

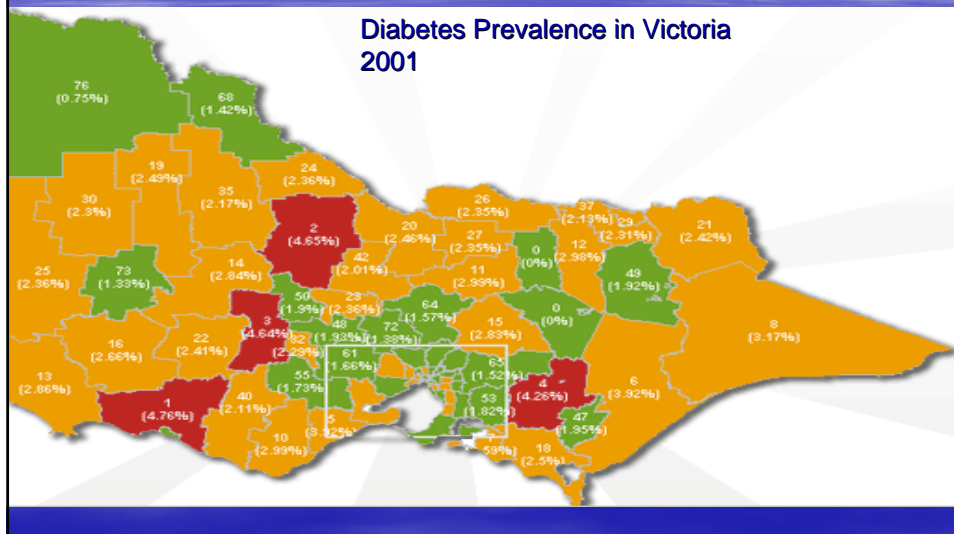


Working Collaboratively Across Hospital and Community Setting

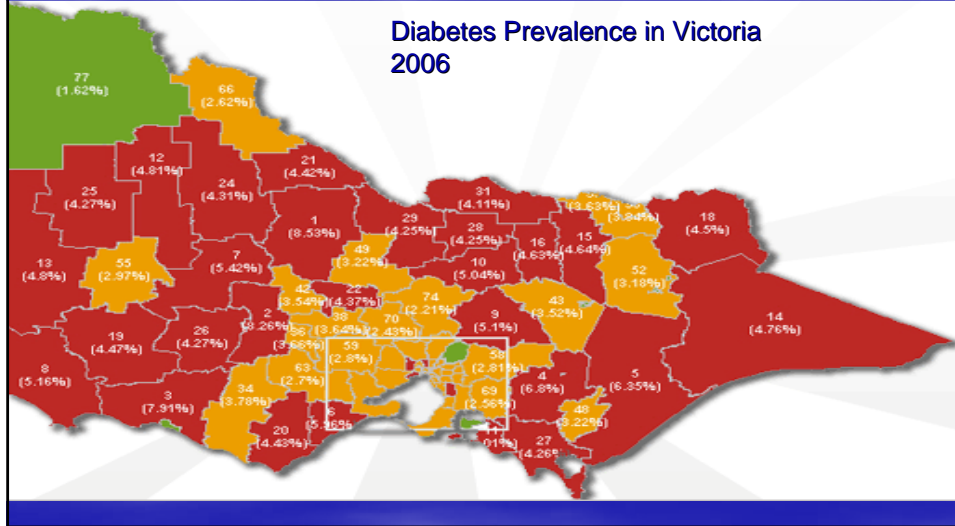
Adam Taylor
Nurse Project Officer
GP in Community Health Strategy
Western District Health Service

Western District Health Service

Why the need for efficient CDM?



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What we planned to do



- Developed the GP in Community Health Strategy
- Nurse Project Officer to coordinate
- Created a project Steering Group
 - Dr Ford HMG
 - Allied Health –Diabetes Educator, Dietetics, & Reception Staff
 - WDHS Director of Community Services
 - Practice Nurse HMG
 - HARP
 - BHSM
 - Private Allied Health – Exercise Physiologist
- Change the way Chronic Disease is managed

Project Goals



- To develop an integrated and co-ordinated community based support program for Chronic Disease Management, working with local General Practitioners, Allied Health and Community Care Providers.
- Utilise EPC & TCA MBS Items to develop a GP led team approach to chronic disease management in Hamilton.
- Change the local CDM culture from REACTIVE to PROACTIVE

