

Australian Better Health Initiative

WentWest & SWAHS

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28 October 2009



WentWest

- WentWest is a unique organisation providing both the Australian General Practice Training (AGPT) program for general practice vocational training in western Sydney and Division of General Practice services.
- Provides support to over 550 GPs
- Involved in university teaching through Sydney University Department of General Practice
- Involved in development and implementation of integrated primary healthcare solutions in Western Sydney one of which is ABHI.

Australian Better Health Initiative

Background

COAG - Australian Better Health Initiative on 1 July 2006

To strengthen the focus of the health system on prevention, health promotion and the management of chronic disease

There are five priority areas identified under ABHI:

- Promoting Healthy Lifestyles
- Supporting Early Detection of Lifestyle risk factors and chronic disease
- Supporting lifestyle and risk factor modification
- Encouraging active patient self management
- Improving integration and coordination of care

WentWest ABHI

Aim - The project aims to achieve continuity of care for chronic cardiac, chronic respiratory, multiple conditions and aged patients in the area of Blacktown, by integrating the services of the hospital, general practitioner and community health.

Rationale

- Highest number of admissions and readmissions for respiratory, cardiac, cancer and diabetes in SWAHS
- Focus on acute episodic care, and limited contact between SWAHS staff and GPs
- GPs unaware of patients presentation, treatment, discharge, community assessments etc
- Community health unaware of patients clinical management plans.
- Literature review

SWAHS

- Promoting integrated and timely care in the community and hospital (PITCCH)
- Sixteen solutions recommended by PITCCH
- Care Navigation

GAPS

- Rehabilitation programs
- Discharge planning
- OPERA/ASET
- Communication
- Community Health

Gaps Identified - GPs

- Communication from hospital.
- Quality of information on the discharge summary.
- Access to information is difficult
- Multiple contacts within the system, don't know whom to call
- GP is not approached preadmission, or through admission
- There need to be better collaboration, including a better discharge summary which is a tool to improve communication.
- Absence of shared protocols for management.

Solutions Implemented

- Integrate hospital and GPs and vice versa
 - GP notifications from ED on discharge
 - Discharge teleconference
- Integrate community health and GP's and vice versa
 - GPs register into ABHI program
 - GPs fax template and GPMP to community nurse
 - Community nurse visits patient and provides written feedback to the GPs
 - GP Liaison Nurse helps to organise case conference
 - Ongoing feedback from community nurse and GPLN

Summary of the Discharge Case Conference

Please use I.D. label or block print

Date: _____ **Start Time:** _____ **Finish Time:** _____

Duration of meeting | **15-29 minutes** | **30-45 minutes** | **>45 minutes**
 GP contributes: 768 771 773

Surname:	MRN
Given Name:	
DOB:	Sex:
Doctors name:	
GP Name:	

INTERPRETER REQUIRED? COPY /SUMMARY TO PATIENT OR OTHER SERVICE PROVIDERS

Identified Problems	Management Goals	Management Steps/ Activities	Care Provider Details	Discussed With Care Provider, Date etc.,

CONSENT TO PROCEED WITH DISCHARGE CASE CONFERENCE VERBAL CONSENT Date:

My Discharge Planner/ Patient Flow Coordinator has explained the purpose of the Discharge Case Conference and I give/my carer gives permission to discuss the above issues, with the providers listed. I am aware that there is a fee for my GP's involvement in this Discharge Case Conference, for which a Medicare rebate will be payable.

Signature of the Patient _____ Signature of / Patient Flow Coordinator: _____

Full Screen
 Close Full Screen

Successes So Far

GP and Hospital integration:

- ED Notifications from Sep 08 to Sep 09 – 363
- Discharge Case Conferences from Jan 09 to Sep 09 – 50

GP and Community Health integration:

- 30 GPs registered and using integrated care in community

Challenges

- Laborious
- Reluctance to change
- Lack of resources in the system
- Involvement of clinicians.
- Organisational ownership

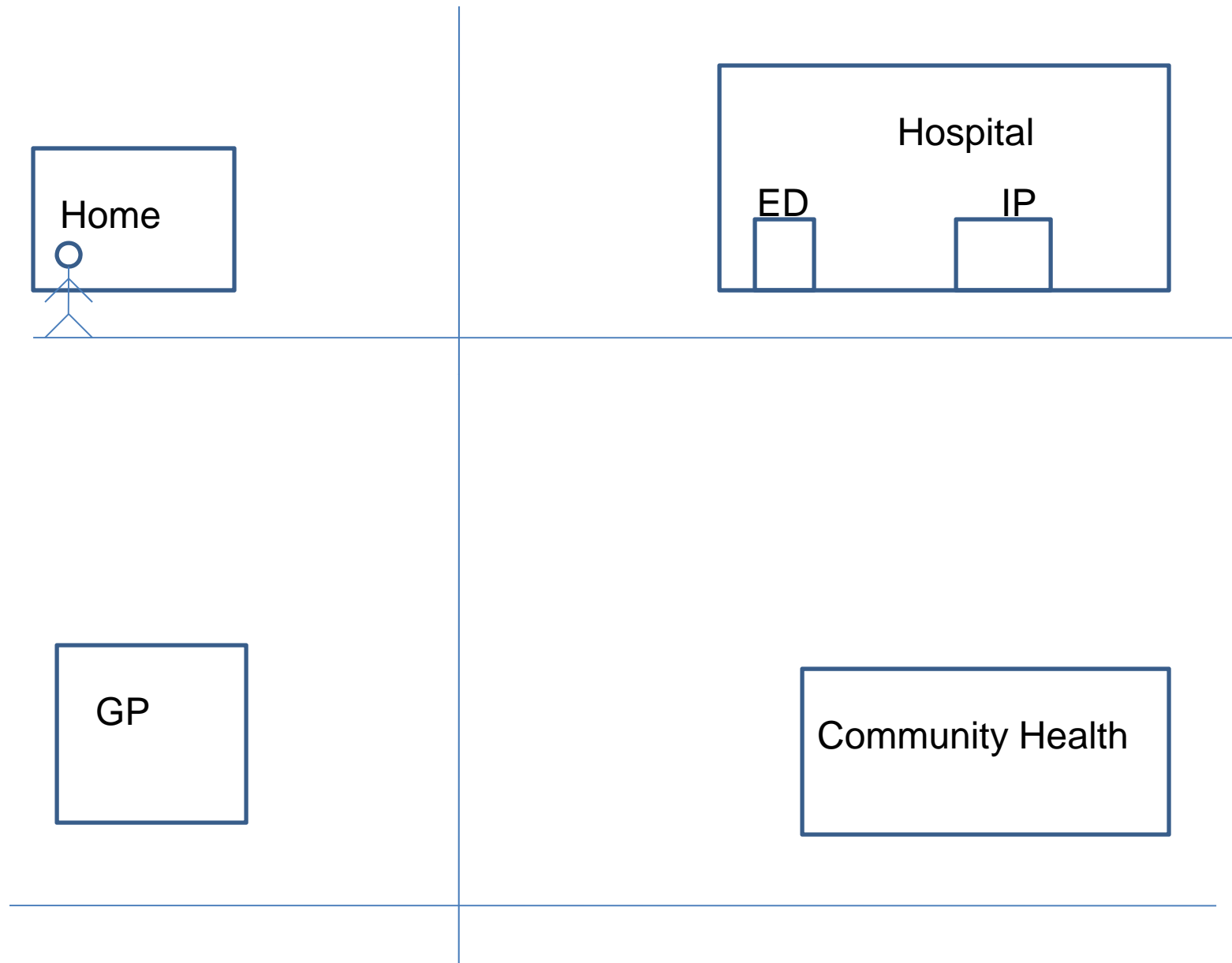
Sustainability

- Notifications from ED
- Discharge teleconferencing
- GPs to send background and care plan as a part of the process
- Written feedback to GPs from community nurses
- Community Case conferences

