Poster Session
HRT11420 –Innovation Awards
November 2014 Melbourne

Diabetes care – primary care capacity building for whole of system change.

Presenter: **Tom Chapman**
Team: Linda Soars, Michael Napoli, Milena Katz.

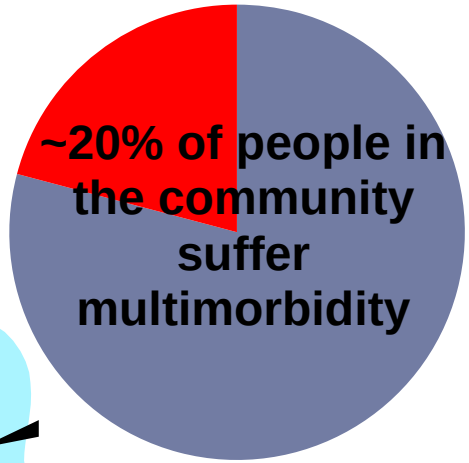
South Eastern Sydney Local Health District

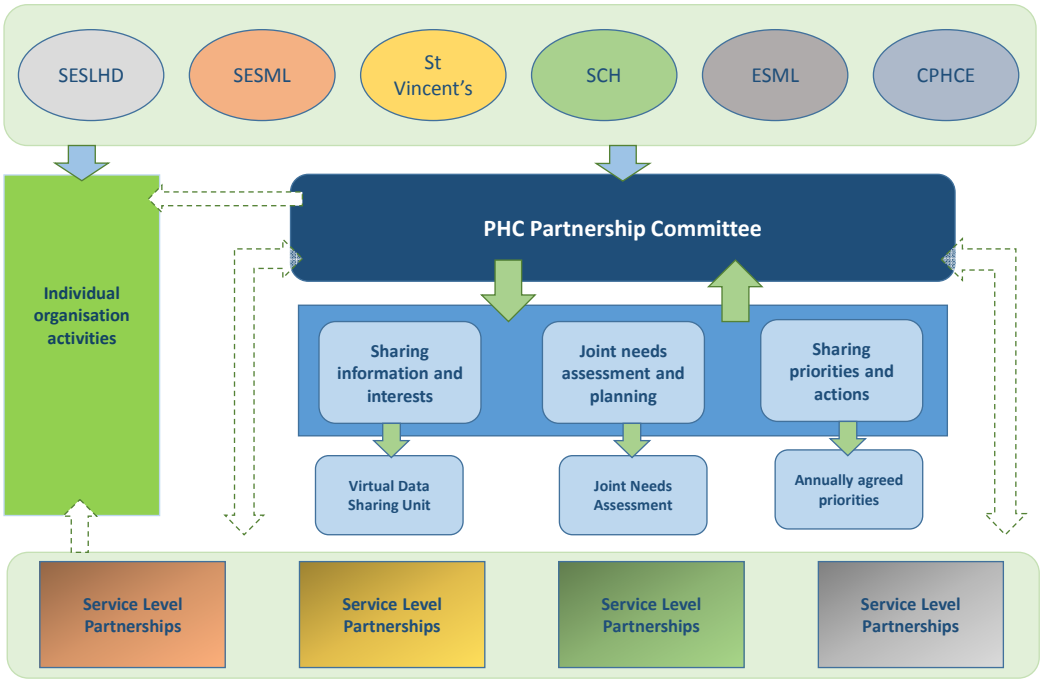
Elevator Pitch- What is the outcome/significance of your presentation?

- People rarely experience health problems one at a time, yet the delivery of care to patients is usually designed like this is the case.
- Review of hospital admissions with extrapolations to the wider community reveal multimorbidity is a large problem.
- There is a need to deliver services better to people confused by multiple care providers and multiple care plans that create unnecessary difficulty in negotiating the system.
- Multimorbidity demands person centred and integrated provision of care.