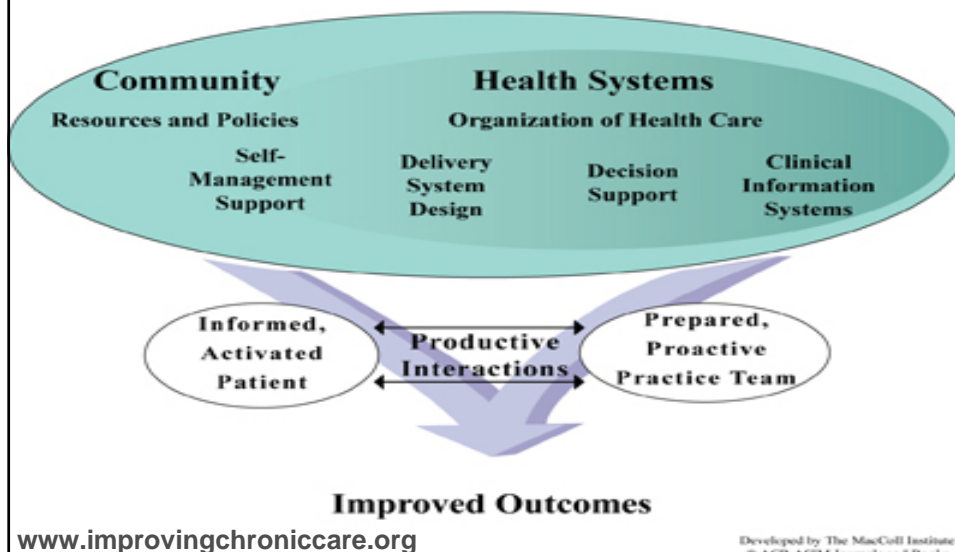
Overview



- **Based in Community Health Centre**
 - FHCC- Off campus to Hospital (WDHS)
 - Outlook / PJB / Vital
 - Paper based referrals
- **Allied Health (WDHS)**
 - Hamilton House (within the hospital)
 - Utilise Outlook / PJB / Vital
 - All major Allied Health Services
 - Lengthy waiting times (Podiatry up to 1- 2yrs)
- **Hamilton Medical Group (Private Practice)**
 - 13 GP's, 3 Physicians & 8 Practice Nurses.
 - Medical Director
 - ARGUS
 - Aging workforce
 - Work closely with WDHS

A Guide To Assist With Set Up

The Chronic Care Model



Working across systems



- COMMUNICATION!!!
 - Meetings (Steering Group)
- Having support from organisational leaders
 - HMG – GP's, Practice Manager
 - WDHS – CEO, DCS, DCEO, Finance Manager
- Involvement in IT
 - WDHS IT Management Team
 - SWARH
 - Otway Division General Practice

Working across systems



- Utilise what is available
 - If its not broken why change it?
 - Improve on current systems
- Enhance IT capacity
 - Simplify referral process eg ARGUS (encrypted email)
 - Recall systems (utilising reception staff, PJB)
 - Feedback to GP from Allied Health
- Involving all in decision process

Challenges



- Access to Private Allied Health Services
- Allied Health employed at WDHS to receive Medicare provider numbers
- Ability to provide private Allied Health services through a public hospital – sorting through legalities
- Implementing new IT systems
 - Electronic referral using VSWRF on MD through ARGUS
 - Feedback between AH and GP's using ARGUS
 - Time involved to implement across all services!!
 - Training
 - Having this process used by all involved
- Being patient in seeing change occur

Enablers



- Supportive GP and Private Practice
 - Given access and training on Medical Director
- HMG and WDHS support
 - CEO, DCS, Managers and staff
- Allied Health
 - Working across public and private settings
 - Changing practice methods
- Team motivated towards change
- SWARH
- PCP - Funding to train PN at HMG

The Nurse



- Plays important role
 - Assists with GPMP (reduce GP workload)
 - Resourcing community services
 - Educating both client and other health professionals
 - Assess both physical and psychosocial issues
 - Assist with the referral process/ paperwork
 - Promote proactive change in CDM

What we offer the client



- Fully Bulk Billed Service
- Single care plan with a team care approach (GPMP- MBS ITEM 721)
- 5 X Allied Health Consultations per year (TCA- MBS ITEM 723)
- GPMP- 1hr+ per client assessment that covers physical and life style issues.
- Skills to Self Manage with a written plan (GPMP)
- 3-6/12 review of their GPMP (MBS ITEM 725)- set new goals
- Disease status monitored