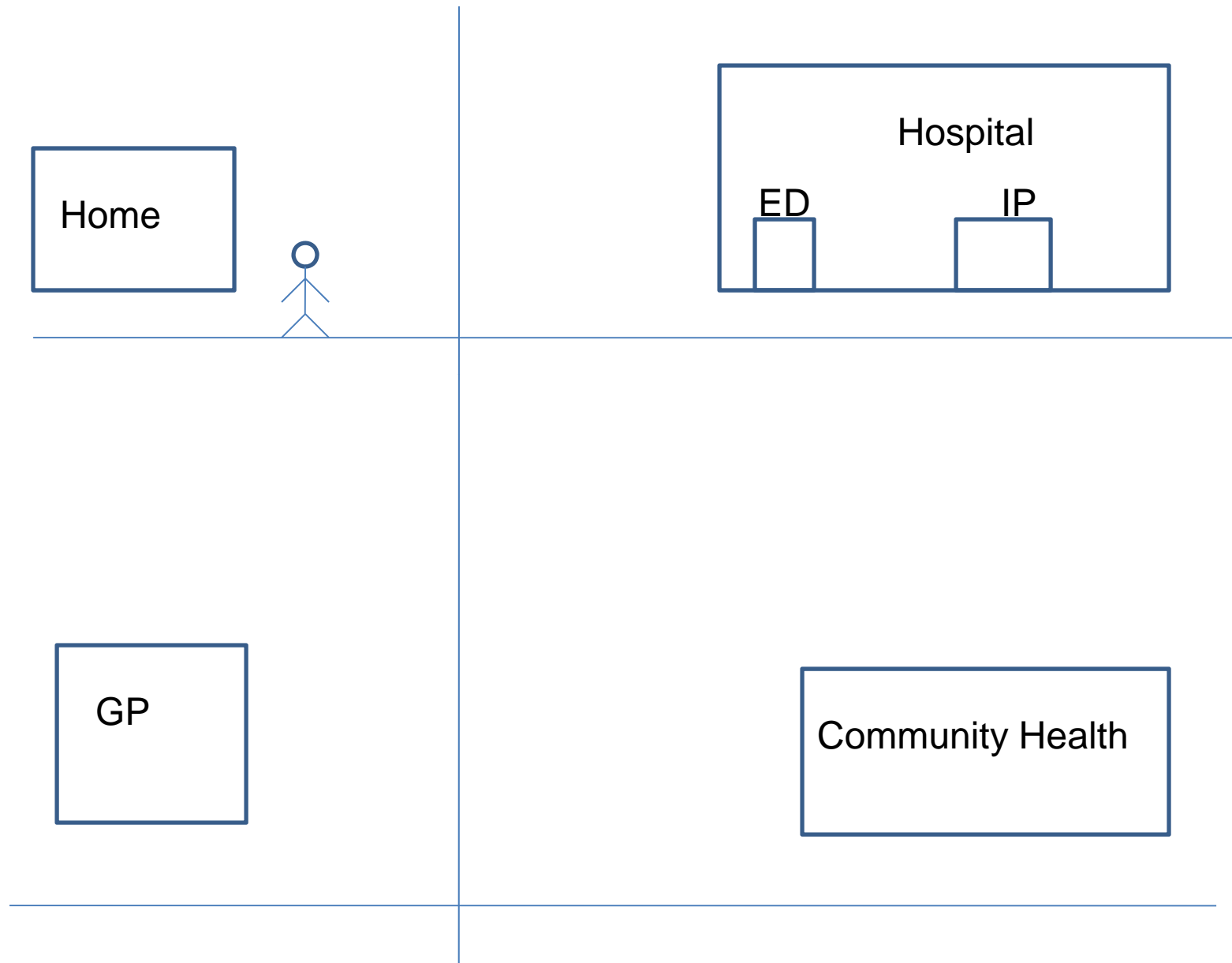
WentWest - ABHI

The Picture – In Summary

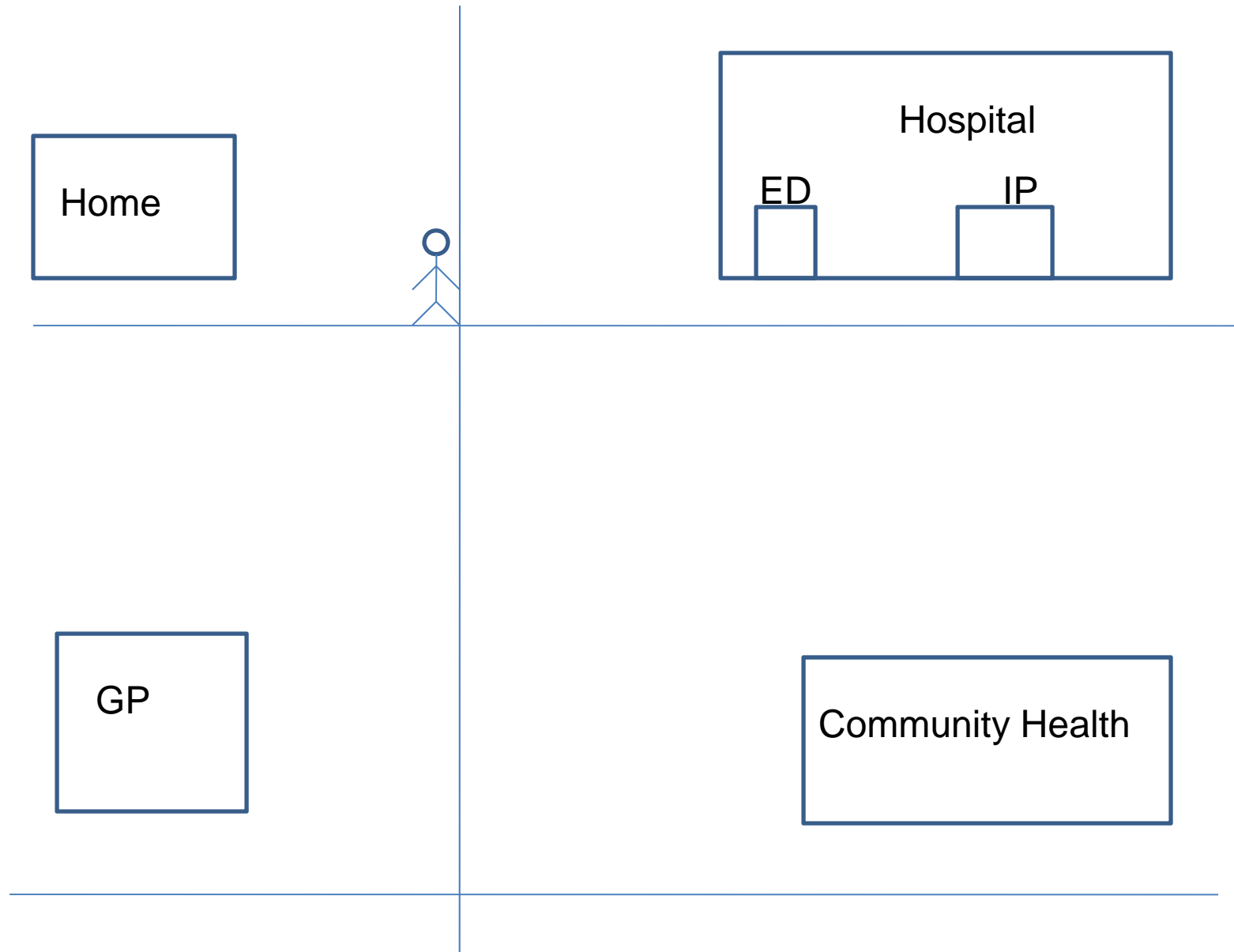
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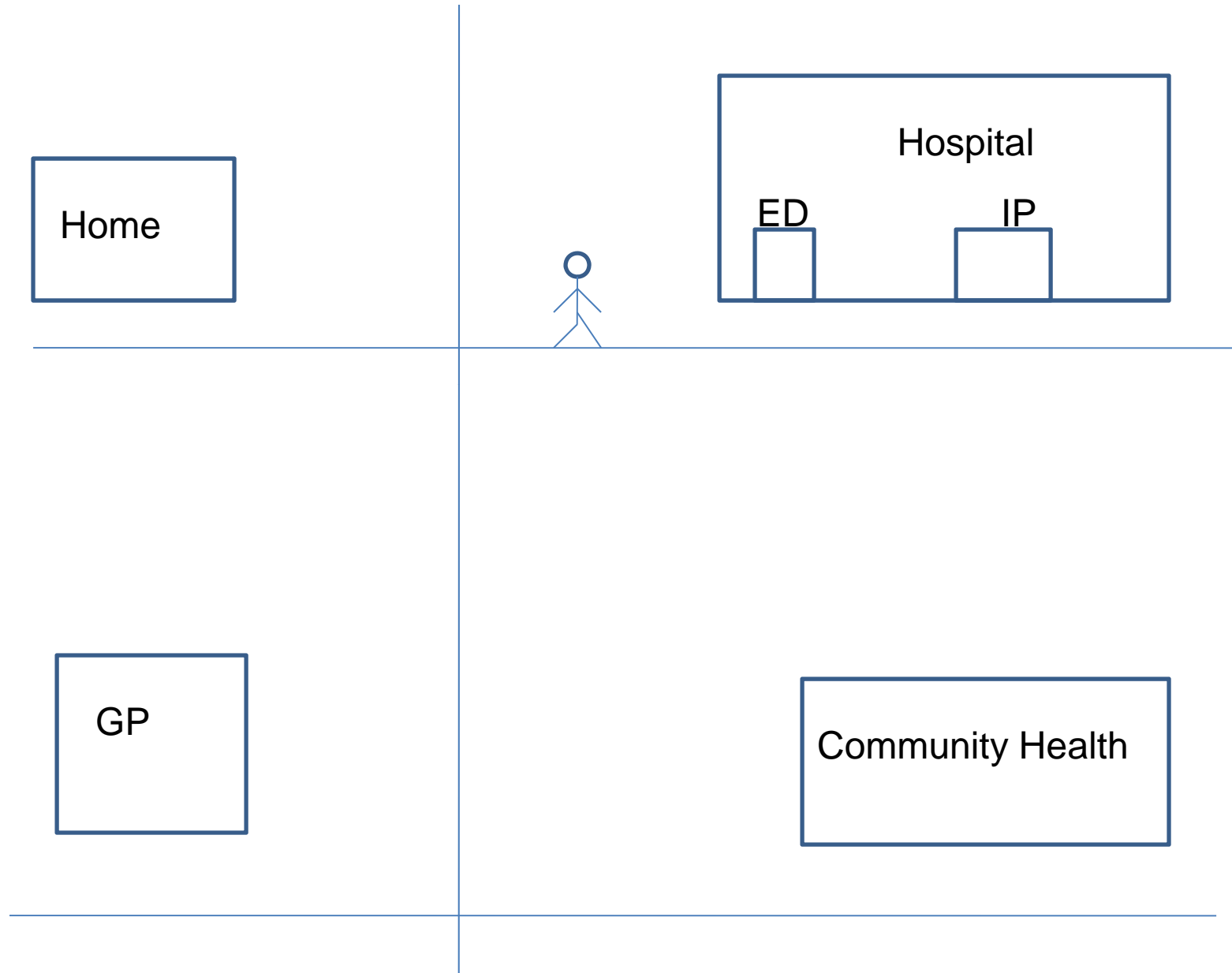
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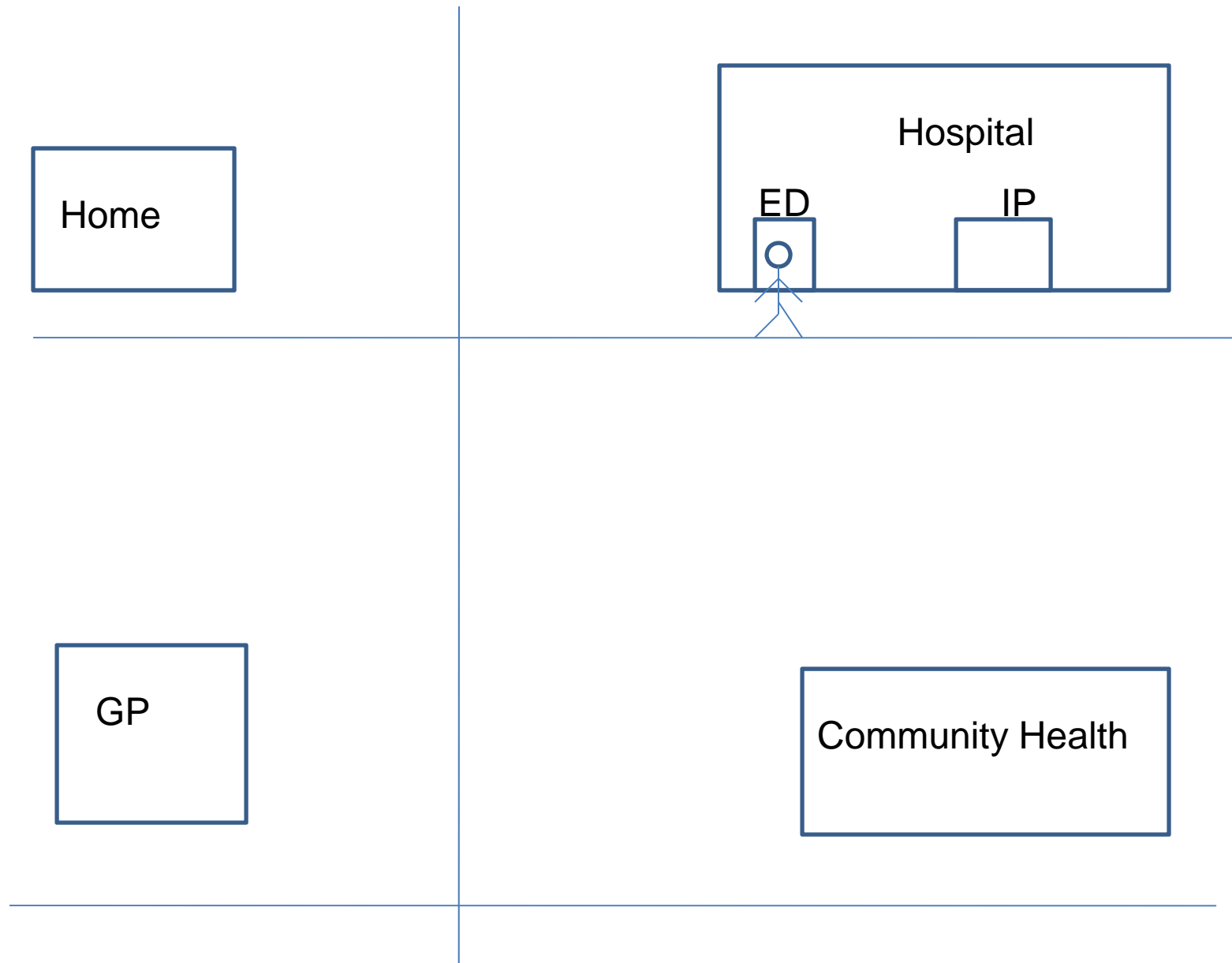
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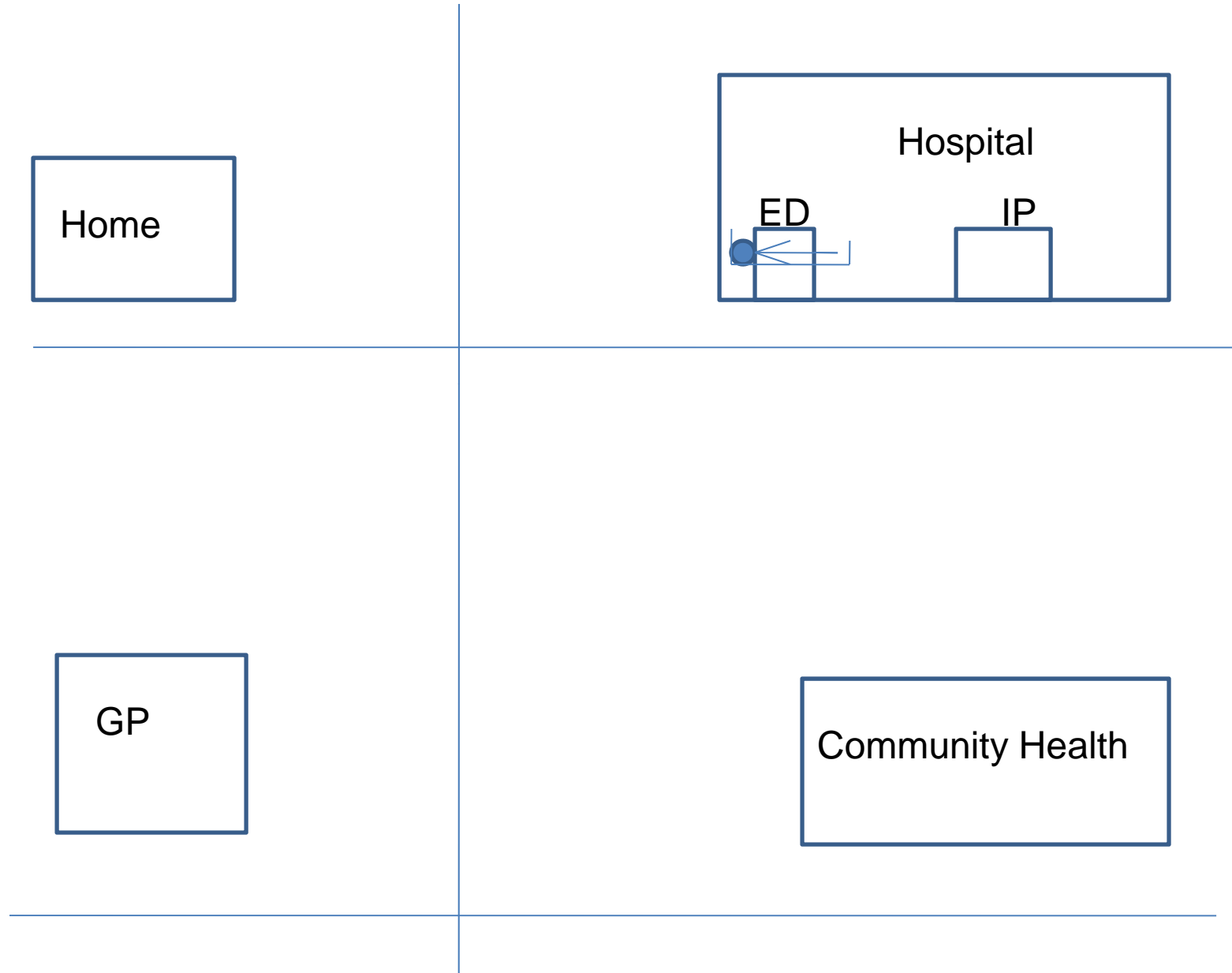
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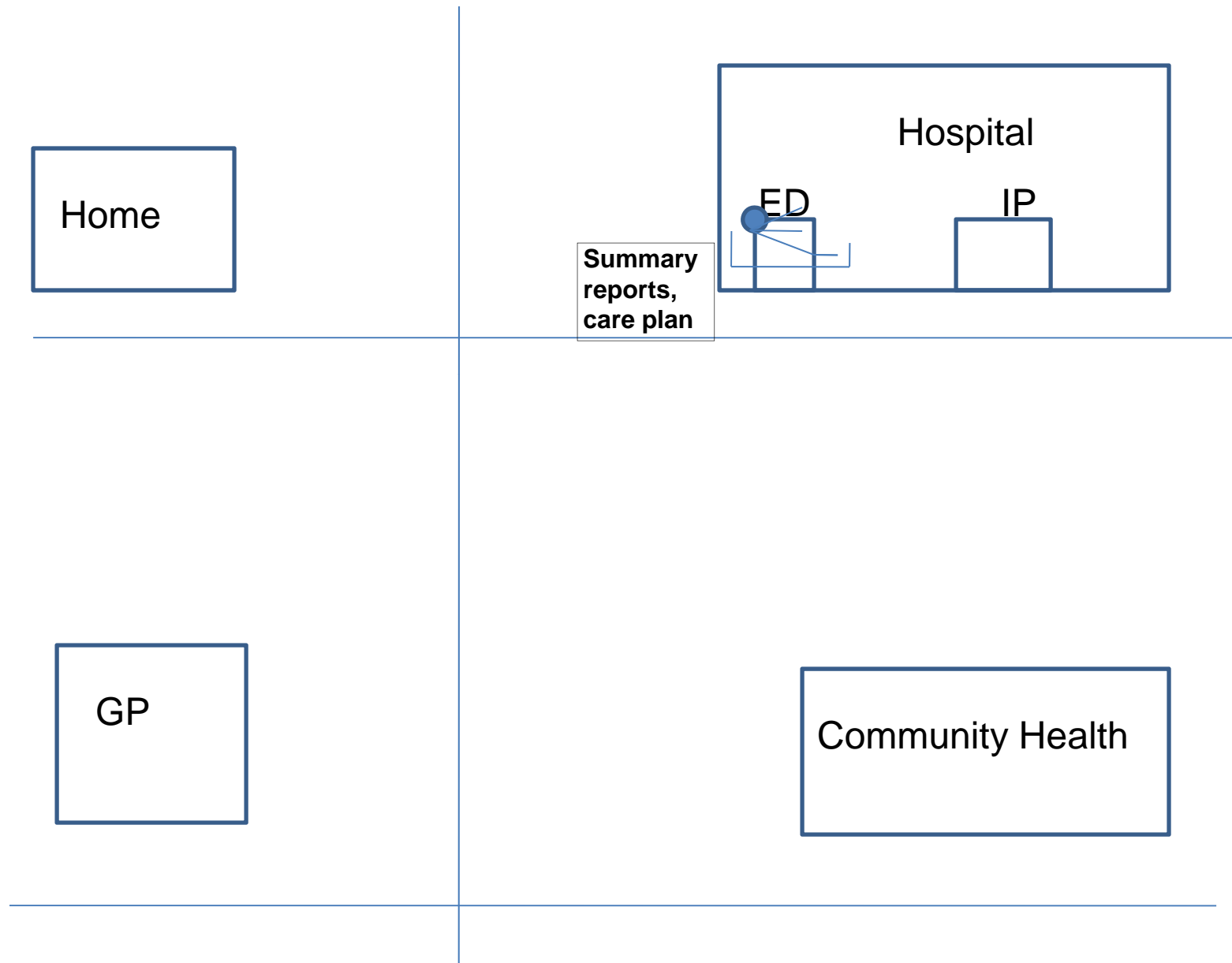
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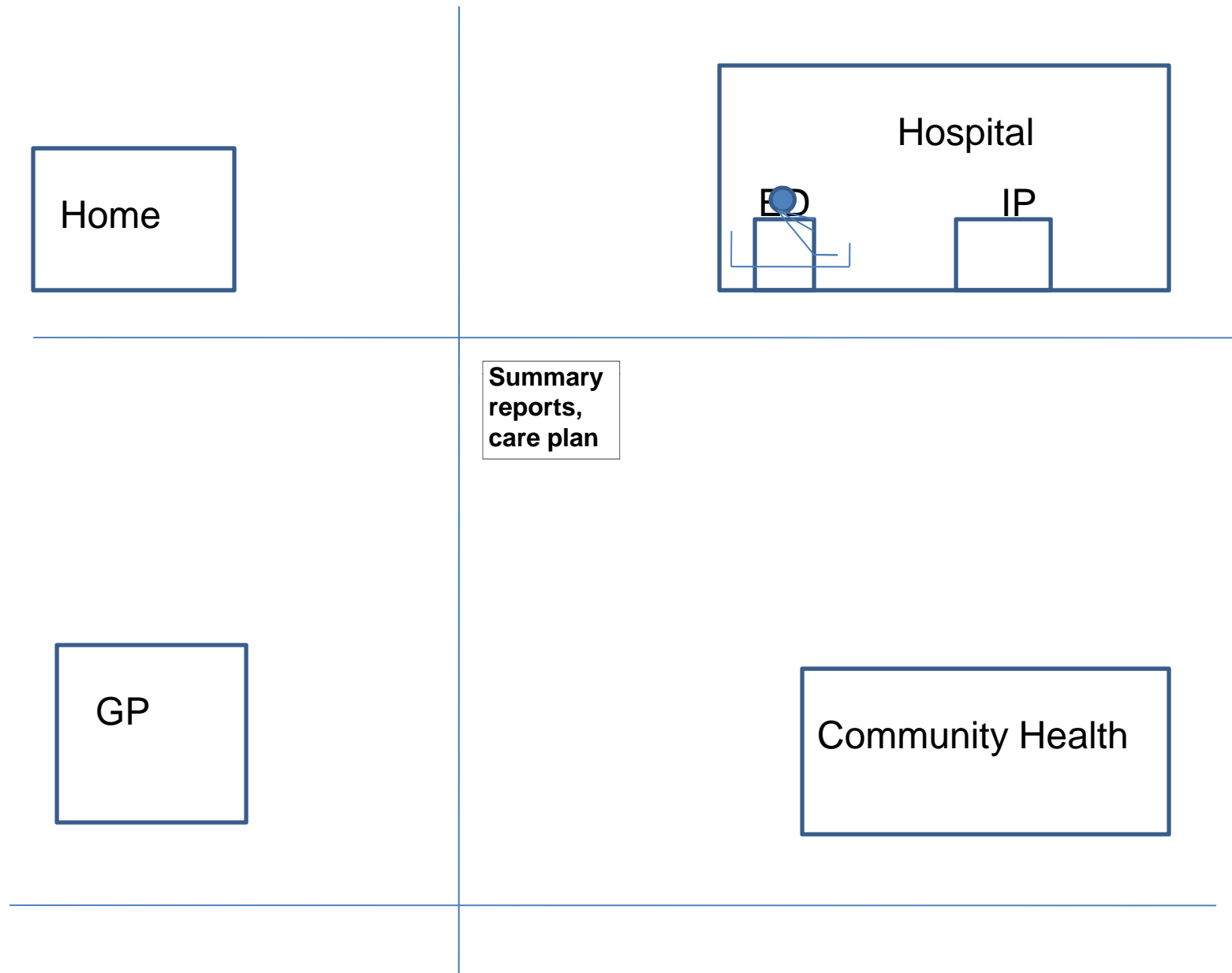