Presenters Summary

- The delivery of person centred and integrated care to people with multimorbidity is vital.
- The level of multimorbidity means we need to do things differently.
- Outcomes
  - **Integrated Care Strategy**
  - **Primary Care Partnership**
  - "Deep dive" data analysis, including "asset" mapping
  - Localised risk stratification
  - Personalised care planning,
  - Use of patient activation measures
  - Proactive "anticipatory care"
  - Shared patient registers
  - IT based care logistics
  - Use of mHealth technologies





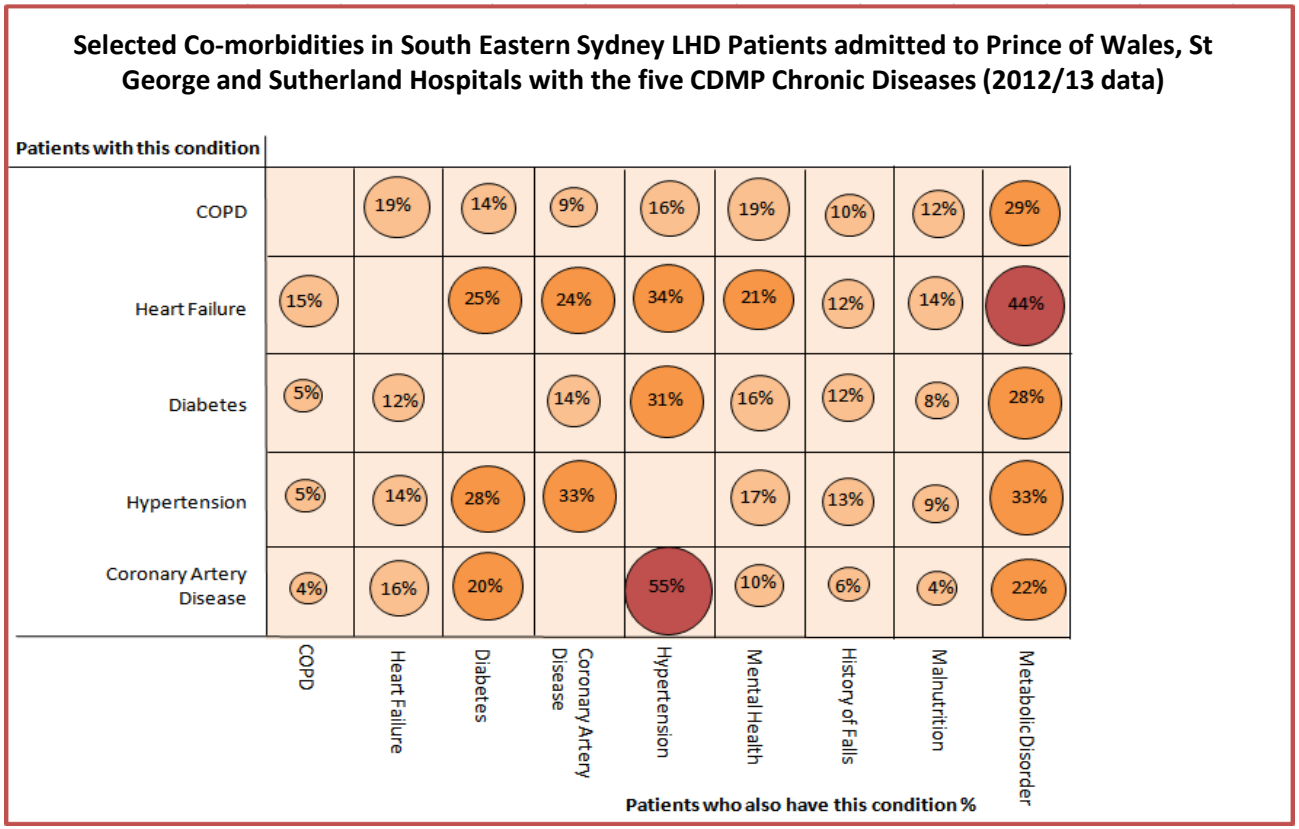
KEY PROBLEM

- Multimorbidity is a barrier to delivering coordinated care to patients and families[1,2.]
- Coordination of care is difficult when there are multiple care providers for multiple conditions.
- Care continuity is affected adversely through lack of adequate communication channels and/or lack of relationships or trust between service providers.
- The extent of multimorbidity has surfaced as an issue upon investigation of integrated diabetes solutions.

