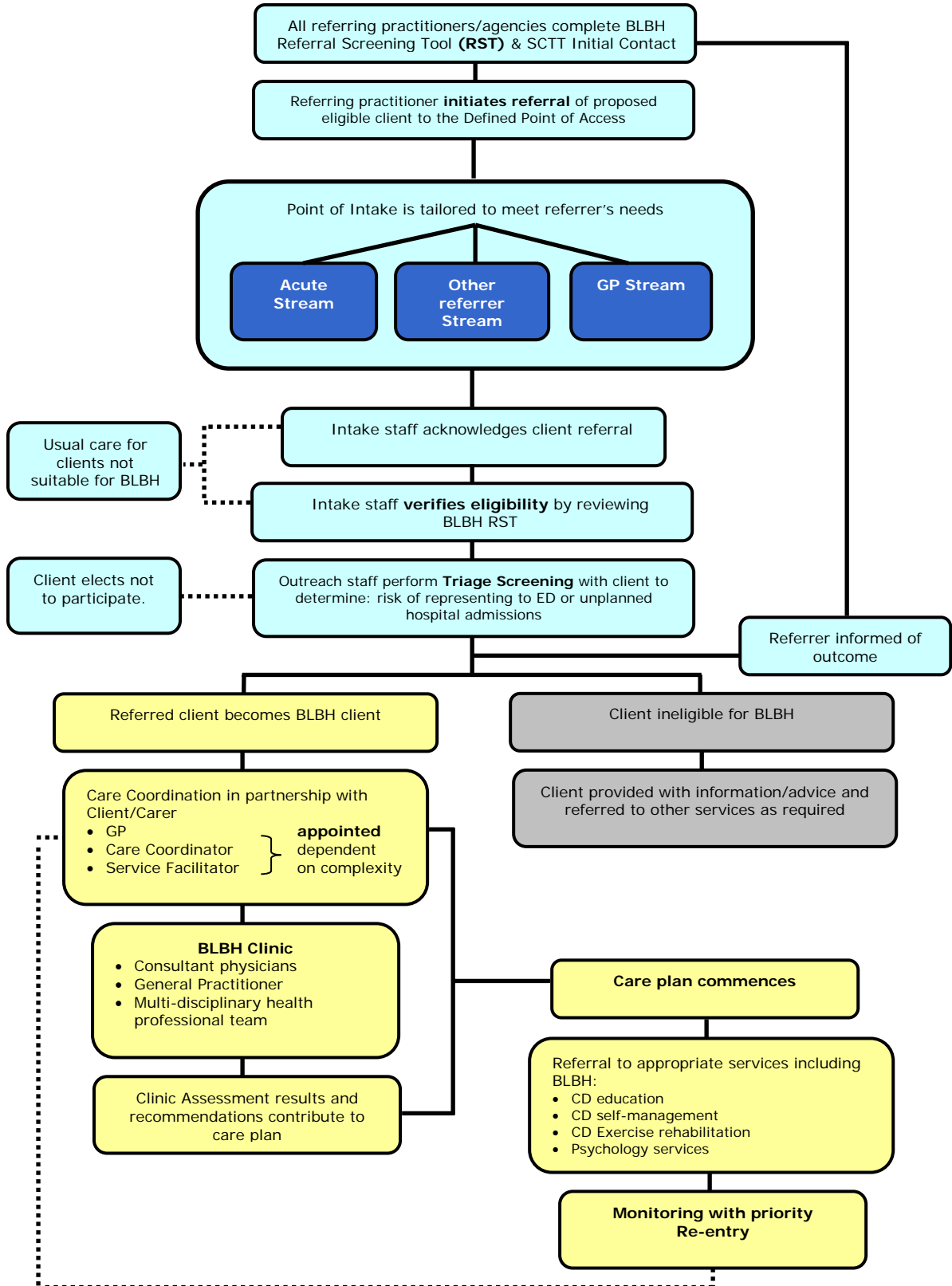
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Partners/Stakeholders: Southern Health, Central Bayside CHS, Consumer Representatives, Deakin University (evaluators), Divisions of General Practice, Local Government, Monashlink CHS Primary Care Partnerships, Royal District Nursing Service.