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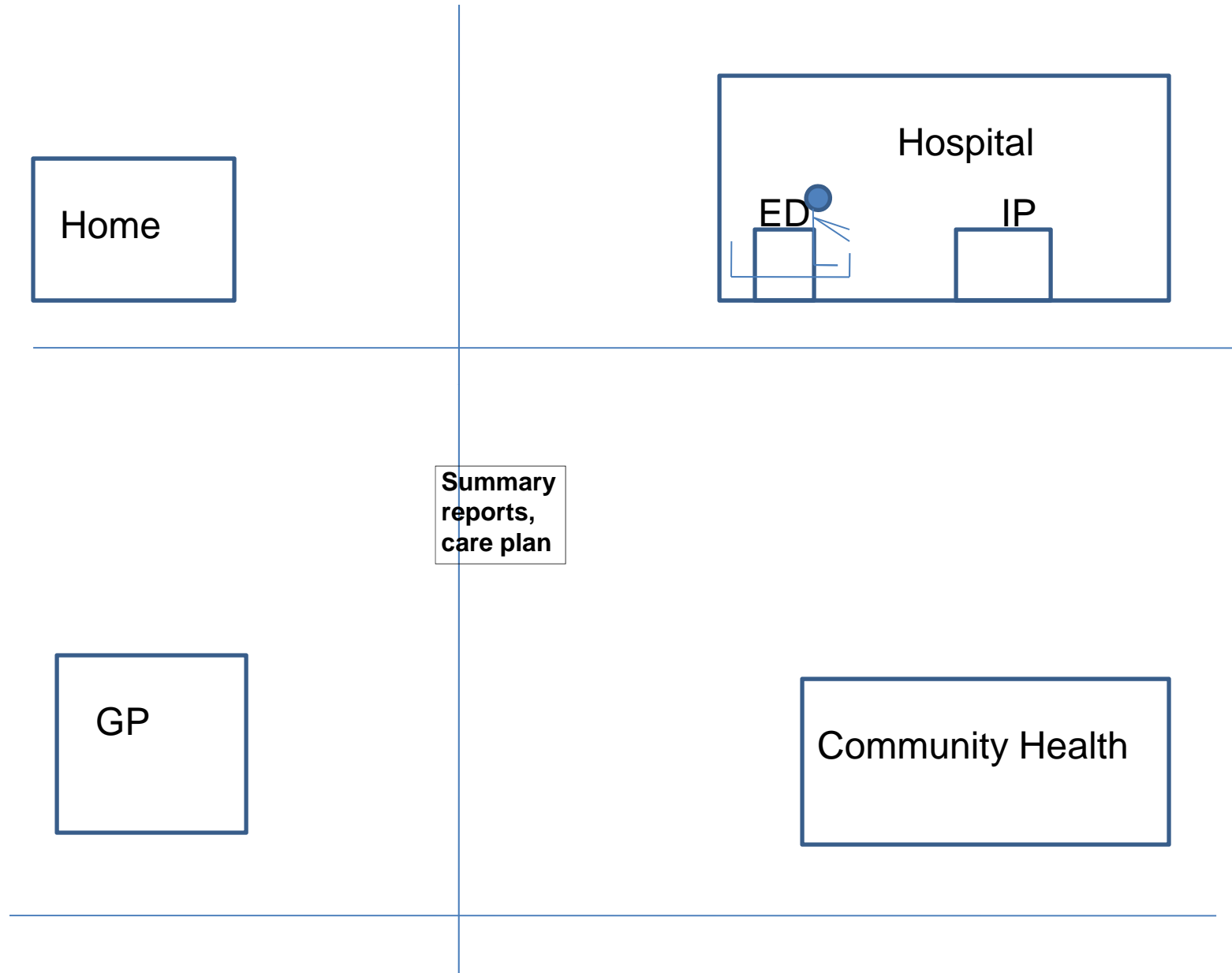
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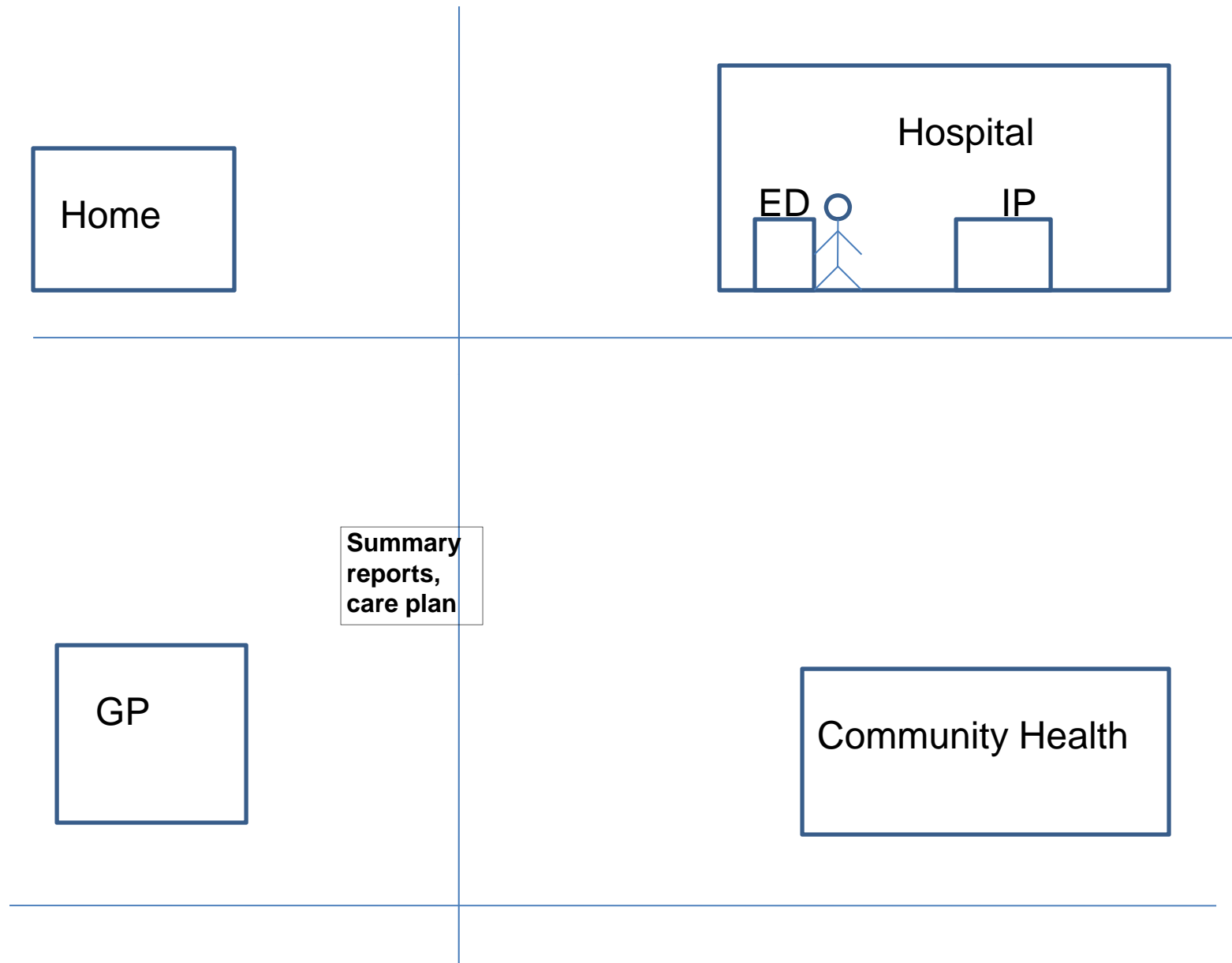
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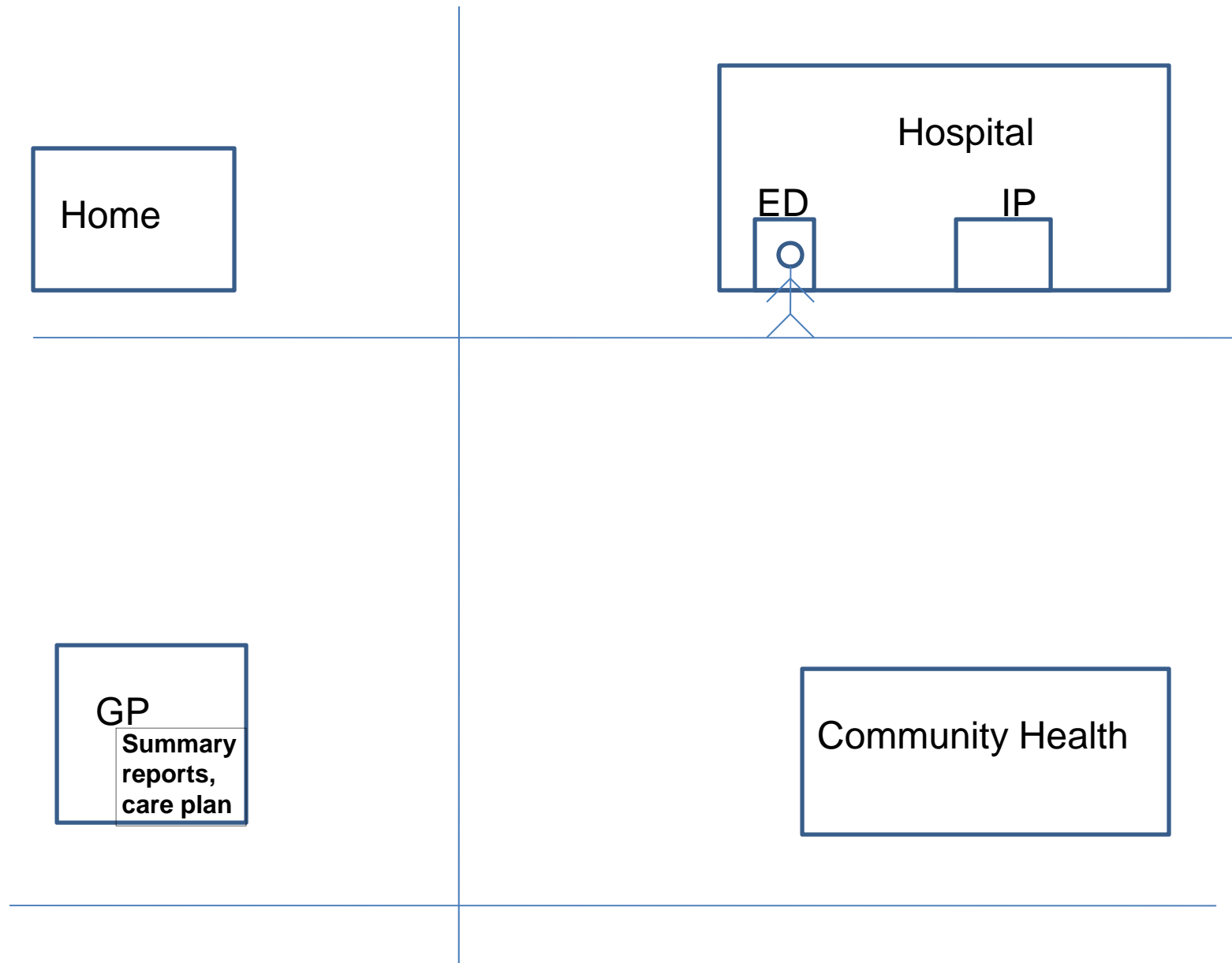
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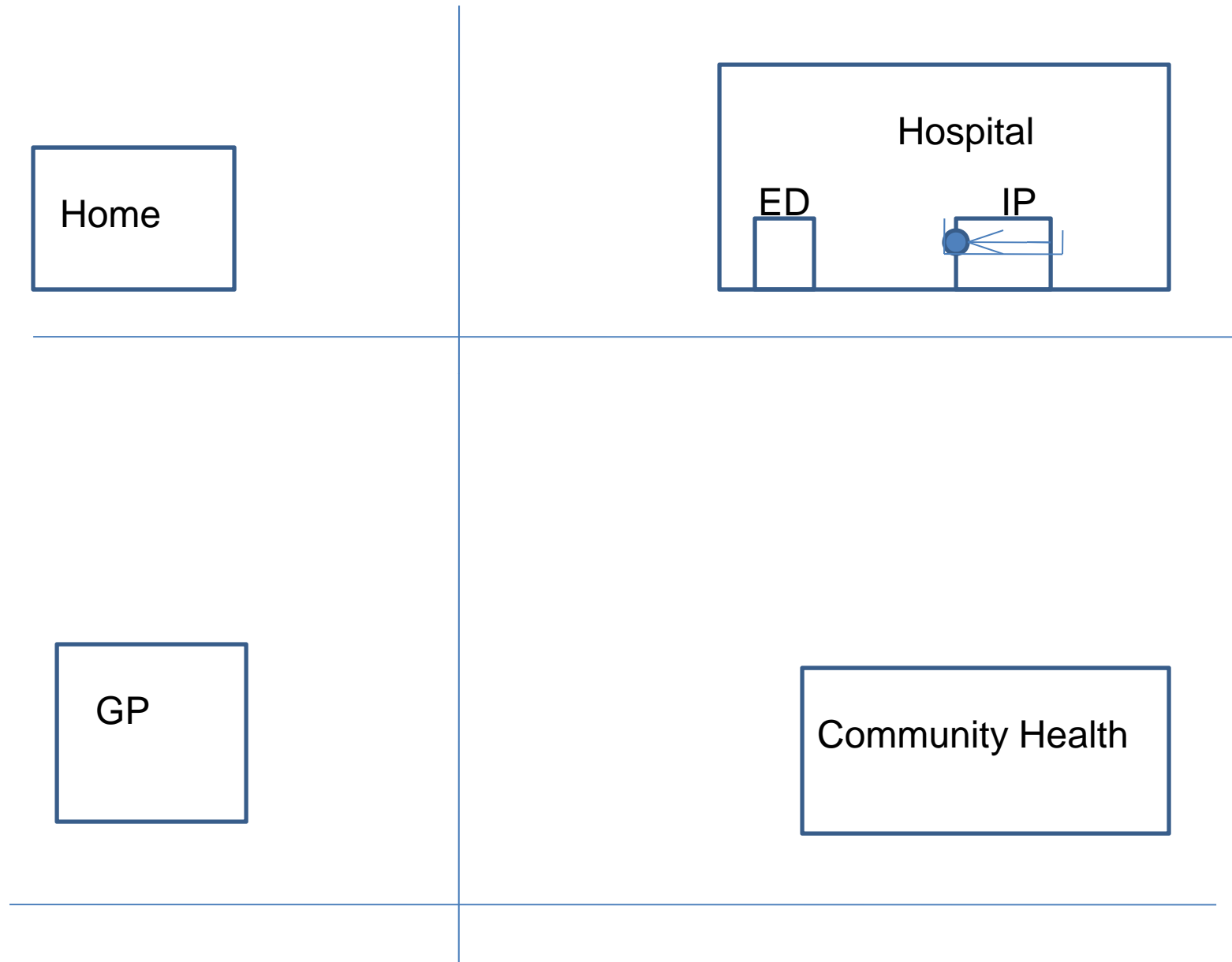
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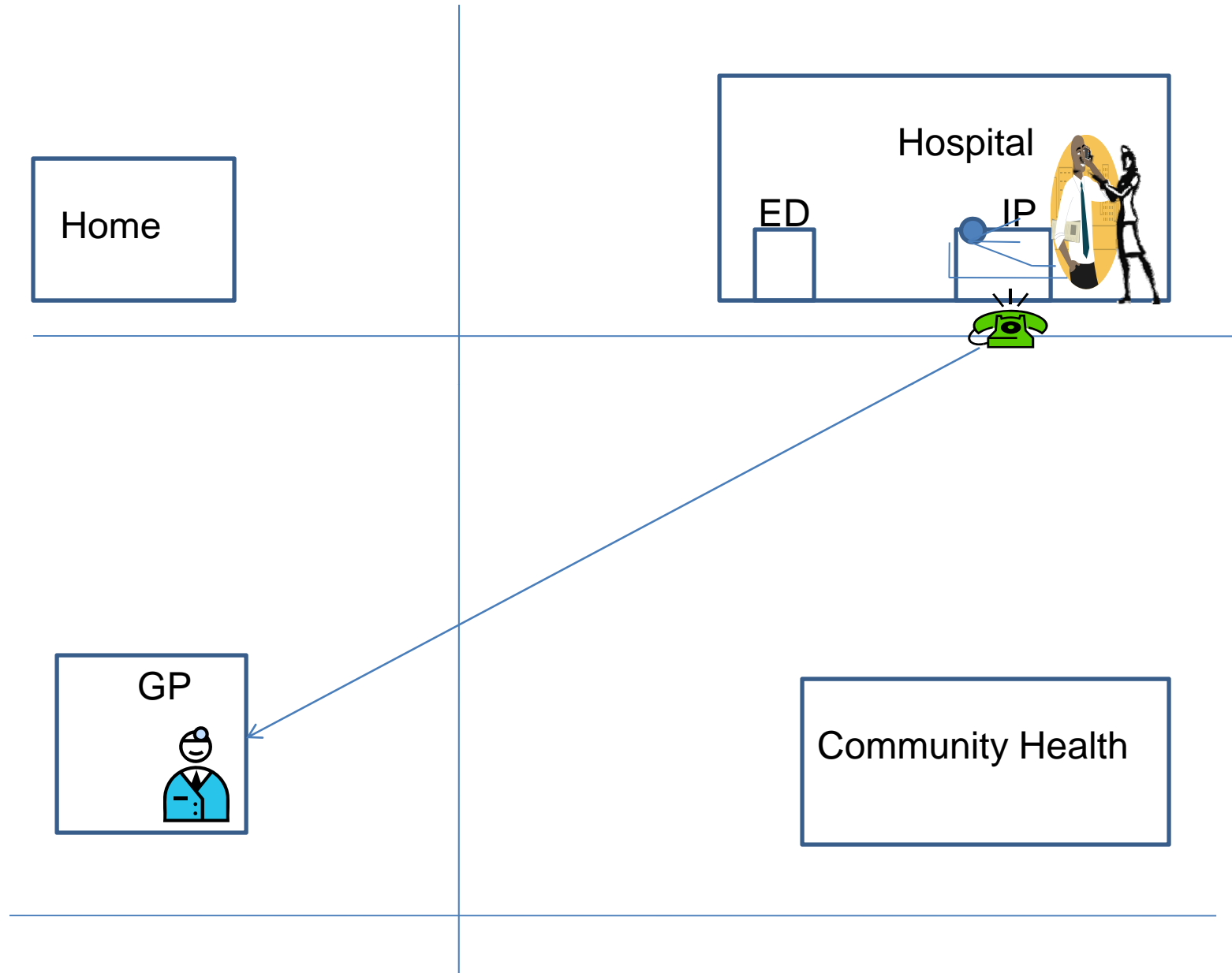
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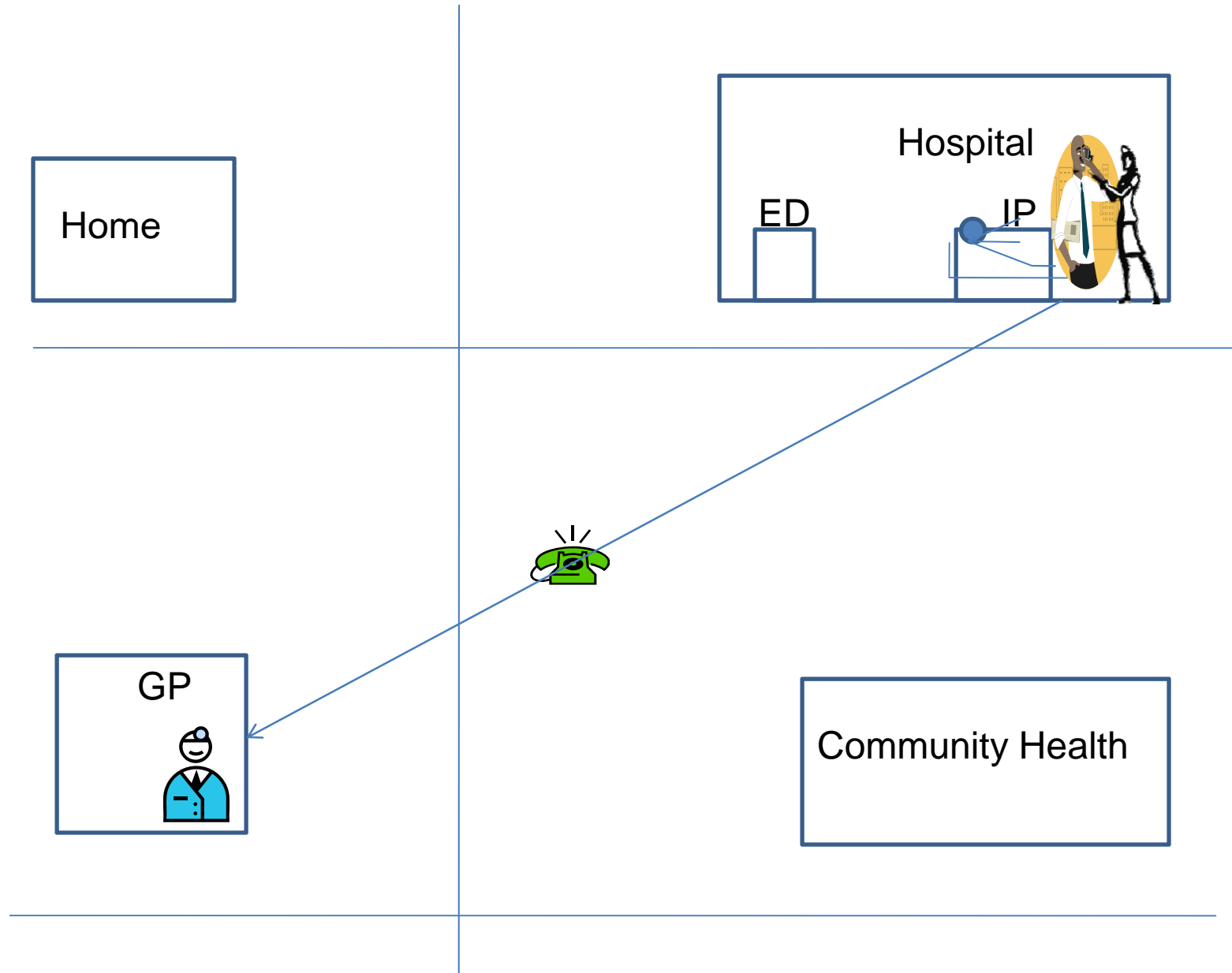