What we offer the client

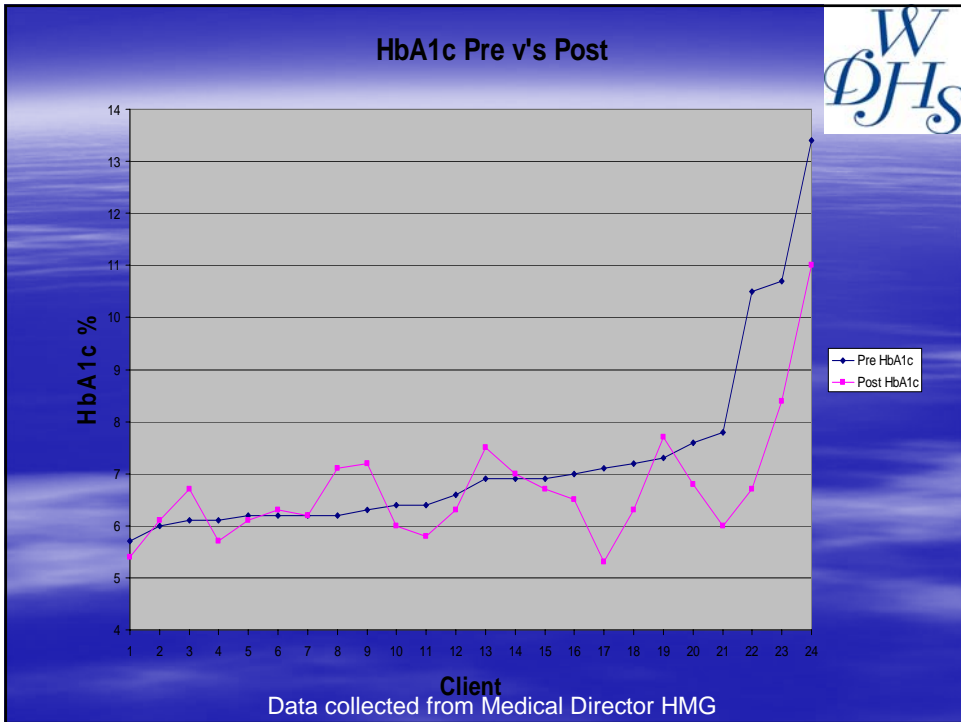
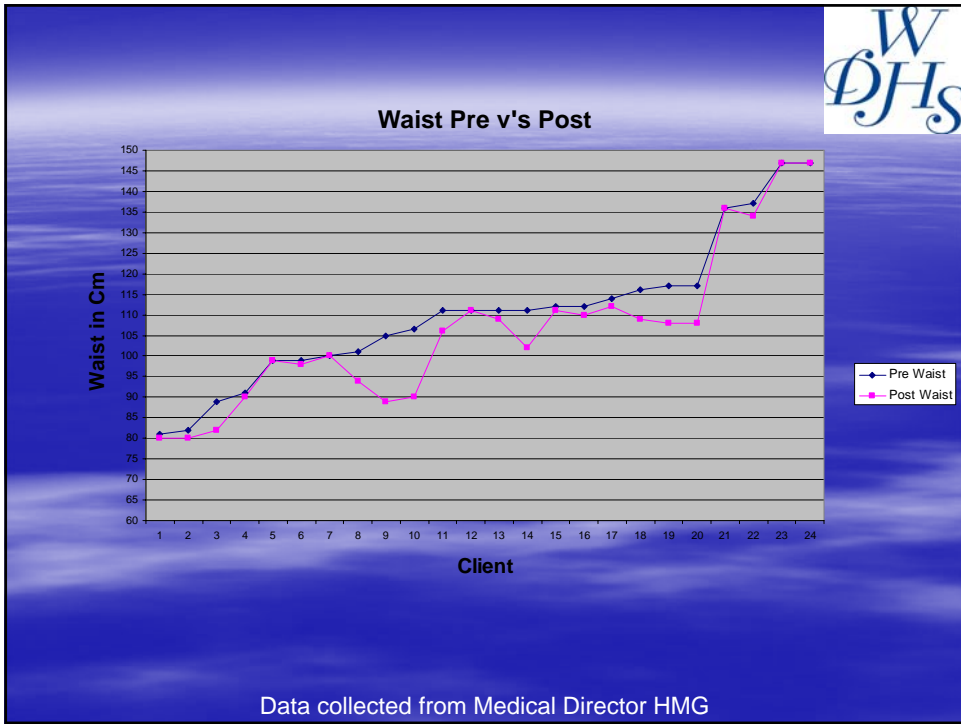


- Education- chronic illness, Sx of exacerbations, Self Mx.
- Preventative strategies, services available.
- Planned Follow up / support.
- Care coordination
- Self management course (Better Health Self Management – 8 week course)
- TIME!