INDEX

BACKGROUND	2
INTRODUCTION	2
VISION	3
KEY OBJECTIVES	3
PRINCIPLES	3
KEY FEATURES	4
BLBH GUIDELINES	5
1.1 DEFINED POINT OF ACCESS (DPOA)	6
1.2 ASSESSMENT AND STRATIFICATION	8
1.3 CARE COORDINATION	9
1.4 MONITORING AND REVIEW	11
1.5 INTERDISCIPLINARY APPROACH AND MULTIDISCIPLINARY TEAMS	12
1.6 EDUCATION AND SELF – MANAGEMENT	13
1.7 ROLE OF THE GENERAL PRACTITIONER (GP)	13
1.8 PSYCHOSOCIAL SUPPORT	14
1.9 SPECIALIST SERVICES	15
1.10 FLEXIBLE SERVICE PROVISION	17
1.11 24 HOUR ADVICE	18
1.12 REFERRAL AND LINKS TO OTHER SERVICES	18
CONCLUSION	20
GLOSSARY OF TERMS	21

BLBH MODEL OF CARE FLOWCHART



Information builds from the Referral Screening Tool, Triage Screening and the Comprehensive Assessment to contribute to care plan.

BACKGROUND

The Better Living Better Health Program (BLBH) focuses on continuing to improve the management of people with defined chronic diseases and complex needs who frequently use hospitals or are at risk of hospitalisation. BLBH involves embedding models of care that have emerged through HARP from 2001 to 2004 into the Victorian service system. ¹

(Page 4)

The target population for BLBH are those people who are most likely to benefit from integrated care and have the potential to reduce avoidable hospital use.

Services delivered within BLBH target people with the following conditions:

- Chronic respiratory disease;
- Chronic heart disease;
- Diabetes;
- Complex needs; and
- Complex psychosocial needs.
- Other specific services currently still being refined by the DHS¹ (Page 5)

BLBH care streams include:

- Chronic Heart Failure
- Chronic Respiratory Disease
- Complex needs and Complex psychosocial needs & Paediatric Asthma
- Diabetes
 - For paediatrics with Type I diabetes
 - For adults with Type II diabetes and identified cardiovascular risks
- Pharmacy Outreach
- Health for Kids in the development of a paediatric model of care

INTRODUCTION

This proposed model of care has been developed in the context of:

- Key stakeholder consultation including consumer involvement in the development of the proposed model
- Successful models internationally
- Key learning's from the current BLBH projects

¹ Current Edition of the HARP CDM Guidelines; Department of Human Services
Note: BLBH refers to the Southern Health program and related catchment area, unless otherwise stated.

- Department of Human Services HARP Chronic Disease Management Guidelines

Key Stakeholder forums

There has been extensive consultation into the development of this Model of Care. Implementation of this new mainstreamed Model is being overseen by the governance committee – the South East Chronic Care Collaborative (SECCC). This governance group will oversee the implementation phase of BLBH from July 01, 2006 to December 31, 2007.

VISION

Visioning of the BLBH program has been a key part of the work undertaken to date with key stakeholders. Consistently the following vision was expressed by key stakeholders: “To provide the right care, at the right time and in the right care setting” for the BLBH target population.

KEY OBJECTIVES

- To improve patient outcomes;
- To provide integrated seamless care within and across hospital and, community and primary care;
- To reduce avoidable hospital admissions and Emergency Department presentations; and
- To ensure equitable access to healthcare^{1 (Page 4)}
- To increase the integration and partnership across the BLBH program

PRINCIPLES

- Care that is holistic and client focused, ensuring client priorities are identified and incorporated into care plans.
- Proactive management systems that support self management and attainment of stability of chronic conditions where possible, thus preventing repeated Emergency Department presentations.
 - All clients are empowered to manage their care needs to the best of their ability.
- Coordinated and integrated community based care.
 - Care delivered in partnership with clients and Continuing Care as the pivotal organising sector for providing continuity of care.

- Clients no longer requiring BLBH interventions will be discharged from the program with priority re-entry.
- Promotion of synergies with existing services to enhance the effective and efficient use of existing resources.
- Standardised processes and tools that are efficient and easy to use by staff and health professionals referring into the Program.
- Support and coordination as required.
- Care coordination involving multidisciplinary teams with specific chronic disease management (CDM) training, capable of working within and across health care sectors.
- Continuous quality improvement.
- Evidence Based Practice.

KEY FEATURES

- Consistent eligibility, stratification and assessment processes and protocols to ensure objective decision making for entry, assessment, care planning, care coordination, referral and discharge.
- Levels of Care Coordination based on complexity (see Figure 1.3).
- Training and skills development in the principles and practice of self management, for clinicians providing BLBH services.
- Development of care pathways to enhance utilisation of services, and utilisation of the broader service system.
- Improved communication and interface between acute and community based providers including General Practitioners.
- Use of multidisciplinary teams and interagency collaboration for optimal health outcomes for BLBH clients.
- Clinical leadership via the Clinical Leadership Group that reports to the South East Chronic Care Collaborative.
- Improved information management to ensure optimal access to relevant client information to support care coordination and clinical decision making and consistent reporting to DHS.
- Improved information flow across organisational boundaries to enhance collaborative care.