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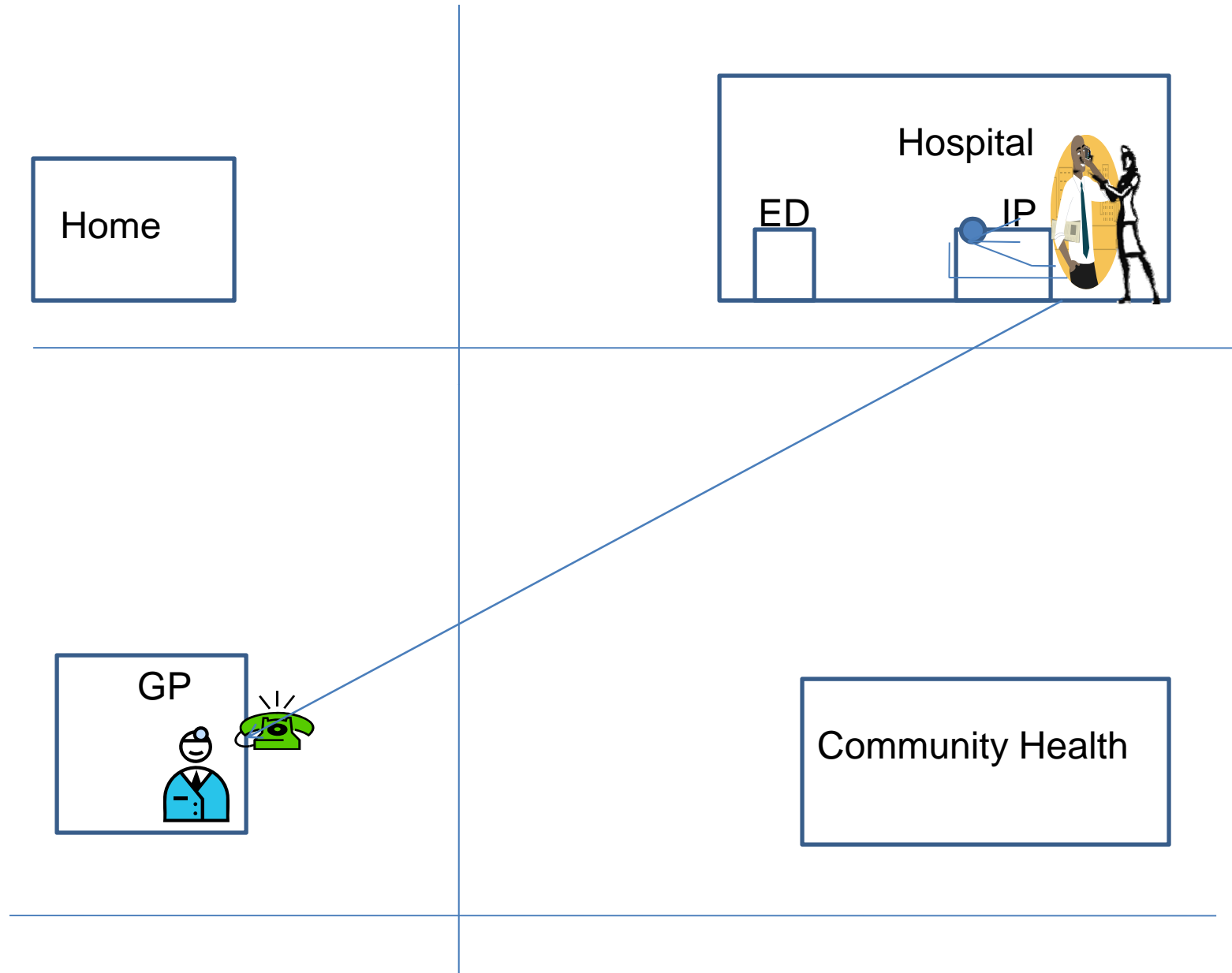
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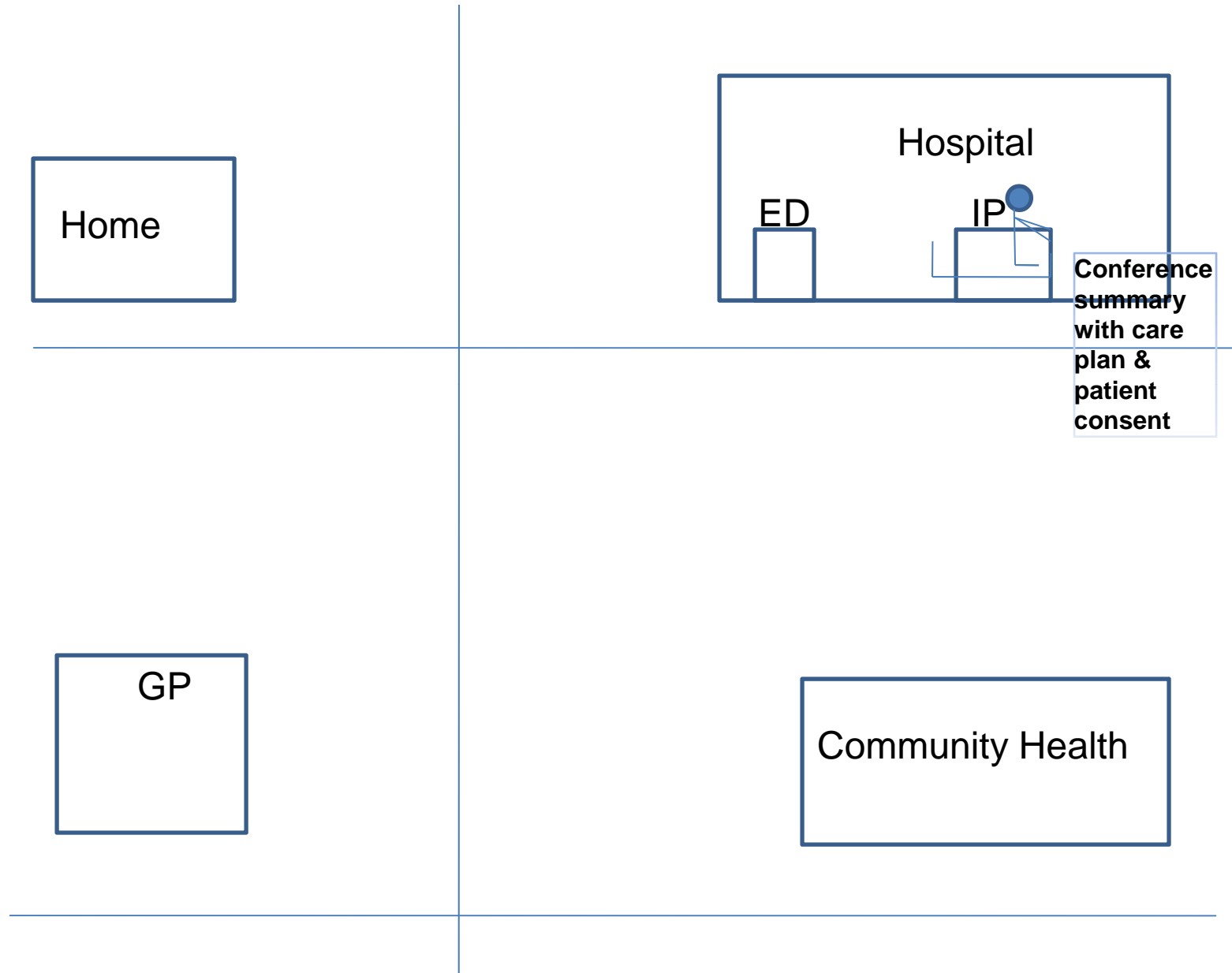
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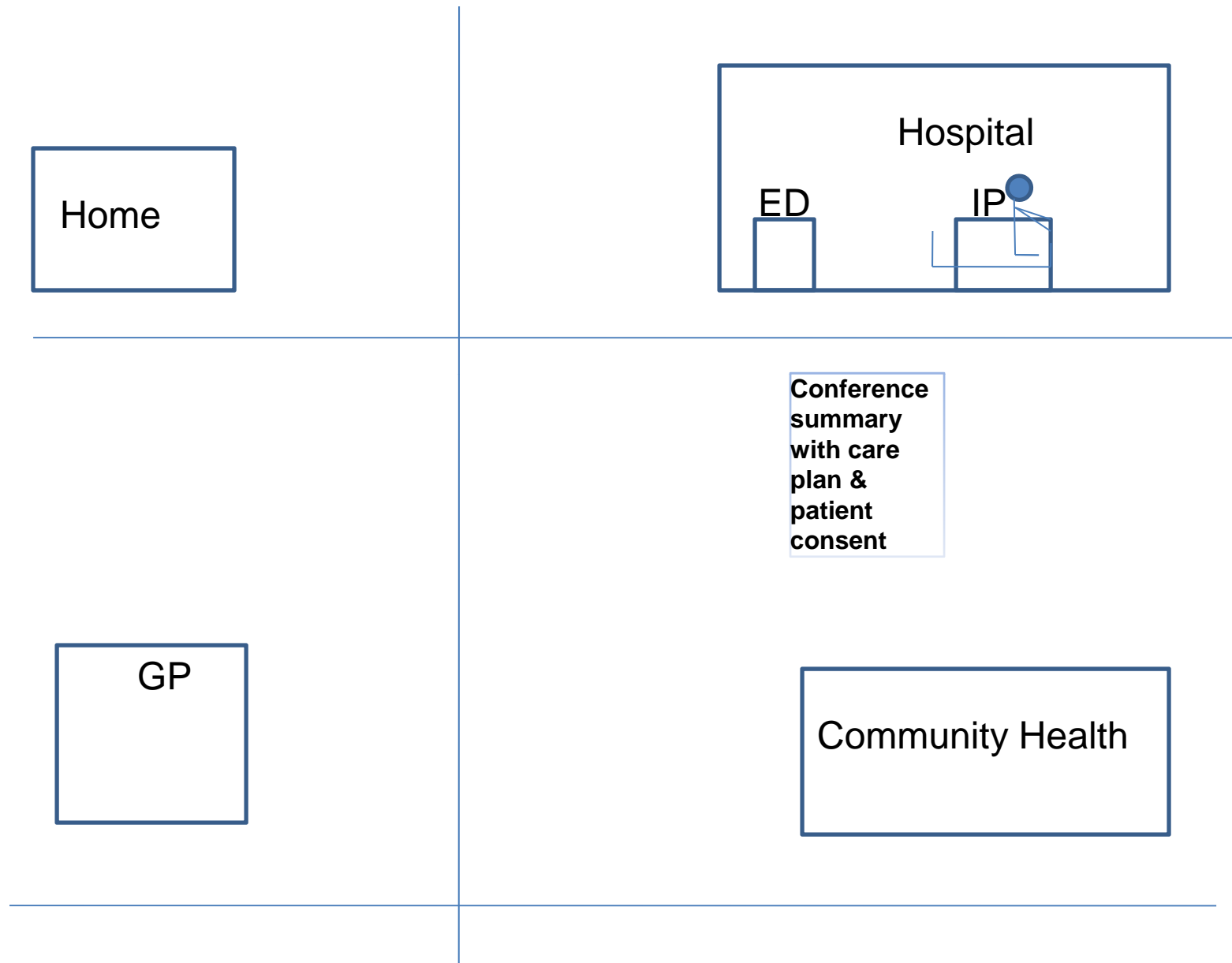
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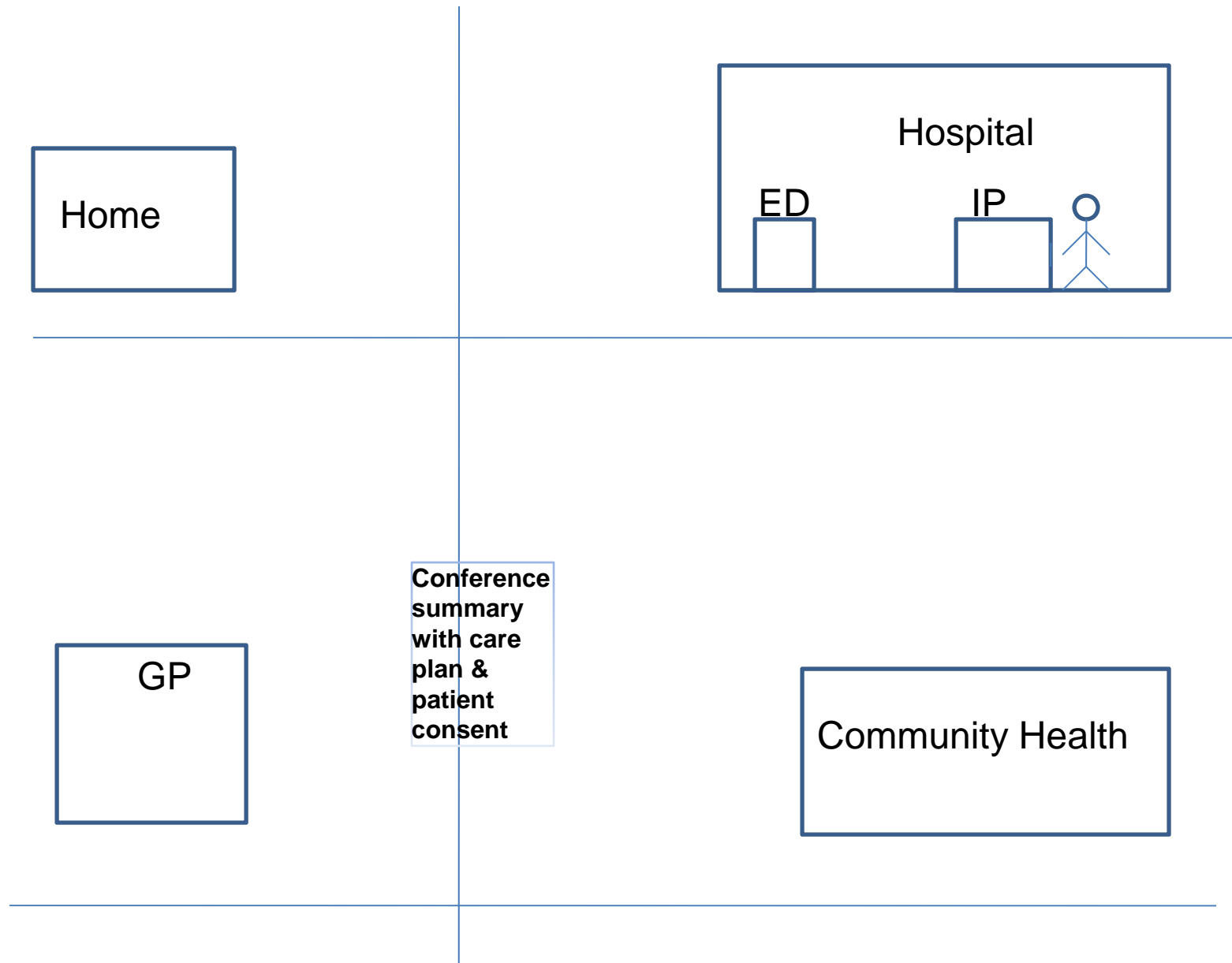
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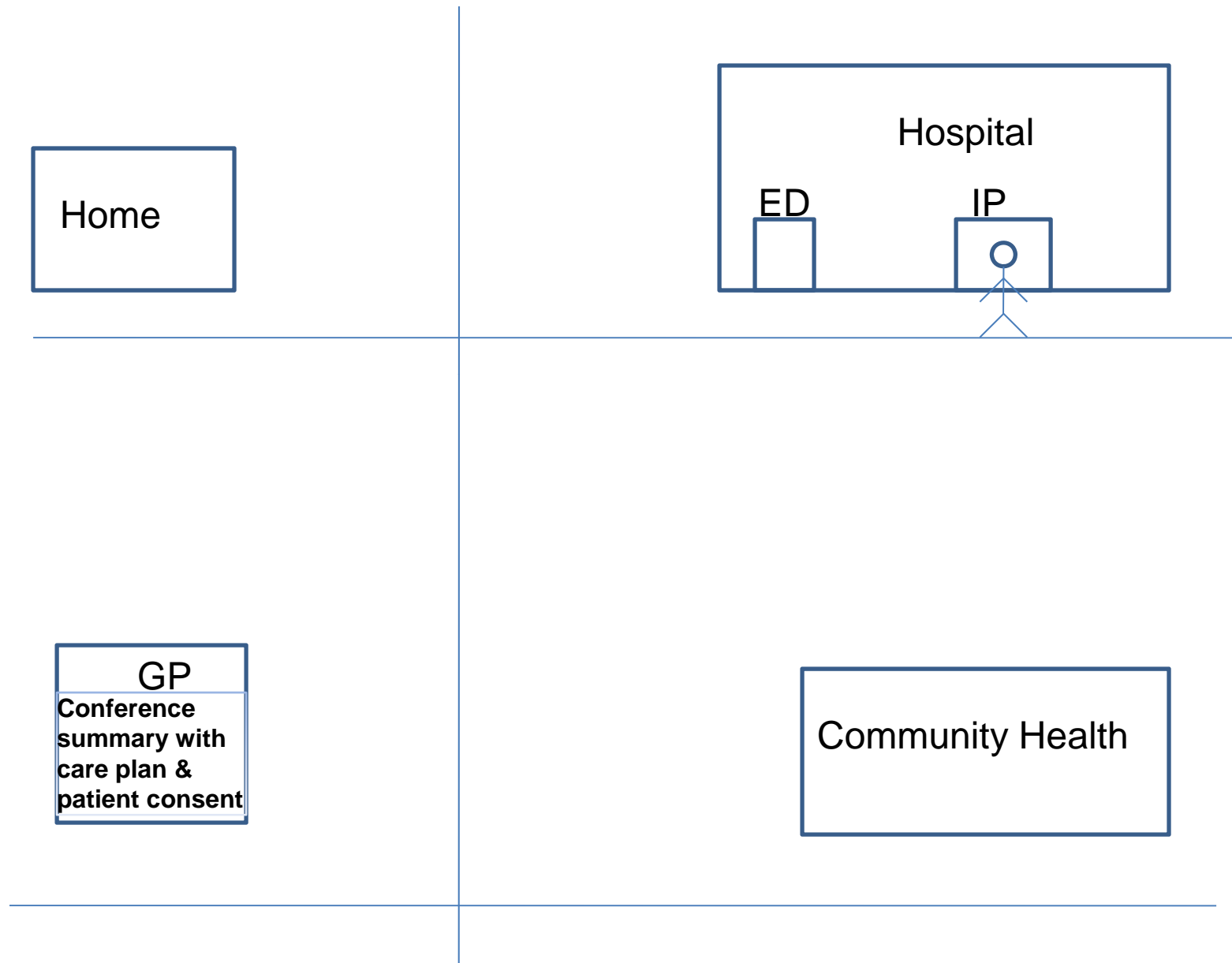
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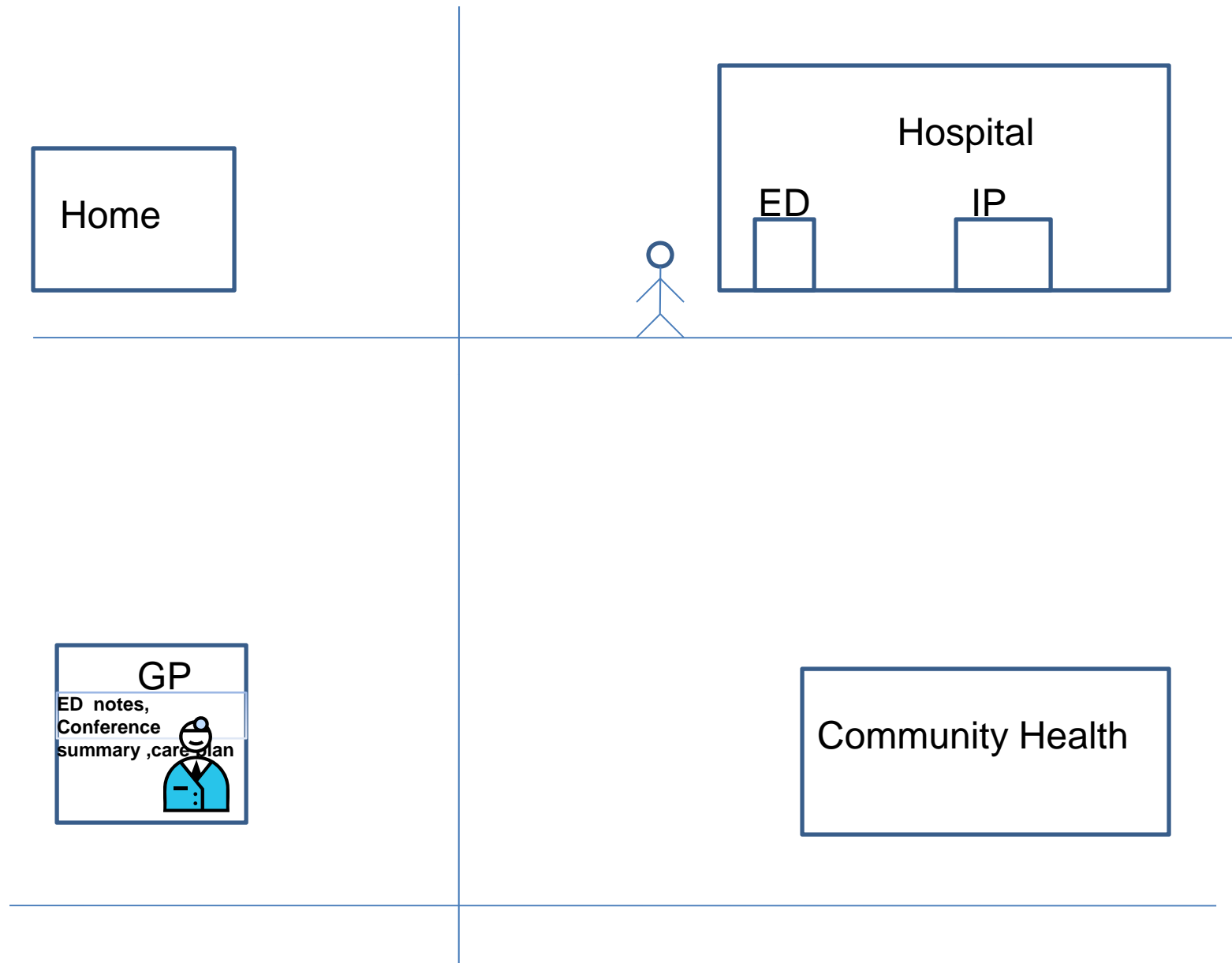