Where we are at



- 57 referrals with 42 GPMP completed
- 24 Review of GPMP at 3- 6 months
- Have a total of 6 GP's referring
- Not about getting a large volume of clients until the process is implemented correctly



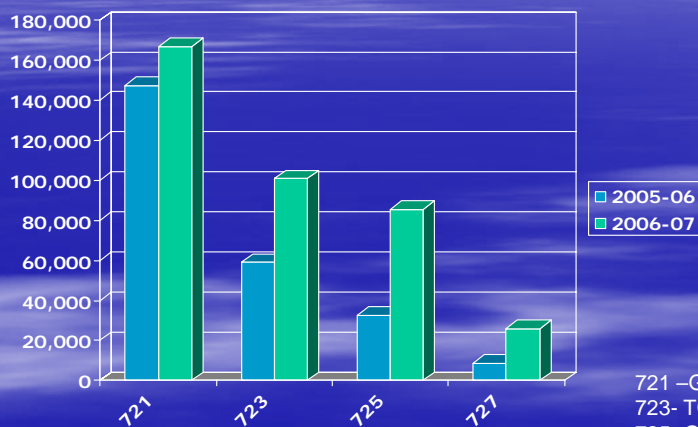
Proactive CDM



- To be proactive in the way CDM in primary care is delivered
- Change culture!!!
 - Private GP Practice
 - Community Health Setting
 - Allied Health
- Implement appropriate and effective communication and referral systems
- Offer self management skills, education and decision support for the client –EMPOWER THE CLIENT
- Decrease unwanted complications, exacerbations & hospitalisations
- Provide client with a written plan with client orientated goals

Uptake of Care Planning MBS items - GPs in Victoria

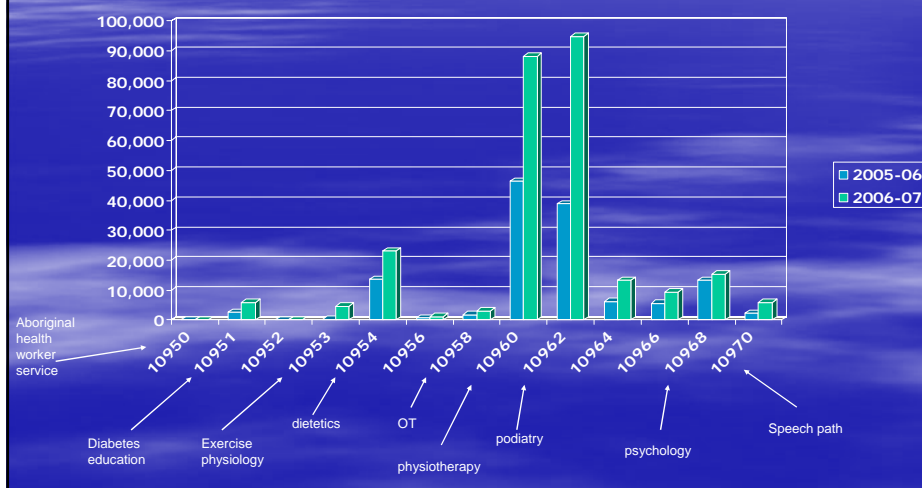
(Source Peter Larter DHS/ Medicare Australia)



721 –GPMP Preparation
723- TCA Coordination
725- GPMP Review
727- TCA Review

Uptake of Allied Health MBS items AH providers in Victoria

(Source: Peter Lanier DHS/ Medicare Australia)



Conclusion



- Supportive health organisation and leaders
- Involve all in service design and delivery
- Effective communication and recall systems
- Supportive GP's willing to promote change
- Provide decision support – empower client
- Create motivated, informed clients
- Shift the way primary health care is given from “reactive” to “proactive”



QUESTIONS



HAMILTON MEDICAL GROUP

Western District Health Service