DEMAND MANAGEMENT

Demand management will be vital to the success of the program. Experience internationally suggests that over time, client caseloads for chronic disease models can be increased as care coordinators become increasingly skilled and processes, tools and communication systems are in place to support practice.

Broadening the care coordination base to include general practitioners and the development of levels of care coordination to include Service Facilitators by RDNS and GP practice nurses, also assists demand management.

Other strategies for demand management include:

- Ensuring eligibility is defined.
- An effective Triage Screening process to determine with greater precision eligibility for the Program.
- Utilising the broader service system appropriately.
- Active discharge planning will commence at the initiation of the Care Plan where agreed discharge options will be incorporated. Discharge will be presented to clients as a goal of their care.
- Formal structured review processes and ongoing proactive management of the waiting list.
- Adequate resources and the right skills mix.
- Utilising data to forecast growth.

BLBH GUIDELINES

The BLBH guidelines have been developed by the Department of Human Services in consultation with the Statewide Planning Group. The guidelines build on recognised elements for successful models of care for the target group.

This proposed Model of Care utilises the Continuum of Care components of the Guidelines as the framework for the model.

Where Program Guidelines are documented in this proposed model of care this information has been derived directly from the DHS HARP Chronic Disease Management Guidelines;

The Continuum of Care Guidelines include:

- 1.1 Defined Point of Access
- 1.2 Assessment and Stratification
- 1.3 Care Coordination
- 1.4 Monitoring and Review
- 1.5 Interdisciplinary approach and multidisciplinary teams
- 1.6 Education and self - management
- 1.7 Role of the General practitioner
- 1.8 Psychosocial support
- 1.9 Specialist Services
- 1.10 Flexible service provision
- 1.11 24 hour advice
- 1.12 Referral and links to other services

1.1 DEFINED POINT OF ACCESS (DPOA)

Excerpt from DHS HARP Chronic Disease Management Guideline:

BLBH is required to provide a defined point of access at the program level for clients, carers and referrers. A defined point of access may be virtual, in that it may consist of several entry mechanisms, but appear streamlined and simple to the referrer. For example, BLBH should work towards a single phone number and unified marketing strategy, but may have several strategies for recruiting clients. ^{1 (Page 13)}

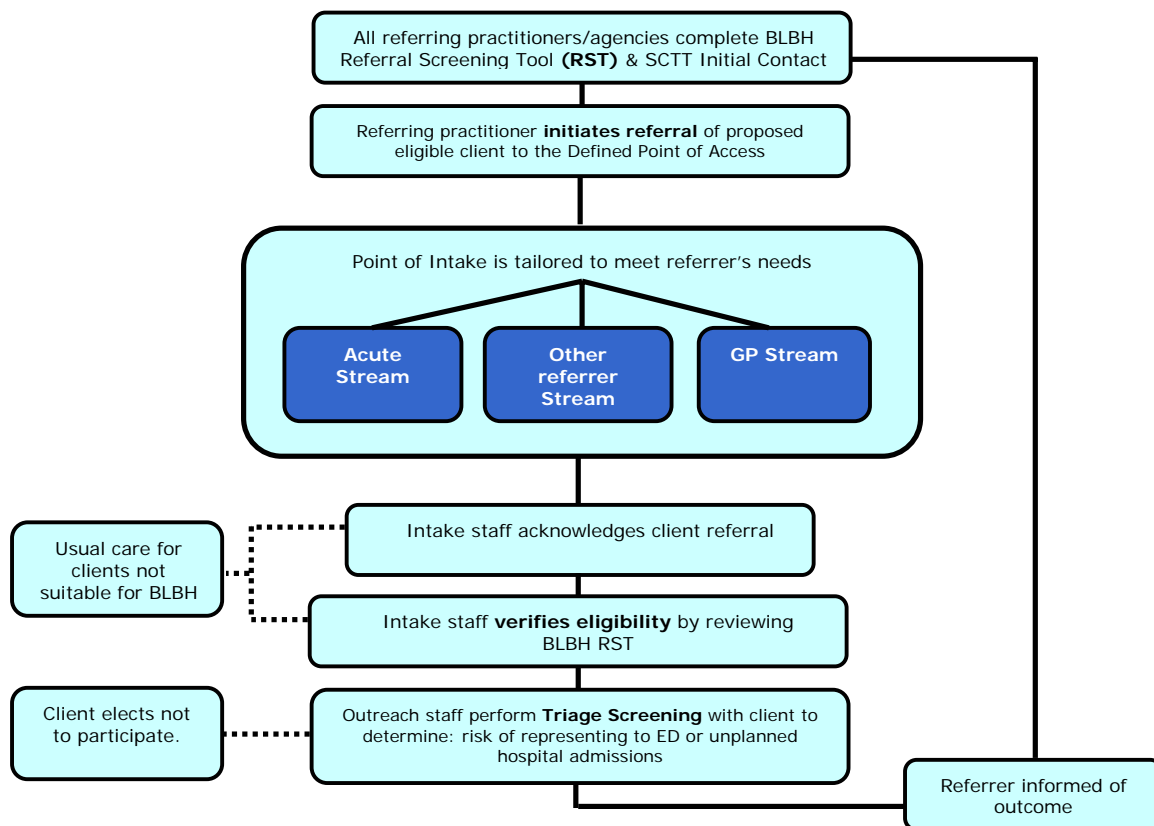
Referrers can be hospital inpatient services, hospital outpatient and ambulatory services, community service providers, General Practitioners, potential clients and their carers. ^{1 (Page 13)}