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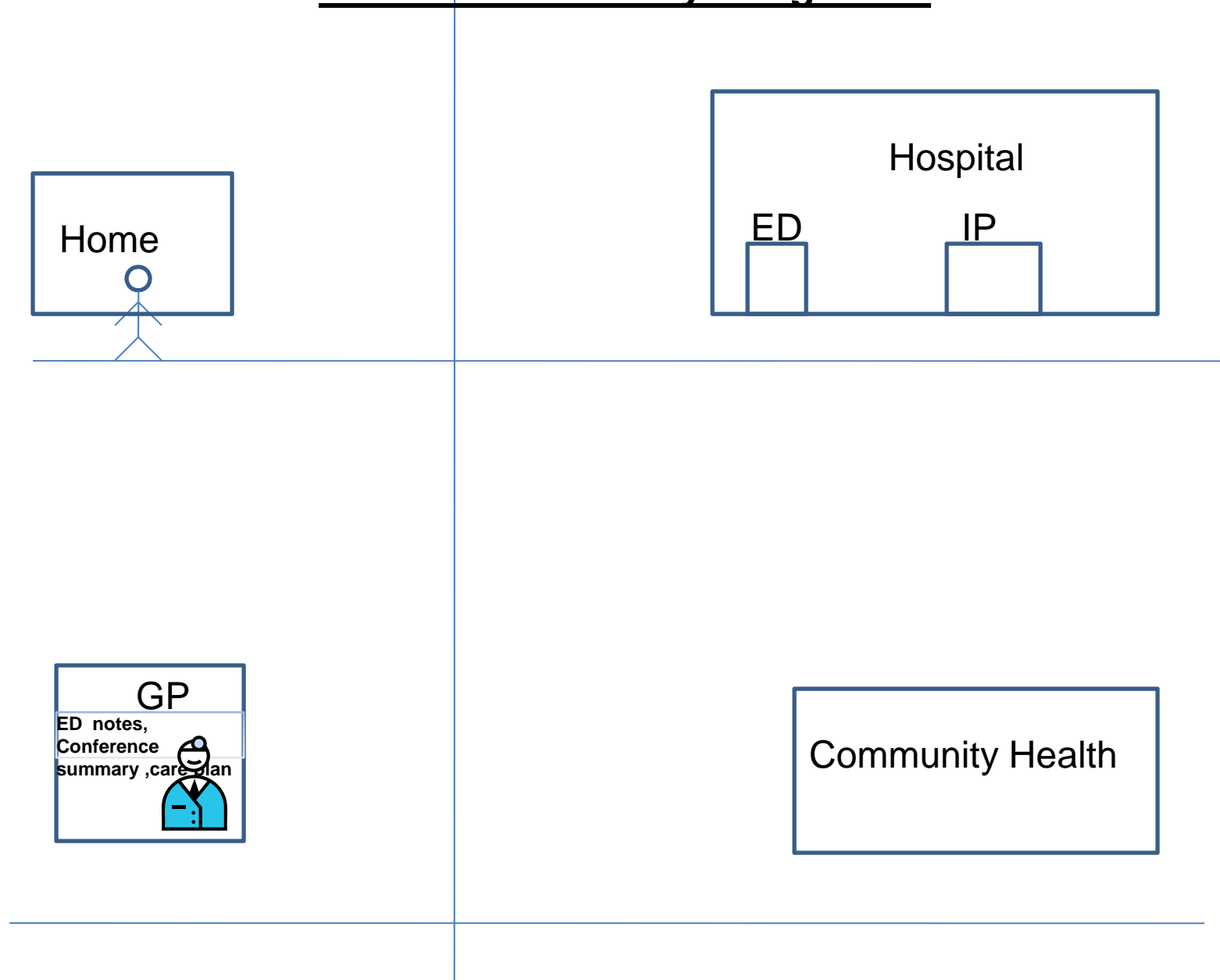
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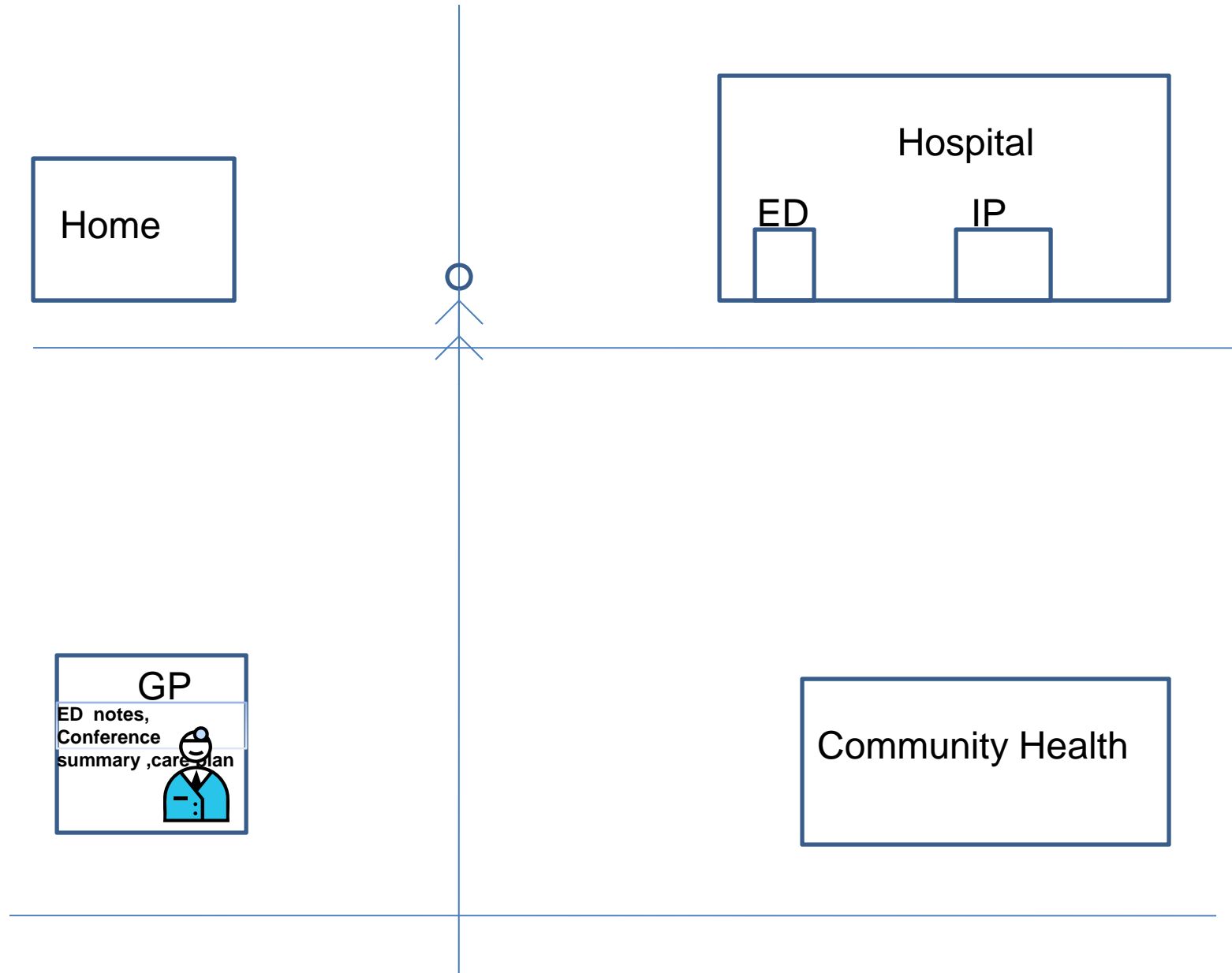
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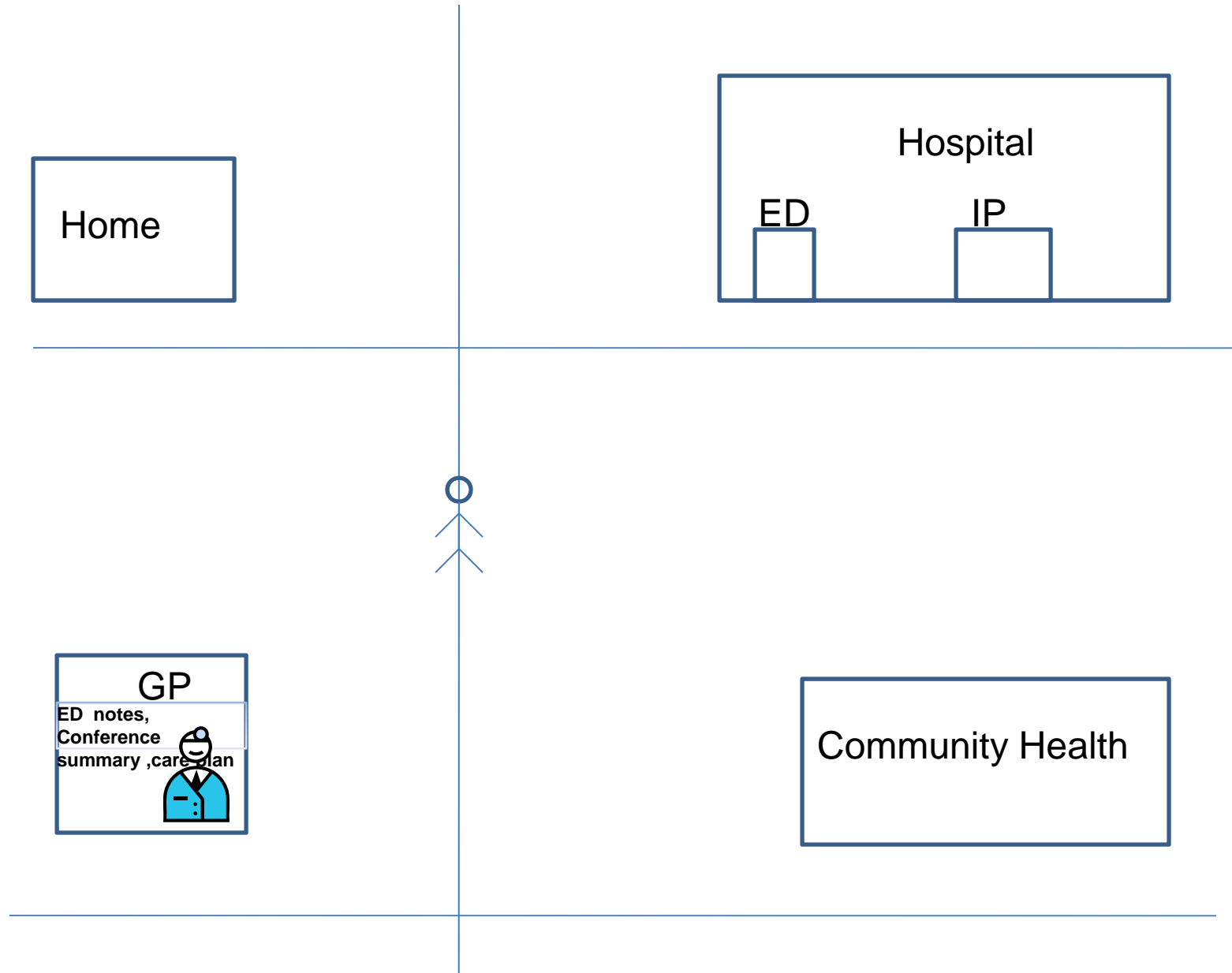
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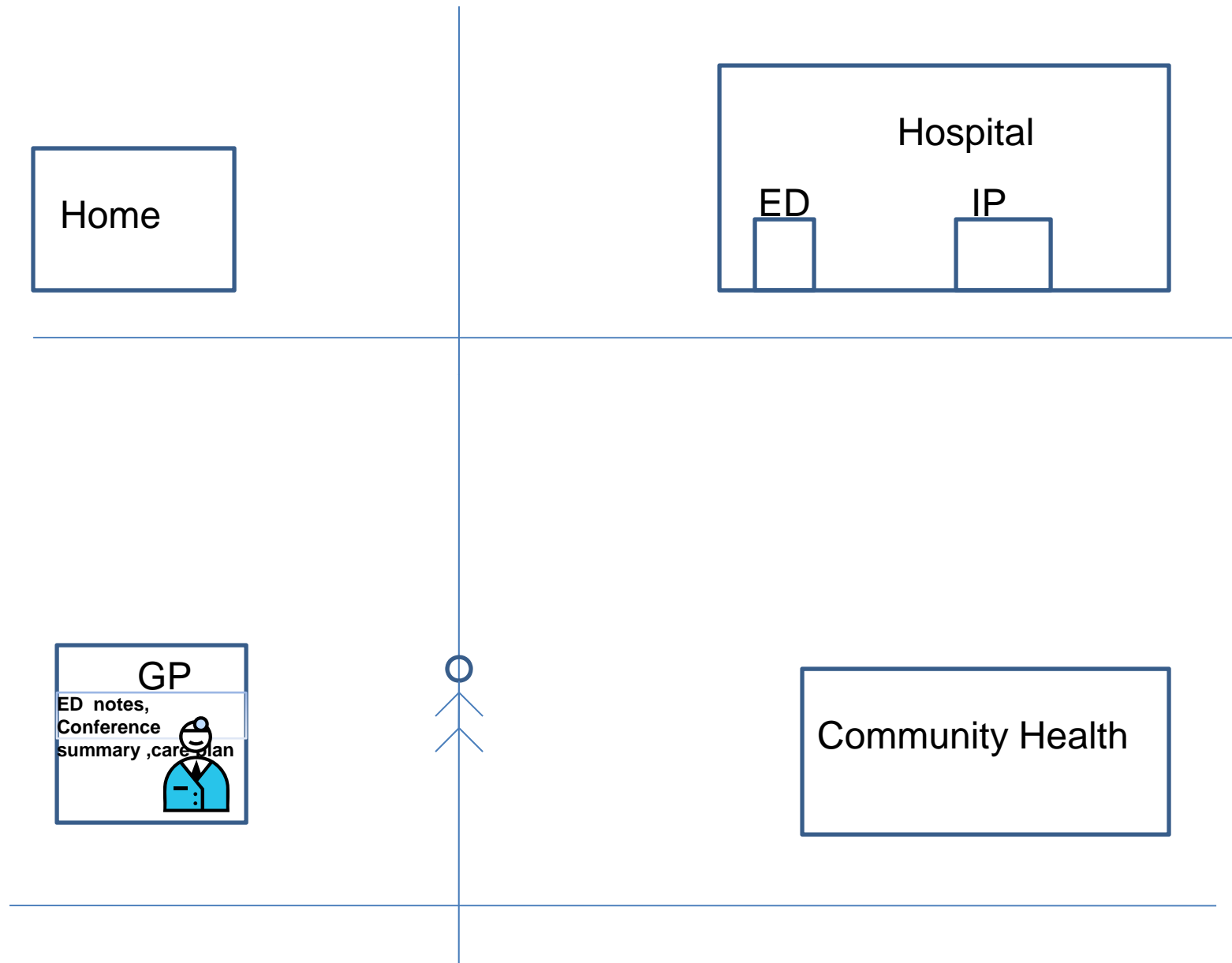
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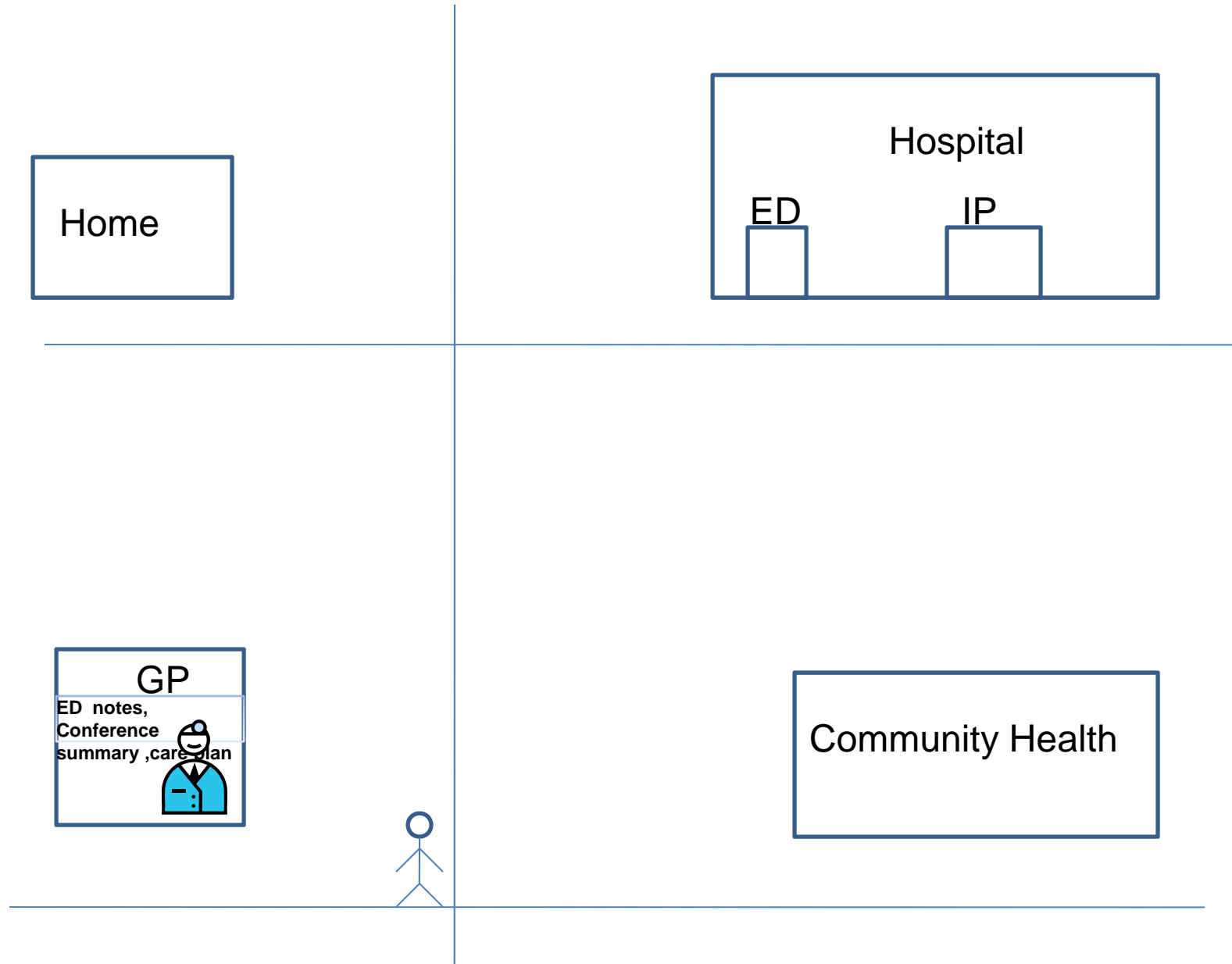
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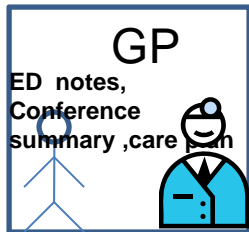
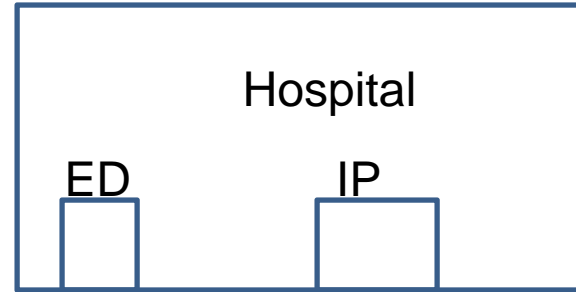


