GP down south

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GP down south Chronic Conditions Care Coordination Service

Overview and Case Example

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Integrated Chronic Disease Care (ICDC) Program
Chronic Conditions Care Coordination
Information Sheet for Health Professionals

Who We Are:

GP down south is a not for profit, community-based organisation providing health and wellbeing services in the Peel and South West regions of WA since 1994. GP down south is funded predominantly through Commonwealth and State Health Departments, with Commonwealth funding received via WA Primary Health Alliance (WAPHA).

Integrated Chronic Disease Care Program (ICDC)

GP down south is working as a member of the SW Chronic Conditions Collaborative to improve the health outcomes of people with chronic conditions in the South West of WA. Funded by WAPHA, the ICDC program focuses on improving the integration and coordination of services for people with chronic conditions within the region.

In addition to our well established Diabetes Education services GP down south also provides community based Chronic Conditions Care Coordination services for people whose care is managed in the primary health setting.

Community Based Chronic Conditions Care Coordination

Effective coordination of patient care is essential in achieving optimal health outcomes.

People with chronic conditions often have multiple conditions and complex health needs which can lead to poor health outcomes, comorbid mental health conditions and a decline in social and occupational functioning.

Often there are multiple health professionals and services involved in providing care and assistance for people with chronic conditions across primary, secondary and tertiary levels of the health system.

Our Care Coordinators will work with people to assist them manage their chronic health conditions through the development of individual plans which augment already existing GP Management Plans or specialist treatment plans and increase self-management capacity.

Our Care Coordinators will:

- **Use evidence-based patient focused assessment and care planning tools**
- **Work with your patients/clients to develop individualised plans based on their current health needs and goals**
- **Facilitate engagement in existing GP Management Plans**
- **Provide specific education regarding their health conditions**
- **Support people to develop skills and strategies to self-manage their conditions**
- **Encourage the use of disease specific action plans**
- **Provide support to make health and lifestyle change**
- **Refer to other health professionals, health and wellbeing services as needed**
- **Provide liaison and advocacy**
- **Linkage to local community based supports**
- **Communicate with you regarding the person's progress on a regular basis.**

Who Can Access This Service?

People living in the South West of WA who have one or more of the following chronic health conditions:

- Cardiac conditions including heart failure
- Respiratory conditions including COPD and asthma
- Diabetes

People who are aged 16 years or older

People who have difficulty accessing services or are currently experiencing financial or social disadvantage.

How Much Does This Service Cost?

This is a free service for eligible people.

How Can I Refer To This Service?

GPs and other health professionals are able to refer to the GP down south Chronic Conditions Care Coordination Service using the referral form which is located on our website www.gpdownsouth.com.au

If you would like further information please contact Nicola Hilyard - Program Coordinator at GP down south P: 9754 3662 E:swprograms@gpdownsouth.com.au

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WA Primary Health Alliance
Better health, together

phn
PERTH NORTH, PERTH SOUTH, COUNTRY WA

This service has been made possible through funding provided by the Australian Government under the PHN Program

Case example; Carol

Assessment/ Background

- 58yr old lady referred by *WACHS-SW CCCC*. Admitted with pulmonary oedema and leg cellulitis.
- Background of decompensated heart failure (HF), morbid obesity, insulin requiring type 2 diabetes, multiple falls; fractured hip, depression, and self-neglect.
- Living alone. House cluttered. Daughter living locally; very engaged and keen to know how to help.
- Disability pension. NDIS pending
- Socially isolated but enjoys craft. Used to go to craft-group but too far/hard now.
- *Flinders Program* assessments completed and issues identified:
    - Poor knowledge of Heart Failure (HF) and Diabetes, medications, HF self-management strategies and healthy lifestyle
    - low mood impacting her ability to self-manage
    - falls
    - carer stress
    - Carol forgets to take her medications

Goal-setting and Management

Carol's self-identified problems; *I fall over all the time…don't know why I get sick so much*

Carol's goals; "*…to walk better and not fall over". "…to stay out of hospital".*