Defined Point of Access for BLBH

DPOA from a BLBH perspective includes:

- Initial contact
- 3 streams tailored to the needs of referrers (please see below)
- Acknowledgement of referral
- Verifying eligibility
- Triage screening for acceptance to the program

Figure 1.1 DPOA components of the Model of Care Flowchart



** Allocation of a Care Coordinator or Service Facilitator occurs after Triage Screening

The BLBH DPOA proposed in this document has 3 streams. Although 3 streams are offered it is important from a referrer perspective that this appears to be a single point of access that is simple to use and offers support and assistance as required.

The 3 BLBH streams are:

- **Acute based stream** - service available to wards and departments in person or via phone or email contact. (Emergency Departments and Inpatient including Sub Acute services).

This acute based stream brings together individual programs into a BLBH team that provides consistency for referrers and coordinated access to services for clients. Specialist program expertise is utilised when required.

- **Community based General Practitioner stream**

Specific for GP referrals to the program with staff that are experienced in working with GPs and who are able to facilitate and assist GP referrers.

Specific experience will be required in understanding the use of the GP MBS items for Chronic Disease Management.

- **Community based Other Referrer stream**

It is envisaged that these referrers will be familiar with the Service Coordination Tool Templates (SCTT) and would require little assistance.

1.2 ASSESSMENT AND STRATIFICATION

Excerpt from DHS HARP Chronic Disease Management Guideline:

In order to determine whether clients are eligible to receive BLBH services they will be required to undergo an eligibility screening process. The eligibility screening process will determine clients who are regular hospital users or at risk of avoidable hospital presentations. The eligibility screening process will be developed in collaboration with the Community of Practice[‡].

All screened clients determined to be at risk of avoidable hospitalisation and who consent to participate, are enrolled in BLBH and comprehensively assessed. The needs of carers of enrolled clients are also to be assessed when consent is given. All enrolled clients are to be stratified based on priority and type of need as determined by the screening and initial assessment findings. All enrolled clients are to be reviewed for exit or suspension from BLBH, where there is a period of six months with no additional BLBH services to usual care, or the client is deriving no measureable benefit from the service.

All enrolled clients are to be discharged from BLBH in the event of their death or a period of one year with no provision of BLBH services. Re-entry for clients who are discharged and then deteriorate should be smooth. Clients who move out of the area need to be referred to the appropriate BLBH services in that area.

Referrers and the nominated GP are notified of outcome of referral; where the eligibility criteria are met the client is enrolled in BLBH and assessed. Where the eligibility criteria are not met the client is not enrolled and feedback is provided to the referrer.

Referrers and the nominated GP are notified of the assessment determination and services to be provided.

[‡] The Community of Practice is a Department of Human Services forum for BLBH programs

Screening Process

The BLBH has developed a Referral Screening Tool (RST). The RST aims to assist those seeking to refer, clarifying who is most likely to benefit from a referral. The RST is received by the Defined Point of Access, please see 1.1 for Defined Point of Access process.

Triage Screening (Stratification):

Stratification refers to “the process of categorising clients into levels of service according to needs.”

- Triage screening will confirm eligibility of clients for BLBH
- Clients are either enrolled into BLBH or provided with information / advice, and referred to other appropriate services as required.
- Referring practitioners are notified as to the outcome of referral.
- All clients enrolled to BLBH will be assessed using a standardised tool. Further assessment will follow according to clinical indicators within BLBH parameters.
- Assessment and subsequent care will seek to stabilise health issues relevant to BLBH with a view to discharging them to usual care in the community.