1. Barnett K. et al. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012; 380: 37–43
2. Britt HC et al. Prevalence and patterns of multimorbidity in Australia. MJA 2008; 189: 72–77

AIM OF THIS INNOVATION

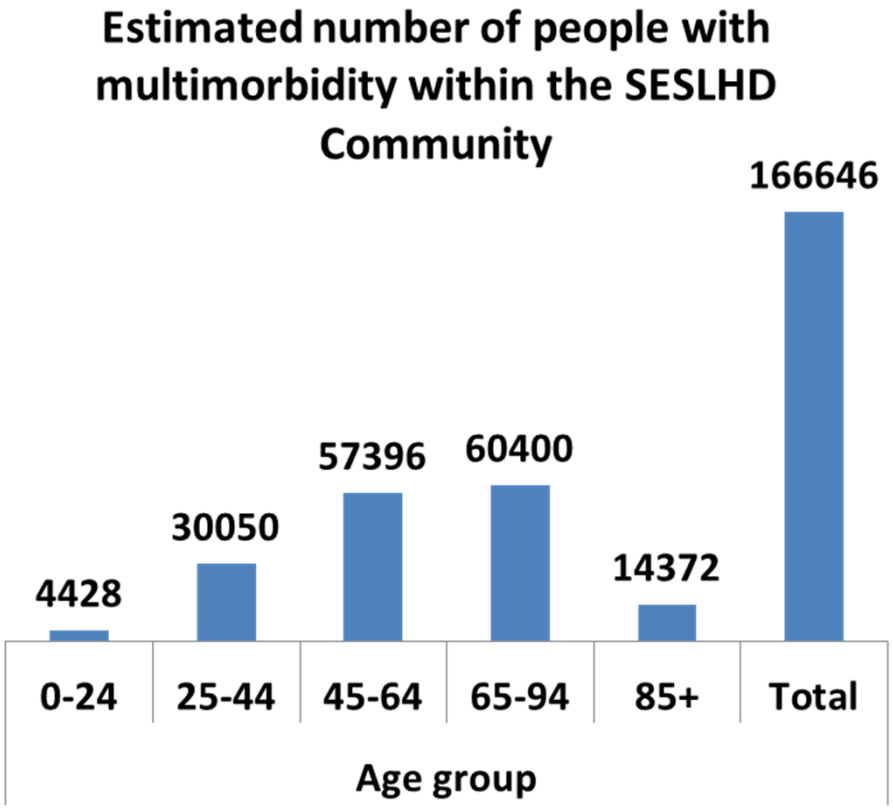
- To investigate the level of multimorbidity in the wider South Eastern Sydney Local Health District community from initial hospital data.
- To use this data to drive changes in care provision for people with long term conditions.