Agreed Management plan. Provide Carol and her daughter with:

- education on heart failure and self-management strategies
- HF and chest-pain Action Plans, resources: *Living Well with Heart Failure*, *Heart Attack Action Plan*
- diet and exercise; referral to cardio-pulmonary rehabilitation, dietitian and diabetes educator, resources *Healthy Eating for Adults, and NDSS Healthy Snacks & Making Healthy Food Choices,*
- link in with local social/ craft groups,
- suggest to Carol's GP that she might benefit from a *Home Medication Review* and *Webster Pack*, and
- provide daughter with information about *Carers' WA, Community Home Care* (CHC) and *NDIS.*

Outcome

Due to Carol's intermittent confusion, multiple falls and hospital admissions she eventually moved in with her daughter. Daughter deferred her full-time study to care for her mother.

Daughter now fully conversant with HF and diabetes management strategies. She:

- monitors Carol's fluid and salt intake,
- makes sure she takes her medications and eat well, and
- encourages Carol to exercise more, going for walks with her daily.

- *Community Home Support Program (CHSP) services* were increased to support Carol and provide respite for her daughter.

- GP informed intermittently throughout, of Carol's progress.

Carol happy and well cared for at last meeting; great improvement in health and QOL noted at discharge. Carol was seeing her GP regularly and had not been in hospital for some time.

Carol proud of her weight-loss, and enjoyed telling me about her outings with her carers for shopping to buy a dress, to have coffee or to craft-group.

Carol's daughter started an on-line 'carers' course and was going to Bingo on Friday's when the CHC carer was with Carol.

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PRO/ICDC-FRM-801.09
REFERRAL FORM – ICDC.CCCC

ICDC – Chronic Conditions Care Coordination Service

Please send this Completed Referral Form and supporting clinical documents to GP down south fax number: 9754 2985

Client Details				
Medicare No:	Ref:	Exp:	Client Address:	
Client Surname:				
Client First Name:				
D.O.B:	☎:			
Email:			Home-visit risk? ☐ Yes	☐ No
Do you identify as:	☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Neither
Gender:	☐ Male	☐ Female	☐ Indeterminate/Intersex/Unspecified	
Speaks English?	☐ Very Well	☐ Well	☐ Not Well	☐ Not at all

Referrer Details	
Name:	Ph:
Practice/Organisation:	Fax:

General Practice/Usual Doctor	
Name:	Ph:
Practice/Organisation:	Fax:

NOTE: TO BE ELIGIBLE PATIENT MUST HAVE ONE OR MORE IDENTIFIED PRIMARY DIAGNOSIS FROM LIST BELOW

PRIMARY DIAGNOSIS ☐ **COPD** ☐ **Chronic Heart Failure** ☐ **Diabetes** ☐ **Asthma**

Comorbid Diagnosis	☐ Kidney Failure	☐ Mental Illness	☐ Other: _____	
Social Situation	☐ Financial Stressors ☐ Housing Pressures	☐ Family Dynamics / Responsibilities	☐ Transport Difficulties ☐ Difficulties Accessing Medical Services	☐ Other (please list):
Services/Allied Health currently in Place	☐ Physiotherapy ☐ Chiropractor	☐ Occupational Therapy ☐ Social Work	☐ Aged Care Package	☐ Other (please list):
Specialist Involvement	☐ Dr Cox ☐ Dr Hinton	☐ Dr de Chanert ☐ Dr Garg	☐ Other (please list):	
Risk Factors	☐ Smoking ☐ Overweight / Obesity ☐ Underweight	☐ High Cholesterol total cholesterol >5.5; HDL<1.0; LDL>2.0	☐ High Blood Pressure >140-90 or on meds	☐ Physical Inactivity ☐ Polypharmacy >5 medications

Brief Synopsis / Reason for Referral

Past Medical History

Current Medications: Please attach accurate list with dosage

Consent
☐ I have discussed this referral with the client who consents to being referred to the Chronic Conditions Care Coordination Service.
Referrers Signature: Date:

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