Assessment:

All clients are comprehensively assessed.

Proposed Assessment process:

Information will build from the Referral Screening Tool and Triage Screening. The Triage Screening process involves the utilisation of the SCTT Profiles. Clients will then undergo a Specialised Assessment as required.

The Department of Human Services will be leading the development of a Generic Assessment tool based on the InterRAI Homecare Assessment.

1.3 CARE COORDINATION

Excerpt from DHS HARP Chronic Disease Management Guideline:

BLBH is required to provide care coordination for each client according to need.

BLBH is required to ensure:

- *Provision of ongoing continuity of care;*
- *Allocation of a care coordinator;*
- *Development of a care plan and possibly case conferencing;*

- *Initiation of supports and services for clients and carers;*
 - *Liaison and communication with service providers including: GPs, specialists and other care providers;*
 - *Provision of information, education, self-management interventions and facilitation of client empowerment;*
 - *Provision of an emergency care plan/contacts to clients and carers;*
 - *Access to specialist or multidisciplinary assessment and early intervention when risk of exacerbation or decline;*
 - *Planned reviews and proactive monitoring;*
 - *Management of medication issues, in collaboration with GPs and pharmacists.*
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Coordinating Care for BLBH Clients:

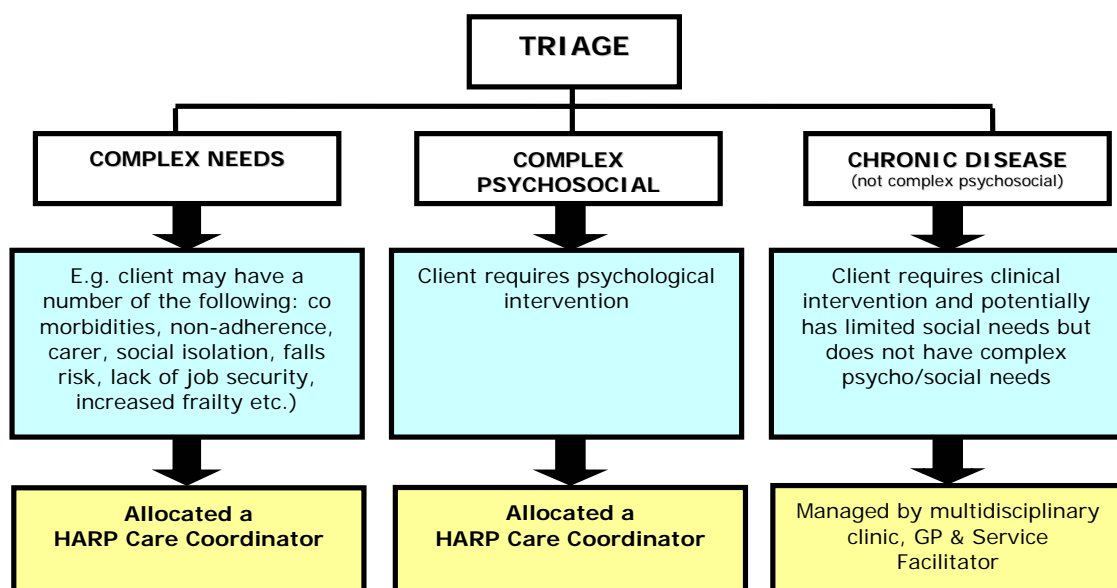
After Triage Screening is complete, there will be consultation with the client's GP to determine who will provide Coordination on behalf of the client.

The aim is to match the level of care coordination with the complexity of client needs.

In partnership with clients / carers, Coordination will be provided by:

- General Practitioners.
- BLBH Care Coordinators.
- Service Facilitators.

The General Practitioner and Specialists provide clinical management. The Coordination model (Figure 3) builds on existing GP practice utilising the Chronic Disease Management (MBS item numbers).



The Coordination model is supported by:

- Clear roles and responsibility statements and outcomes monitored
- Clear accountability statements
- Memorandum of understanding with Divisions of General Practice and Service Facilitation agencies, for example RDNS.
- The provision of education and training.

1.4 MONITORING AND REVIEW

Excerpt from DHS HARP Chronic Disease Management Guideline:

BLBH is required to proactively monitor and review clients.

