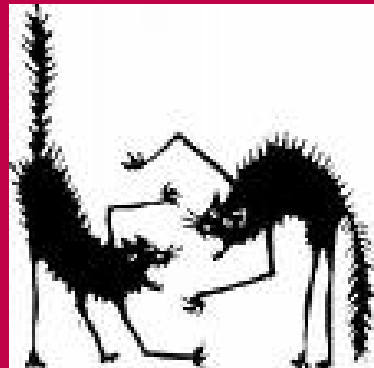


## A more responsive chronic disease approach in rural Victoria.

April 2008

### Background

- Bendigo's HARP CDM and EliCD programs have developed an interface at governance, and clinical service delivery levels.



## Bendigo Health HARP CDM

- Commenced in 2002
- Provides comprehensive multi-stream program
- Respiratory, Cardiovascular, Diabetes, Complex psychosocial, Chronic Kidney Disease, Older Persons, Residential Outreach, ED Care Coordination
- 23 member multidisciplinary team



## Bendigo Community Health ElicD

- Commenced in January 2007
- Single stream currently diabetes - future direction respiratory disease
- 6 member multidisciplinary team
- Over 150 patients enrolled in the program and accepting up to 16 new patients per week



## Joint governance

- Both programs share governance arrangement via the Central Victorian Chronic Disease and Complex Care Alliance
- Group initially established to provide governance to the HARP CDM project



## Governance structure



Central Victorian Chronic Disease and Complex Care Alliance




Chronic Disease Management operations group



Health Promotion teams

**Table 1: Levels of chronic and complex care management**

<p><b>Level 1</b> People with chronic diseases and complex needs who frequently use hospitals and are assessed as meeting the HARP CDM screen</p> <p><b>Level 2</b> People with chronic diseases and complex needs who use hospital or are at risk of hospitalisation and are assessed as meeting the HARP CDM screen</p> <p><b>Level 3</b> People with chronic diseases and/or complex needs</p> <p><b>Level 4</b> Whole population</p>	<p><b>Intensity</b></p> 	<p><b>Intensive care coordination</b></p> <ul style="list-style-type: none"> <li>• Care across the continuum</li> <li>• Tertiary and secondary prevention</li> <li>• Enrolled patient population</li> <li>• Comprehensive assessment and care planning</li> <li>• Specialist medical and GP management</li> <li>• 24 hour advice</li> <li>• Additional services where appropriate</li> <li>• Self-management approach</li> <li>• Comprehensive hospital discharge planning</li> </ul> <p><b>Usual Care</b></p> <ul style="list-style-type: none"> <li>• GP care</li> <li>• Self-management programs</li> <li>• Access to mainstream community services</li> <li>• Generic telephone advice</li> </ul> <p><b>Primary Prevention</b> For example: obesity reduction, smoking cessation</p>
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## Referral between programs

- Determined by acuity of patient
  - Complexity
  - Ongoing needs
  - Service mix
- Implementing “E” referral using connecting care

## Case conferencing

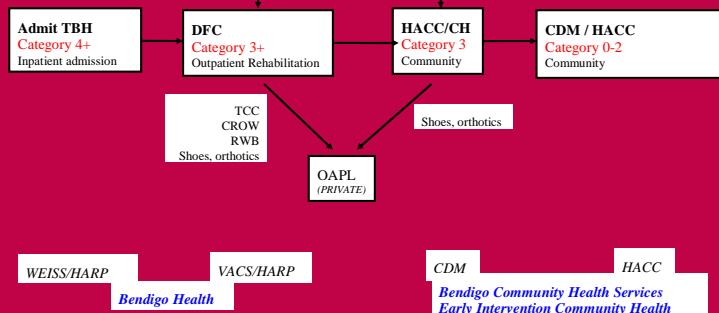
- Occurs between relevant clinicians involved in patient care
- Driven by service mix requirements
- Purpose to coordinate care, prevent duplication and develop or modify care plans (done in collaboration with GP)



## Podiatry pathway

**Category Glossary**  
 0- No peripheral neuropathy (PN)  
 1- PN  
 2- PN and structural deformity of feet  
 3- History of pathology  
 4-6- Active pathology (ulcer, charcot, ischaemia, infection)

**Category 3**  
 Registered DFC and CDM programs.  
 BCHS - Monitoring, reviews  
 DFC - inactive  
 Seamless, reciprocal referrals can be made - phone, email, letter



## Service Improvement Teams

- Continuum of care for Paediatric and Adolescent client with diabetes
- Need identified
- Processes developed with both teams and primary & secondary schools
- Processes implemented



## Barriers/difficulties

- Defining who's patient is who's...
- Confusion about which program does what amongst the broader health community...
- Duplication is an ever present risk...
- Supporting patients when referred between programs...



## The future.....

- Continue to build linkages and strengthen existing partnership
- ELiCD will expand the disease cohort managed within the program...
- HARP CDM continue to refine and consolidate...
- Continued joint work in Health Promotion activities...
- Collocation of the clinical teams...



**'They always say that time changes things, but you actually have to change them yourselves.'**

**Andy Warhol**