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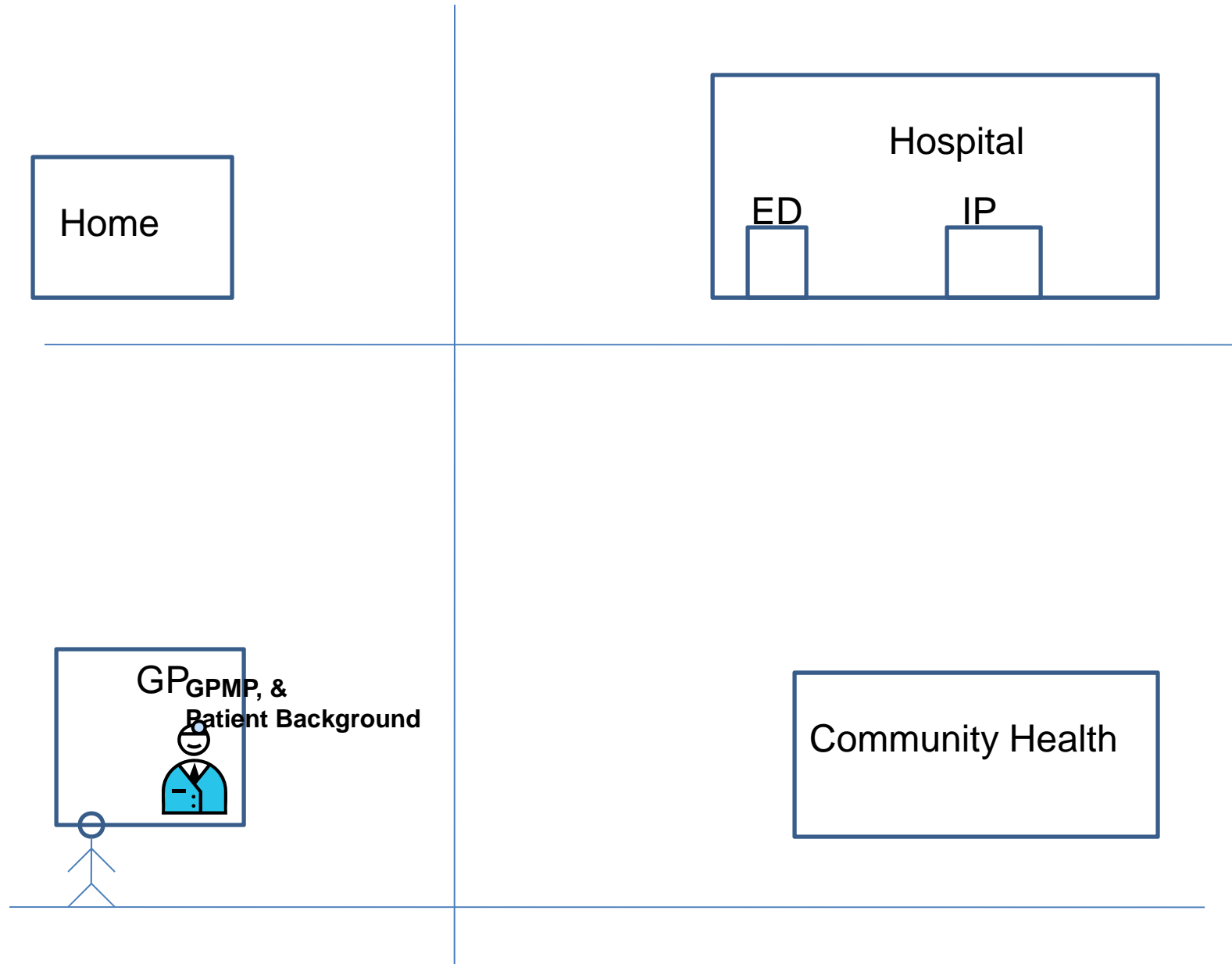
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Home