Proposed model for monitoring and review:

- Clients will be proactively monitored against defined care outcomes. Clients, clinicians providing BLBH services and GPs will undertake this monitoring. Monitoring may occur during telephone reviews, at the BLBH (chronic conditions) Clinic, home-based reviews and GP practices.
- Interventions will be scheduled to work with the client in proactively achieving components of their care plan.
- The principles of self management for chronic disease will be introduced to the client upon admission to BLBH.
- Client self management principles will exist within each monitoring and review intervention.
- Care plans are adjusted according to outcomes of client reviews.
- Care plans will contain an emergency or crisis care components. These will be shared between providers, with the client's consent.
- Client retains a copy of their care plan when it is developed and as it is modified.
- All enrolled clients are to be reviewed for discharge from BLBH. Discharge will see the client return to usual care in partnership with their GP and community based health services as required.
- Discharged clients who require readmission due to predetermined triggers will be able to re-enter the program easily by contacting the clinician who coordinates their care for BLBH.
- Clients who move out of the area need to be referred to the appropriate BLBH in that area.

1.5 INTERDISCIPLINARY APPROACH AND MULTIDISCIPLINARY TEAMS

Excerpt from DHS HARP Chronic Disease Management Guideline:

BLBH is required to provide an interdisciplinary approach to client care with access to a multidisciplinary team that works across hospital and community boundaries.

Proposed model of interdisciplinary approach and multidisciplinary teams:

- Information will build across the Referral, Triage and Assessment to contribute towards the Care Plan.
- Multi-disciplinary clinical assessment and support will be available for clients as required. Access to the range of clinicians will be available upon entry to BLBH through the assessment and ongoing management.
- The program utilises brokerage funds to access additional allied health and other services, as appropriate.

Clinical leaderships for the program will be developed via the Clinical Leadership Group. The Clinical Leadership Group will have multiagency and multidisciplinary representation including:

- General Practitioners
- Emergency Department physicians
- Specialist Physicians
- BLBH Care Coordinators/Practice Nurse & RDNS Service Facilitator Representative
- Emergency Department Care Coordinators
- Community based service providers
- Allied health professionals (psychology, social work, physiotherapy etc.)

The primary purpose of the Clinical Leadership group is to:

- Facilitate multidisciplinary and interagency collaboration thereby improving client care through system change.
- To discuss client management issues across sectors and develop processes and protocols to address these, and
- To build relationships and understanding of each others scope of practice within the Model.

1.6 EDUCATION AND SELF – MANAGEMENT

Excerpt from DHS HARP Chronic Disease Management Guideline:

The principles of self-management should underpin all interactions between clients/carers and clinicians where appropriate. BLBH is required to tailor education, client empowerment and self-management services to meet the personality, learning styles, cultural and language needs, and cognitive ability of clients and/or carers. There are a range of ways in which self-management principles can be delivered and clinicians should explore the most effective method for the individual.

Proposed model for Education and Self management:

- Clients and carers have access to self management programs, as appropriate.
- Client self monitoring is encouraged and proactive follow-up incorporates a review of client self monitoring at each review visit or appointment.
- Clients have a copy of their current care plan including emergency or crisis care plan.
- All BLBH staff understand the principles and value of self management and receive appropriate training.
- Tools for self management are incorporated into practice.
- Education packages are developed for clients enrolled in the program that are tailored to meet the needs of clients and take into account cultural and language needs/cognitive ability.

1.7 ROLE OF THE GENERAL PRACTITIONER (GP)

Excerpt from DHS HARP Chronic Disease Management Guideline:

- *BLBH is required to request that clients nominate a GP.*
 - *Where a client does not have a GP, BLBH should arrange for the client to be referred to an appropriate GP (where feasible).*
 - *BLBH is required to notify the client's GPs of client enrolment.*
 - *BLBH is required to actively engage with the GP and provide the GP with documentation on the care plan, services initiated, tests arranged, follow up appointments and medications.*
 - *BLBH is required to accept appropriate referrals from GPs and provide regular information on client progress, and with client consent, GPs should also provide information via care planning/review.*
-

Proposed model for Role of the General Practitioner:

- A General Practitioner representative is a member of the Governance Group.
- General Practitioners will be encouraged to join the Clinical Leadership group.
- Where the client does not have a General Practitioner involved in their care the program will facilitate the client having a GP involved.
- The General Practitioner is given the opportunity to undertake the Coordination role and a BLBH Care Coordinator or Service Facilitator will be allocated to assist the GP based on complexity of need.
- The Program is committed to support GPs to utilise the chronic disease management items (formally EPC) for care planning, review and service delivery.
- Proactive management review visits will be encouraged between clients / carers and General Practitioners.
- It is intended that clients will be discharged back to GP care with appropriate supports services in place.
- Resources to support the General Practitioner need to be identified and where possible, implemented.
- BLBH will promote re-entry pathways to the program ensuring timely service provision.
- The role of the practice nurse has been developed to provide coordination of care based on complexity of need.

