Hospitals and PHNs – The New Force in the Management of Chronic Conditions (HRT1514)

3 – 4 September 2015, Bayview Eden Hotel, Melbourne

MEETING NOTES

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What strategies have you used, what worked?

X8 Cultural Changes
Transport
Socio – economic challenges
Cultural challenges – older persons & gym encouragement
Exercise physiologist – linking people back into the community
Public/private/community integration
Cultural shift "its ok to have to pay for health care"
Common use of patient portals

X 2 Health literacy program

X2 Targeting Care/Frequent Presenters
Prioritise – Targeting those who are in needs vs the most vocal
Case management holistic approach, multi D approach evidence based linkage with PHC providers
Who are your 'Frequent presenters

X3 Collecting data 'Knowledge'
Measures for each hospital, Knowing your data

What strategies have you used, what worked? Continued…

X 10 Rehab & Follow up

Cardiac Rehab – Alternative ways

- Post discharge follow up.
- Choice – cardiac Rehab locally & Phone follow up

CNC – Care Co-ordination

- Home Community focussed program

Enrolment Rehab Program on 1st Administration

1 week – early review GP/Hospital Staff, Home visit and clinic nurse led program

Phone call early after discharge nurse

48 hour follow up for all chronic & aged

Phone call within 1 day of discharge

Nurse practitioner & Allied Health post follow up, Home visits nurse led clinics c2/52 visits post DC

Introduction in hospital

- Not addressing issue in hospital
- See them at home
- Go home with action plan

Telehealth (home monitoring)

HARP – Follow up

- ED re-presentation daily report
- Links community action plans ie inpatient & Ed care

What strategies have you used, what worked? Continued…

X 7 Pathways of care importance

- GP
- Stepped model

Patient Education works
Sharing of data with primary healthcare a challenge

Action plans however challenging with target to the night clinician & which clinician?
Clinical pathways used as a directory of services. Provides lists of available resources for client – links 1 + 2

Challenges – GP – Sending patients to ED as management strategy

Expanding connecting care program to upskill/build capacity of GP practice nurses

Standardise practice

Worked – technical experts significant experience that can intervene at the point of contact

Building capacity in PHN

Working with primary care nurses

Communication GP – DIC summary

Risk stratification of populations to support early intervention

Build a sustainable system for everyone!

Individualised care

Home Care education – Family inclusion
Patient empowerment
Tailored Individual Health care

Sharing Data

Identifying the areas in our local health networks

When working with PHNS to make change in there geographical areas

Building in education and innovation between the PHN Acute care sector

? Accurate & representative
? Increase to all hospitals
- Disease demographics etc.
- 3D graphs – Age/Disease

Geo mapping t work with GP's who may need assistance with certain disease type

More relevant for GP's – Primary Care

Overlay of social – economic status on maps

Maps LGA
- Rurality
- Chronic disease

Correlate maps to Health Service providers

Yes to maps
- Areas being done well

HRT involved in sharing of data
GP (No HRT) – Hospitals (HRT)

In principle yes to sharing – need to set up forums locally to discuss

Multidisciplinary health care (quality) in one place

Sharon Appleyard Debrief

What can we learn from pharm about how to engage with GP's

Build relationships with public/private NGO's

Change GP opinions.

Engage GP's in new models of care

Work across PHN & LHD's towards same goals

No long term objective – lack of confidence

? Resources? Framework? Transition (2015)

Positive framework

Greater clarity around what is the responsibility in provision of care at hospital vs PHN's

Local measures – Linked with hospitals to work together

Key Issue – Funding models particularly to encourage nurses in GP practices to work top of scope

PHNs engagement with nurse practitioners

Make it like one system.

- Jointly developed patient pathways
- Co-ordinate role hospital/community link (community based)

Cabrini Debrief –Sally Howell

Access in a timely manner
Relationships – transition of care
High level of trust
Connectedness of the COPD program
Advance care planning "respecting patients choice"
Individualised program of care
Self-Management
Patient centred
Maintenance
Re-entry point to the program
Community in reach Works!
Level of engagement in public health vs private differ – A high number of public patients refuse
HARP engagement
Public and Private

- Partnerships
- Sharing Resources
- Collaborative patient care and supports

Cuba

Gary Yip – ICCS Debrief

Requires evidence that the model works. Grounded in the literature
KEY to identify (intervention required) early in the disease trajectory
Catching patient early
Technology to suit patients to have an interaction
Physicians &GPS working side by side – upskill GPs
General Physician specialist , Allied health, pharmacy , nursing social services -- ALL IN ONE hubs in the community
Cuba
Staff Specialists treats patient in the community to treat patients
Key players around the table
What is the funding model & resource model
Co-locating of services
Referral to appropriate other services
Speciality education for CNC
Mentor relationships
Communication with key clinical experts
Shared care model with funding