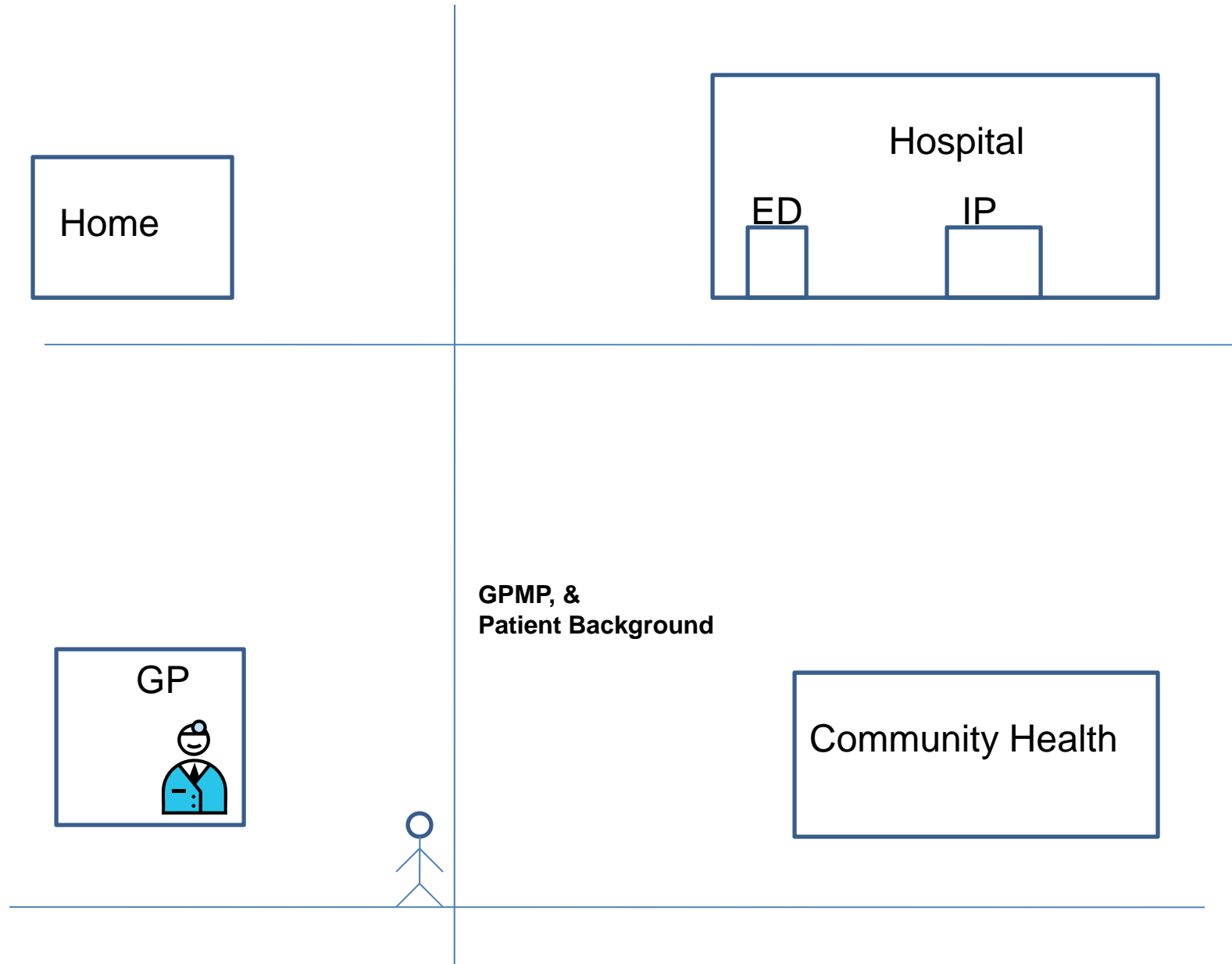


Community Health

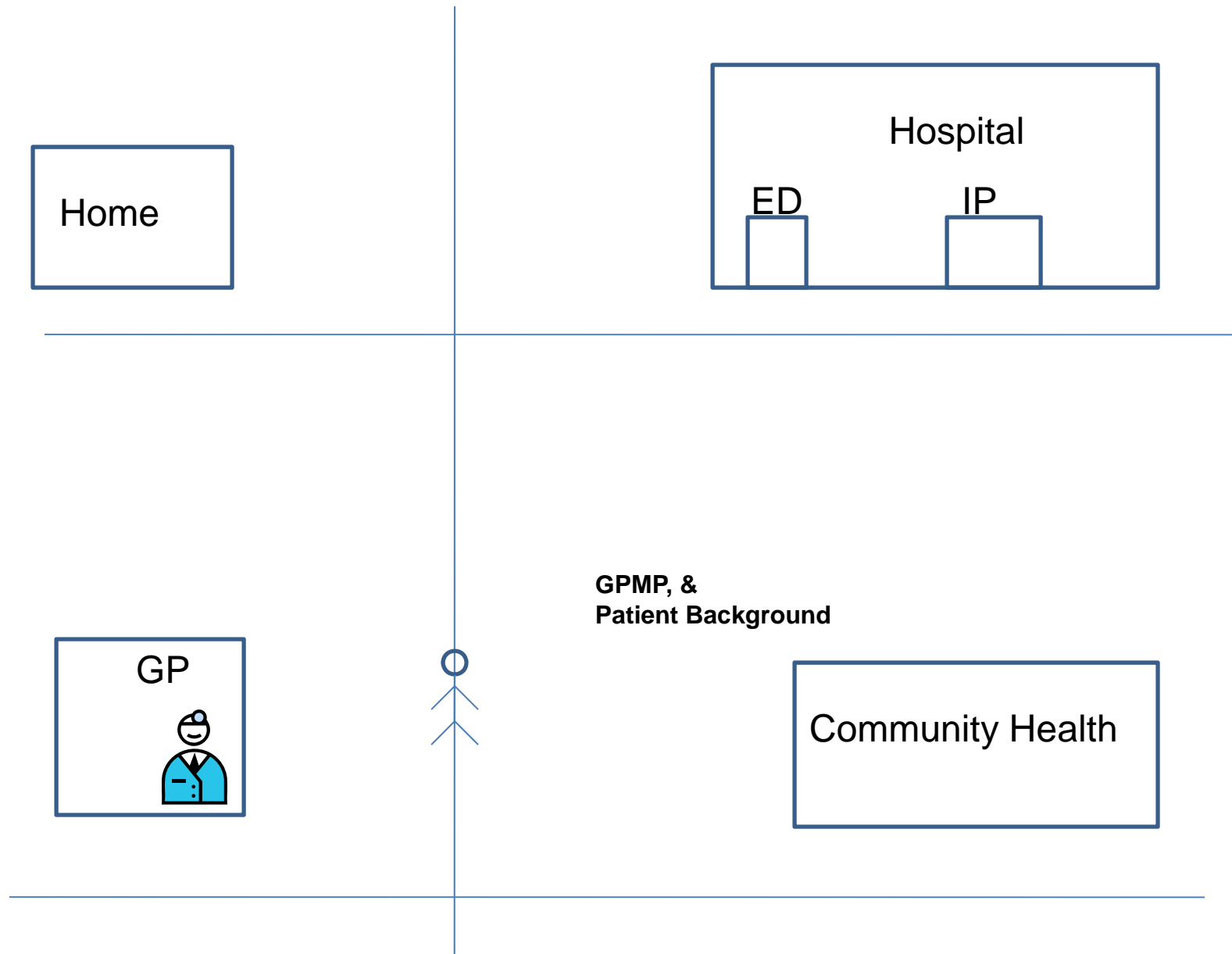
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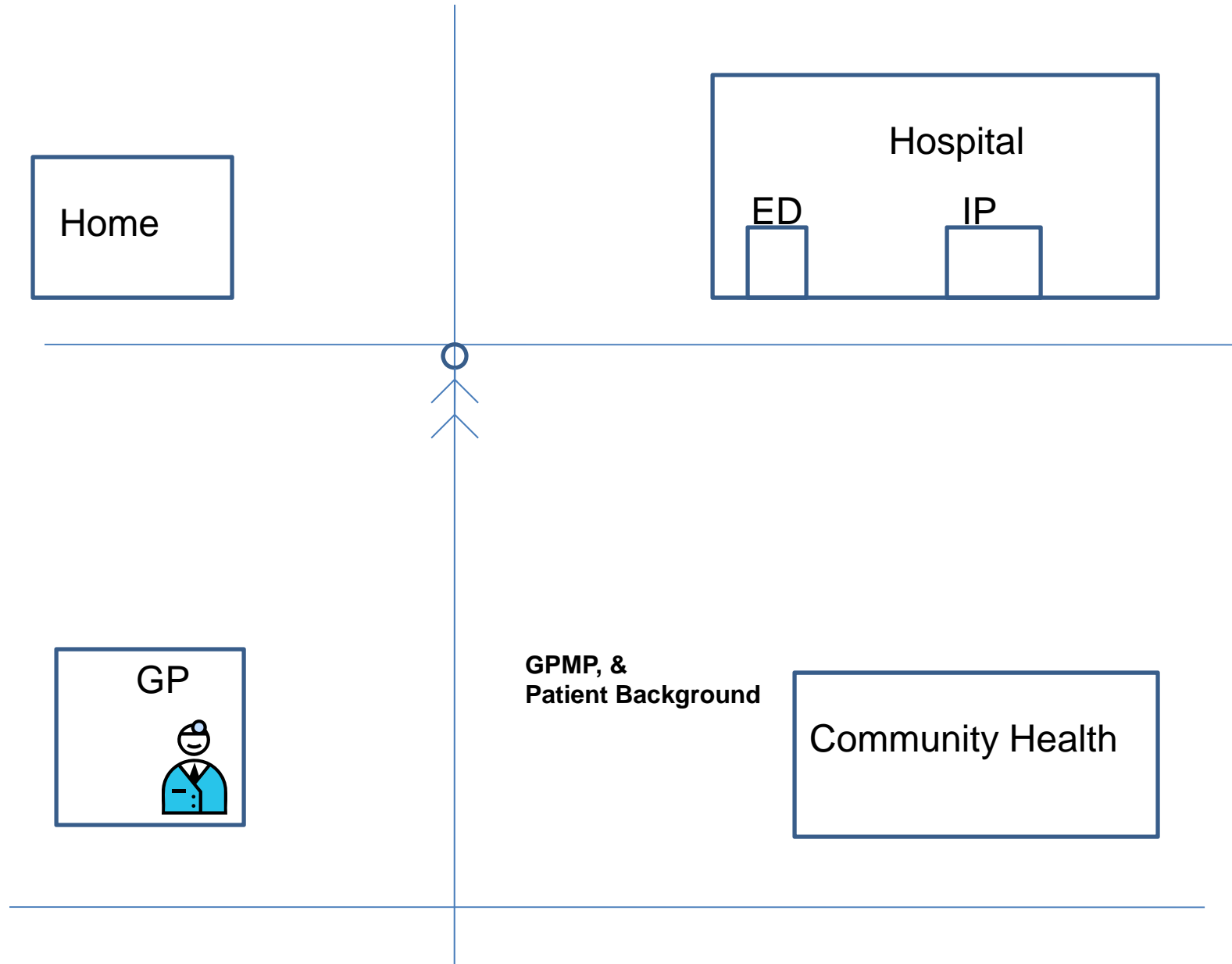
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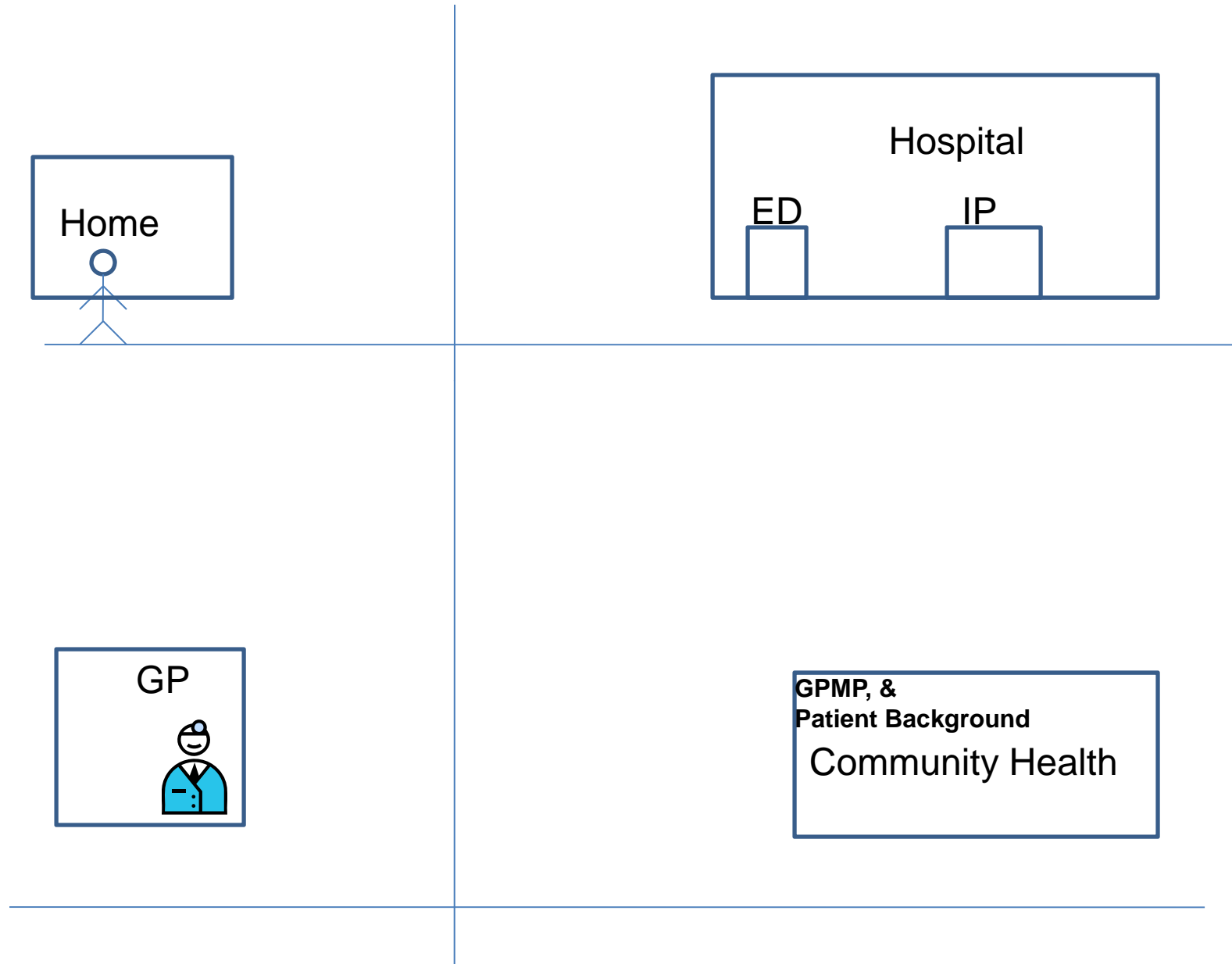
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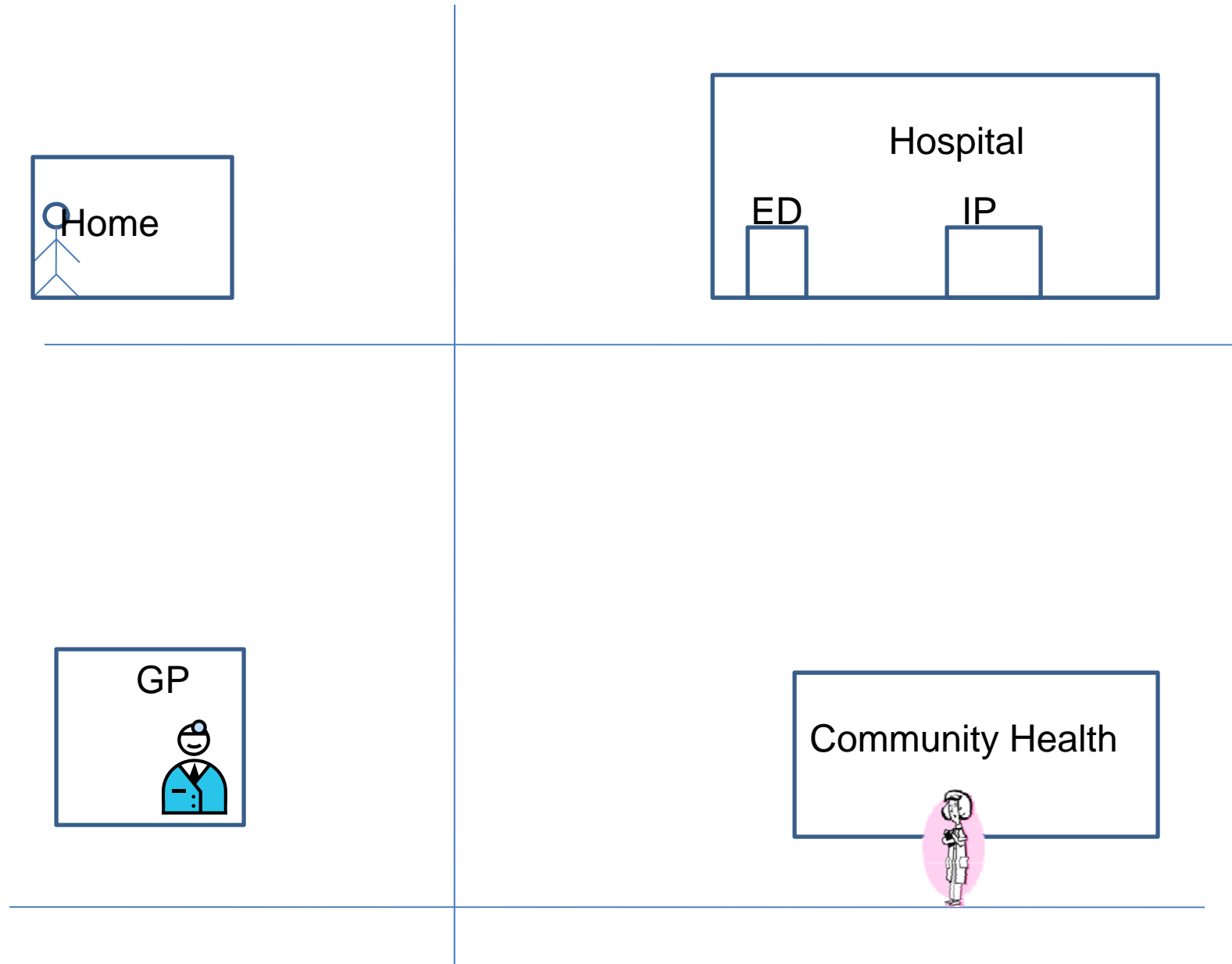
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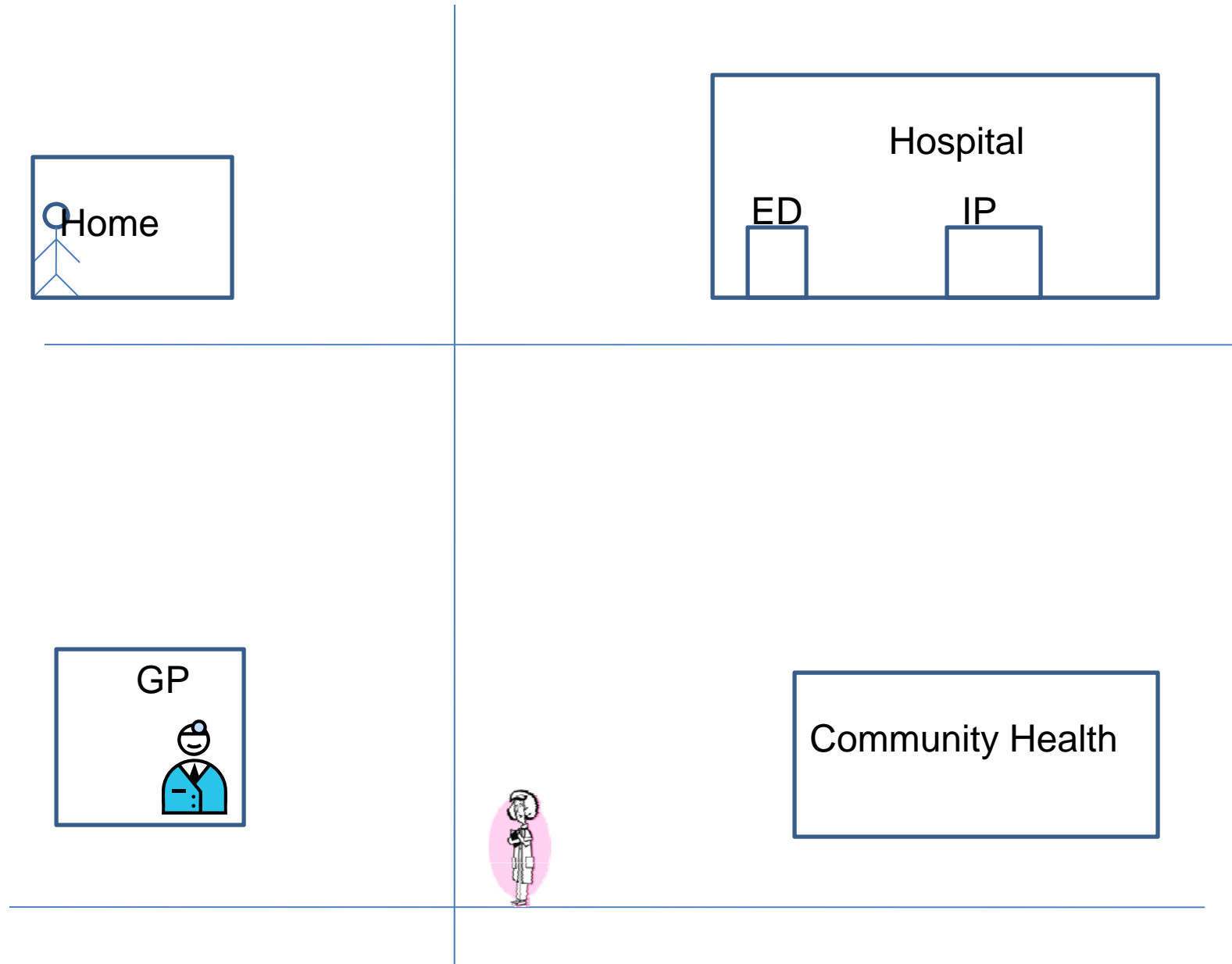
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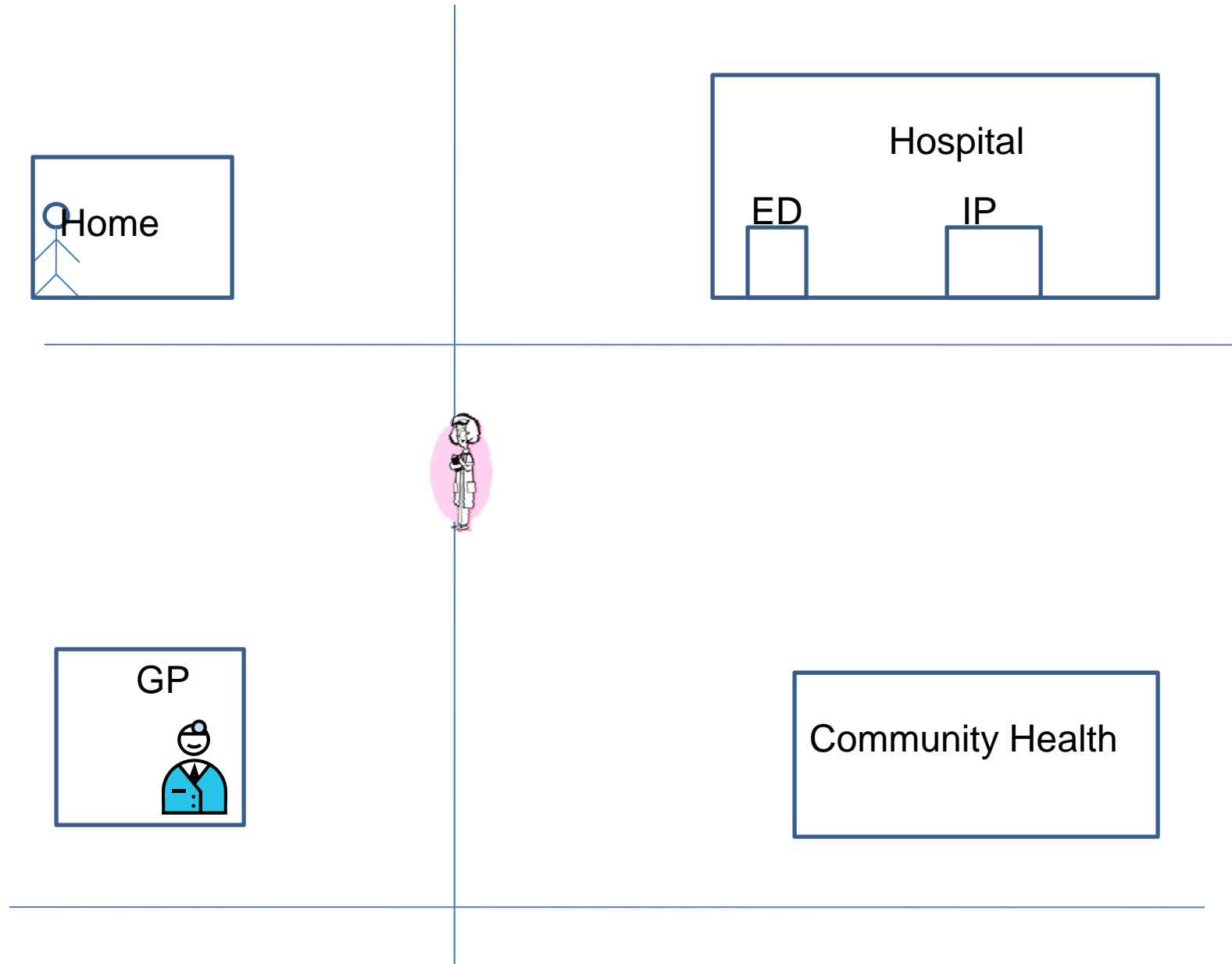
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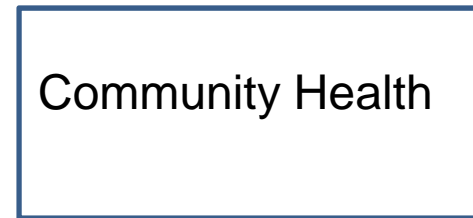
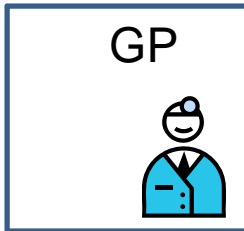
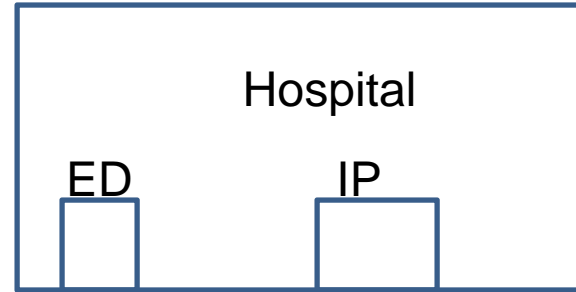
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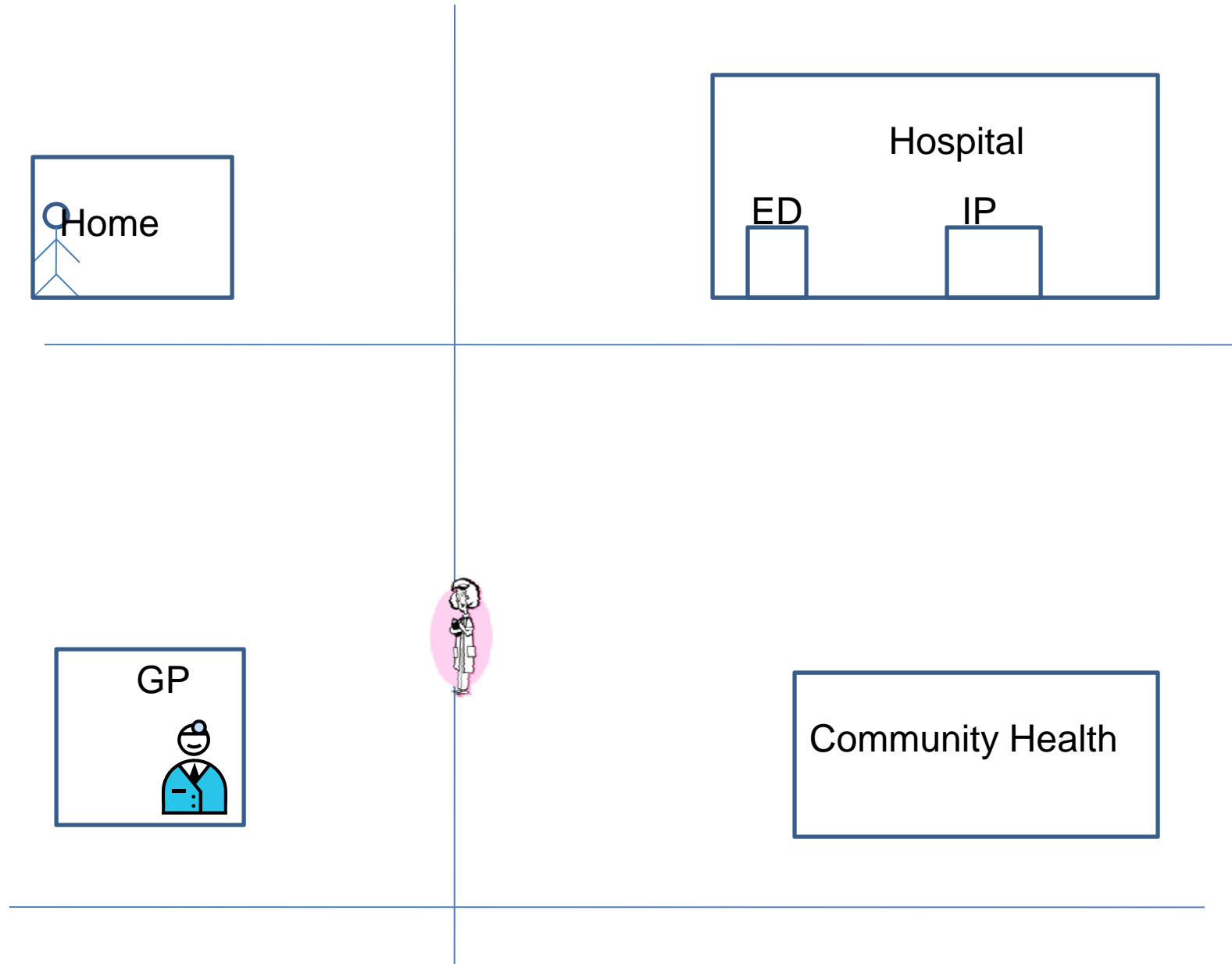
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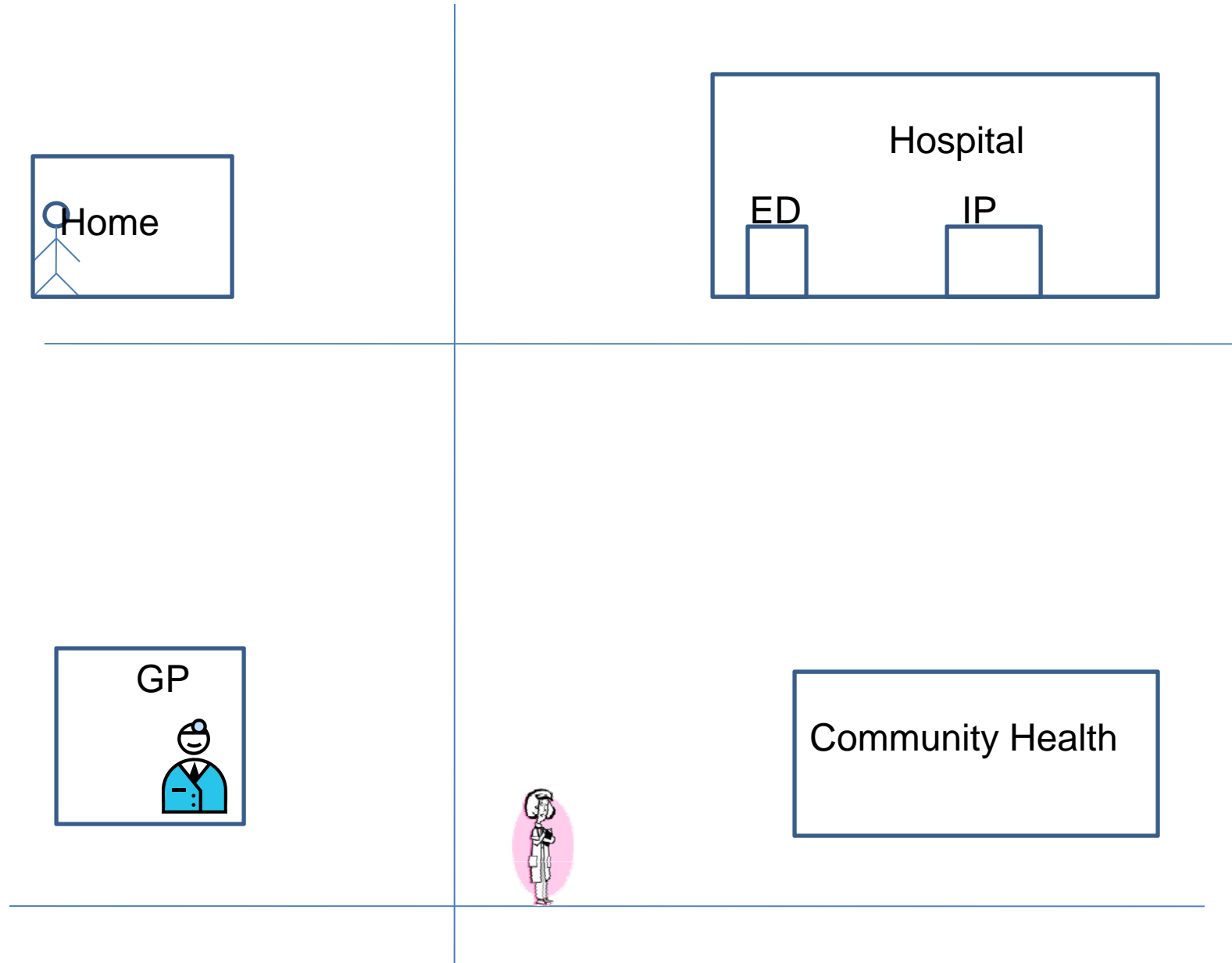
Assessments,
referrals to
Allied Health,
Meals on Wheels etc