1.8 PSYCHOSOCIAL SUPPORT

Excerpt from DHS HARP Chronic Disease Management Guideline:

The term 'psychosocial needs' is used broadly to include drug and alcohol related problems, as well as problems associated with homelessness.

For patients who are psychiatrically acutely unwell, treatment and/or admission by the mental health service is the most appropriate response. However, a large number of patients present with the following problems which, on assessment, are not deemed to require acute psychiatric services:

- *Depression and anxiety;*
- *A personality disorder;*
- *Drug and/or alcohol problems;*
- *Problems related to homelessness or being at risk of homelessness; or*
- *Any or all of the above.*

BLBH is required to provide services to clients with:

- *A primary diagnosis of psychosocial needs, such as a personality disorder, substance abuse and homelessness; and*
- *A secondary diagnosis of psychosocial needs, such as depression and anxiety, as a result of another chronic condition, which may cause considerable impact to the person's functioning and emotional well-being.*

BLBH also provides psychosocial support to enrolled clients with chronic disease.

Proposed model for psychosocial support:

- Complex clients with psychosocial needs have a BLBH Care Coordinator allocated.
- All complex psychosocial needs clients are offered a Case Conference as part of the care planning process.
- BLBH will have the capacity for psychology interventions and the services of a consulting psychiatrist on staff.
- The psychology component targets people with high prevalence disorders, (anxiety and depression), as well as those experiencing significant other psychological distress.
- Psychologists carry out psychological assessments, develop care plans in collaboration with the BLBH Care Coordinators and the client's GP. They are available to provide psychological interventions as required. These positions focus on the adult client population, and are integrated within Community Health.
- In addition to these positions; paediatric psychology position.

1.9 SPECIALIST SERVICES

Excerpt from DHS HARP Chronic Disease Management Guideline:

BLBH is required to provide or facilitate client access to the following specialist services where required:

- *Specialist physicians, for example: cardiologists, respiratory physicians, geriatricians, psychiatrists;*
- *Medical investigations;*
- *Pharmacists, medication education and review services;*
- *Rehabilitation services;*
- *Allied health services;*

- *Case Management services (eg. Linkages, Community Aged Care Packages, Extended Aged Care at Home Packages);*
- *Paediatric services;*
- *Home nursing services for example: wound management, continence, stomal therapy, palliative care;*
- *Specialist clinics, for example: falls and mobility, continence, chronic pain, and cognitive dementia and memory services;*
- *Carer support services, for example: respite;*
- *Mental health services;*
- *Drug and alcohol services;*
- *Palliative care;*
- *Specialist nurse practitioners and educators, for example: respiratory disease nurse;*
- *Aged Care Assessment Services;*
- *Secondary consultations in psychosocial;*
- *ATSI Liaison Officers;*
- *Housing Services.*

BLBH is required to utilise evidence based clinical guidelines for clients who have chronic heart or respiratory illnesses.

Culturally and linguistically diverse clients and carers are to have access to appropriate resources to facilitate care. Aboriginal and Torres Strait Islander clients have access to services that meet their needs.

Proposed model for access to specialist services:

Access is facilitated by:

- Access to CDM clinics that include specialist physicians and multi-disciplinary teams.
- Integration within Community Health Services.
- Defined Point of Access that builds into a broader intake system.
- Care pathways with substitution and diversion programs.
- Interface with Continuing Care Program –the development of pathways to support this interface.
- Development of multidisciplinary teams and outreach services.
- Enhancement of home medication reviews encouraging General Practitioner and other service provider referrals.
- Improved access to interpreters and interpreting services.

- Clinical Leadership Group that identifies issues with access to specialist services and develops strategies to overcome these, where possible.
- Use of brokerage funds to access specialist services where gaps exist for the target group.

Aim of BLBH Clinic:

To provide a multi - disciplinary Chronic Disease Management Clinic that promotes self management, improves quality of life, provides better health outcomes and reduces hospital admissions.

The clinic will provide rapid assessment and short term timely intervention for BLBH clients with chronic complex diseases and will liaise closely with the clients' key stakeholders, including regular General Practitioners.