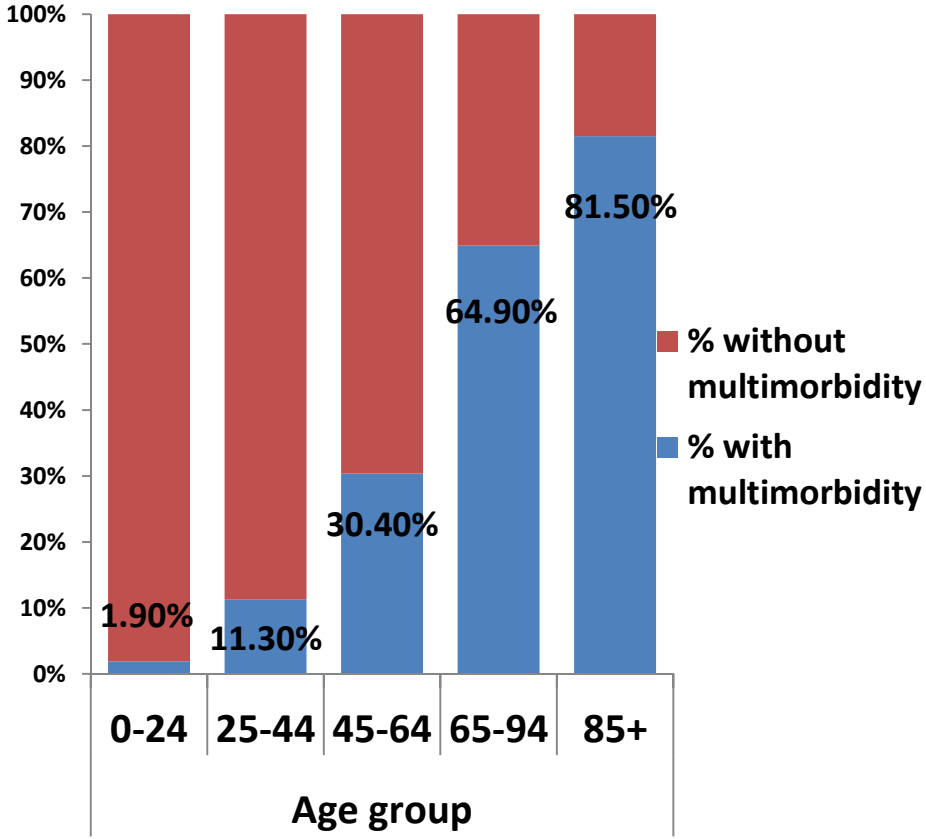


The Health Roundtable

BASELINE DATA

- Using Barnett's method of review it was shown that the level of multimorbdidity within the community is a larger problem than just those attending hopital





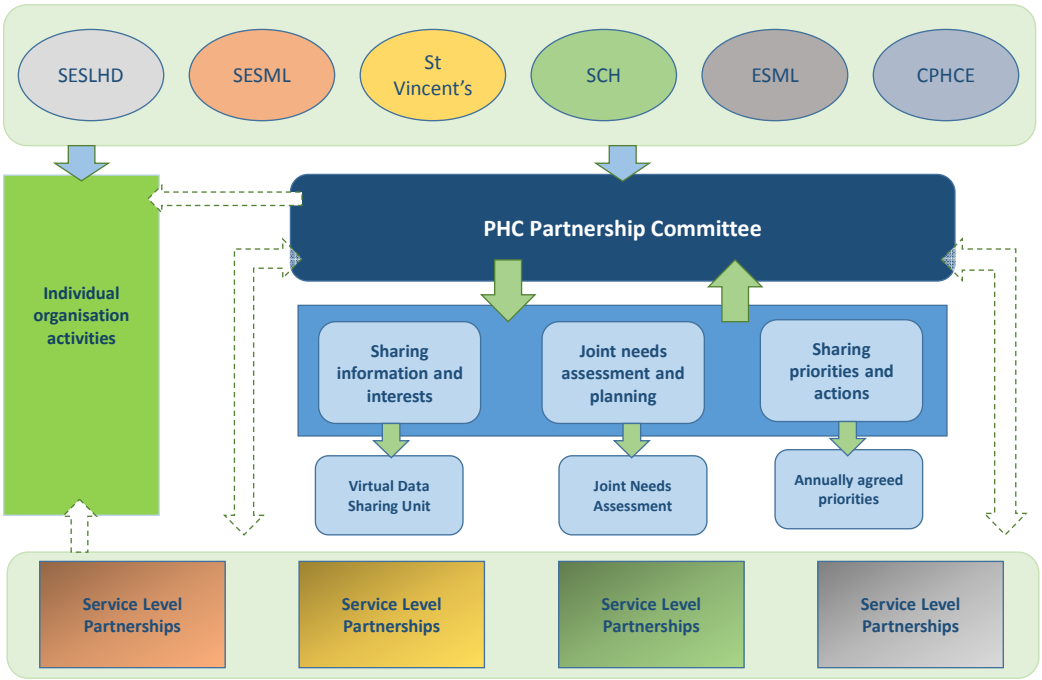
The Health Roundtable

KEY CHANGES IMPLEMENTED

- Development underway of an Integrated Care Strategy

Integrated Care Strategy

- Primary Health Care Partnership underway.



OUTCOMES SO FAR

- Primary Care Partnership
- Integrated Care Strategy

- Next steps:
  - "Deep dive" data analysis, including "asset" mapping
  - Localised risk stratification
  - Personalised care planning,
  - Use of patient activation measures
  - Proactive "anticipatory care"
  - Shared patient registers
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LESSONS LEARNT

- Multimorbidity needs to be addressed
- Person centred care designed around patient and family needs is vital
- Communication of patient care plans is inconsistent
- There is a lack of relationships and trust between care teams adversely affecting transfer of care
- The capacity of the hospital system to deliver this care is limited, unless partnerships with primary care are established.
- In order to treat and manage long term conditions around patient needs and to keep them healthy and out of hospital, we need to integrate more intensely with community/primary care.

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