Objectives of BLBH clinic:

- Increase access to Chronic Disease Management services to improve client outcomes.
- Establish a multi -disciplinary BLBH clinic that delivers a quality service that will be benchmarked against other CDM clinics.
- Reduce avoidable admissions and Emergency Department presentations.
- Provide empowerment to clients through education and self management strategies.
- To provide rapid assessment and timely intervention for BLBH clients with chronic complex disease.
- Prompt transfer back to usual community services.
- Provide continuity of care by progression, if required, to appropriate specialist services.

1.10 FLEXIBLE SERVICE PROVISION

Excerpt from DHS HARP Chronic Disease Management Guideline:

BLBH is required to provide access to a wide range of services, where required that include after hours and outreach services. This may require purchasing one-off services and brokerage services.

Proposed model for Flexible Service provision:

- Where gaps exist in the current service system that impact on the clients ability to meet care plan goals, services will be purchased utilising brokerage funds and following brokerage guidelines.
- Brokerage arrangements are already in place with some providers however new arrangements will continue to be developed as new service options are explored and developed.
- Clear care pathways will be developed with substitution and diversion programs and access to these services including brokerage will be enhanced for eligible clients.
- The option to develop after hours and outreach services is still to be explored.

1.11 24 HOUR ADVICE

Excerpt from DHS HARP Chronic Disease Management Guideline:

BLBH is required to provide advice to clients and carers on how to access information and services on a 24-hour basis. BLBH is required to provide all clients and carers with contact details.

Proposed Model for 24 hr advice:

The Department of Human Services is developing this component of the service on a statewide basis. This requires further scoping.

1.12 REFERRAL AND LINKS TO OTHER SERVICES

Excerpt from DHS HARP Chronic Disease Management Guideline:

BLBH is required to have established referral processes. Referrals to all required supports and services are to be made as soon as possible to avoid lengthy delays. BLBH is required to send written documentation of referral within same day. Clients are to have access to their previous and usual services whilst BLBH provides additional required services.

Proposed model for referral and links to other services:

- Clear eligibility criteria for both BLBH and Early Intervention will ensure that clients are referred into the appropriate service. The BLBH Referral Screening Tool will inform referrers about client eligibility.
- Client privacy is maintained at all times in accordance with legislation.

- Information sharing is based on Primary Care Partnerships Service Coordination protocols. BLBH will participate in e-referral processes (i.e. Infoxchange) as these are developed.

Active Discharge Planning

Excerpt from DHS BLBH Chronic Disease Management Guideline:

Related component under 1.2 Assessment and Stratification.

All enrolled clients are reviewed for exit or suspension from BLBH, where there is a period of six months with no additional BLBH services to usual care or the client is deriving no measurable benefit from the service.

All enrolled clients are to be discharged from BLBH in the event of their death or a period of one year with no provision of BLBH services. Re entry for clients who are discharged and who deteriorate should be smooth. Clients who move out of the area need to be referred to the appropriate BLBH program in that area.

Proposed model for active discharge planning:

- Discharge criteria established.
- Discharge planning commences on admission to the program.
- Care Planning incorporates clearly documented discharge plan.
- Emphasis is on client self management and links to other services that continue after discharge from the program.
- Clients needing to re-enter the program will be fast-tracked for re-entry.

CONCLUSION

The Model of Care for BLBH builds on existing knowledge and expertise both locally and internationally but also proposes new systems and processes to support practice. The BLBH program is seeking to develop a culture of client centered, rather than clinician centered care. This program emphasises active management leading to discharge. The Model of Care will continue to evolve as evidence based practice drives change into the future.

GLOSSARY OF TERMS

Better Living Better Health

An initiative of the Hospital Admission Risk Program / Chronic Disease Management in the Southern Health catchment.

Complex needs and Complex psychosocial needs and Paediatric Asthma

Provides expertise in the management and support of people with chronic/complex conditions and psychosocial needs. In addition to the paediatric Asthma Educators.

HITH

Hospital in the Home. This service seeks to provide ongoing care and support that enables the person to leave hospital and return home. This service provides care that would otherwise require a longer hospital stay.

PAC

Post-acute Care. This service provides an array of support services that support a person to return home with adequate support for independent living.

RASP

Rehabilitation and Aged Services Program.

Screening Process

Determine if a person is a regular hospital user or at risk of an avoidable hospital admission due to chronic disease complications ^{1 (Page 14)}

Stratification

The process of categorising clients into levels of service according to needs.

REFERENCES

1. Metropolitan Health and Aged Care Services Division. **HARP Chronic Disease Management Guidelines**. Department of Human Services 2004.

BLBH RESOURCE:

A Best Practice Manual for Better Living Better Health is currently being developed. This will outline guidelines and protocols for each stage in the model of care flowchart including templates and forms required throughout the patient journey.