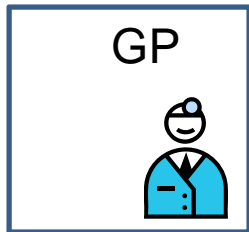
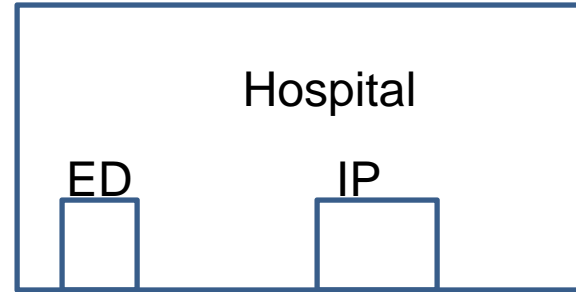
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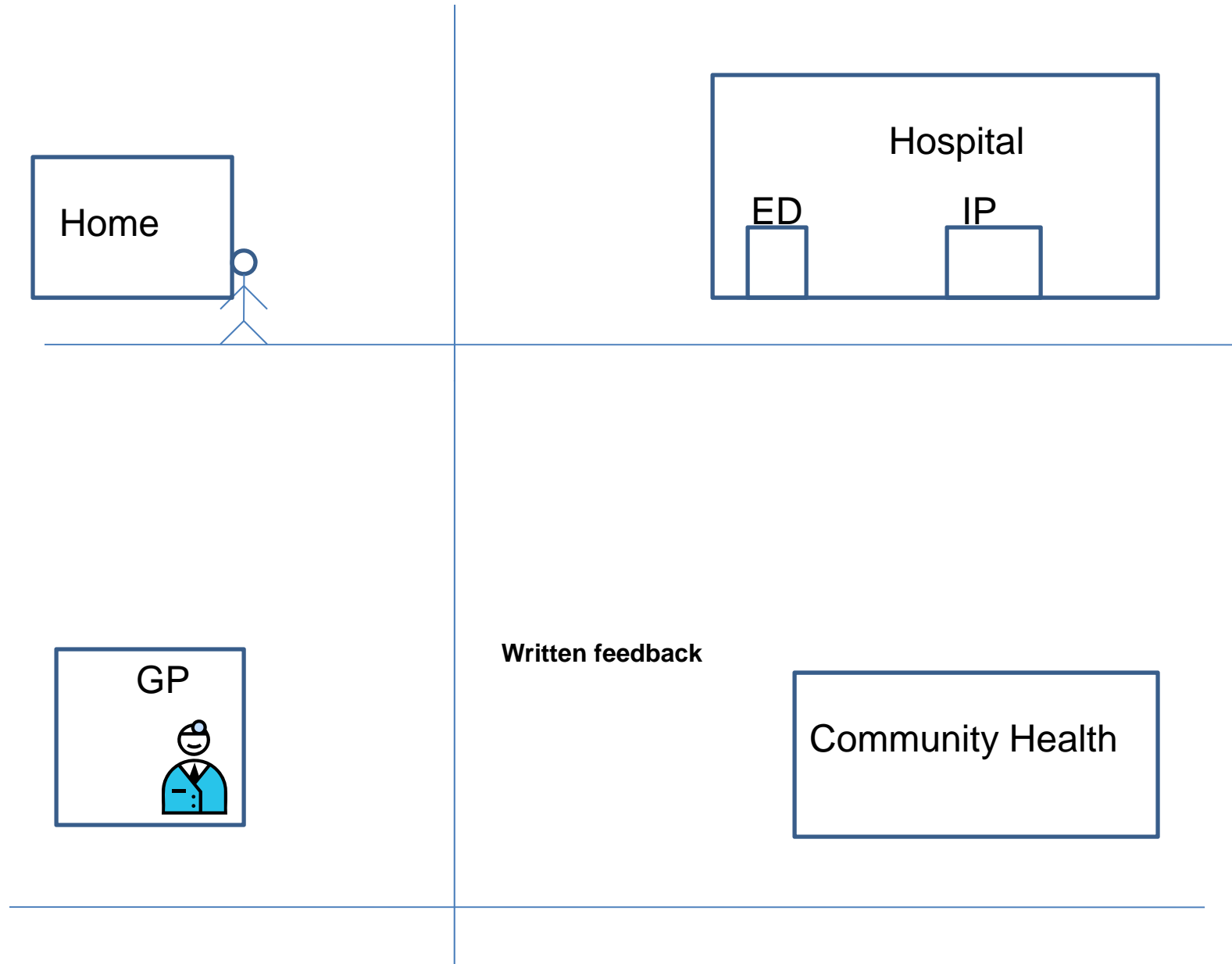
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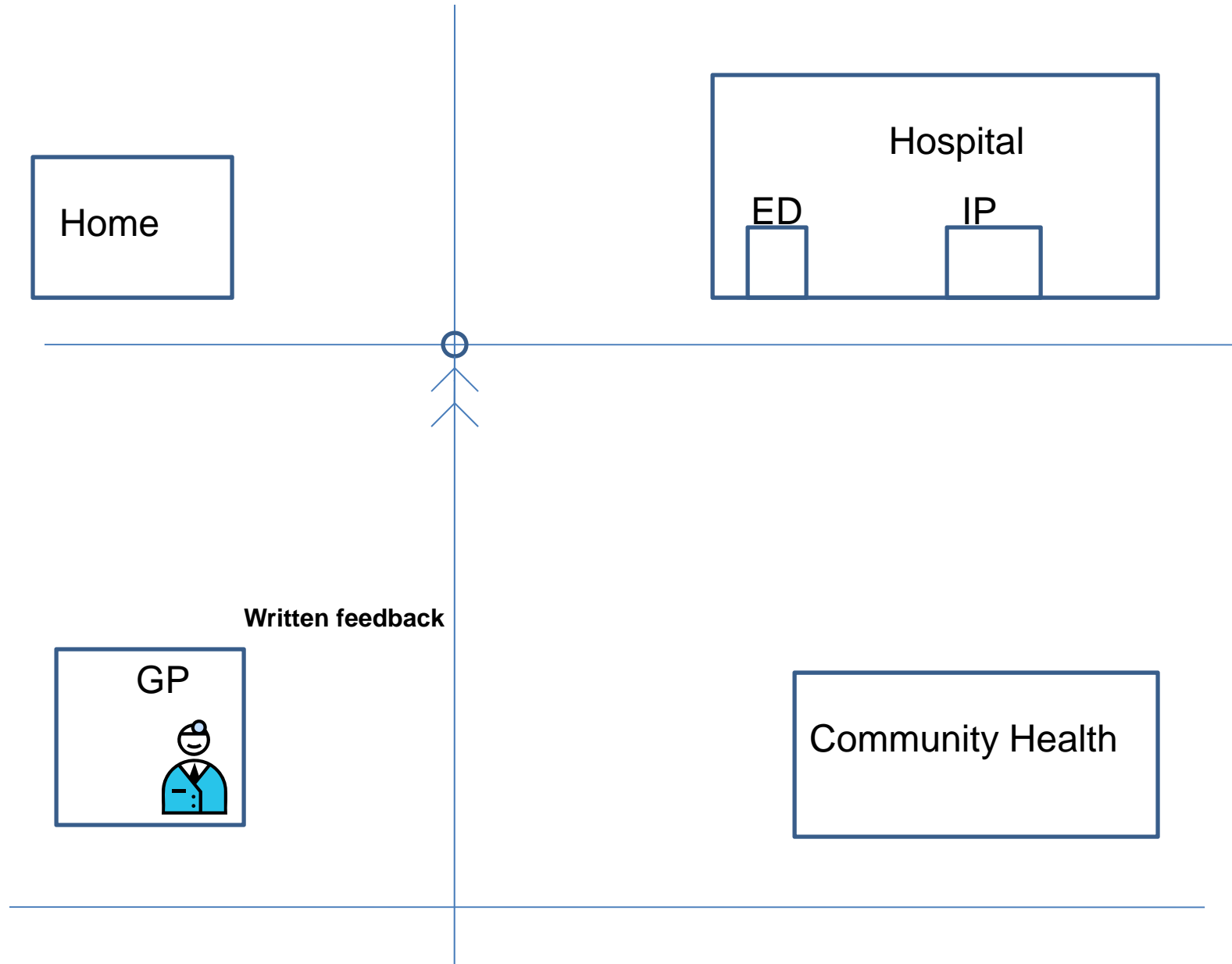
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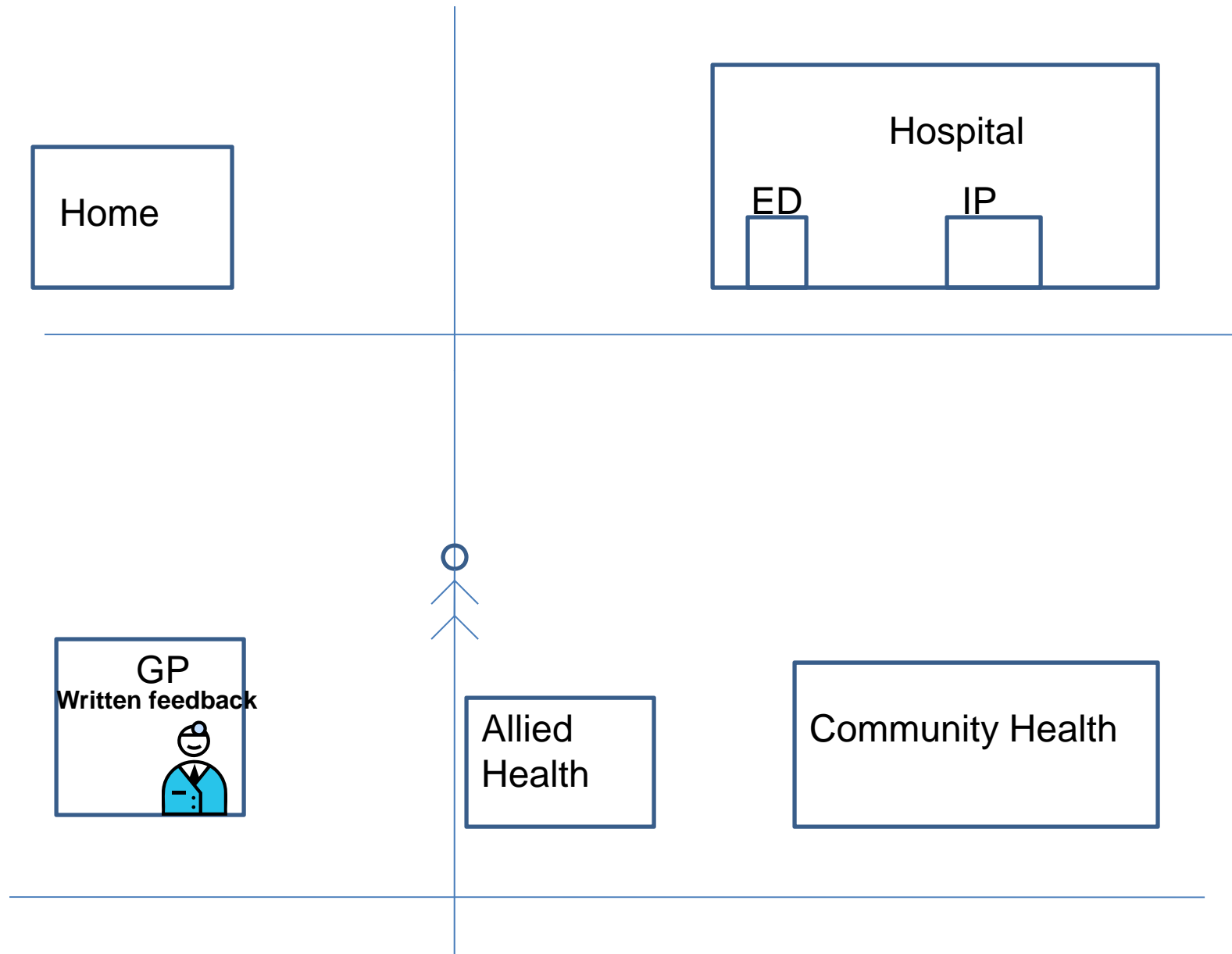
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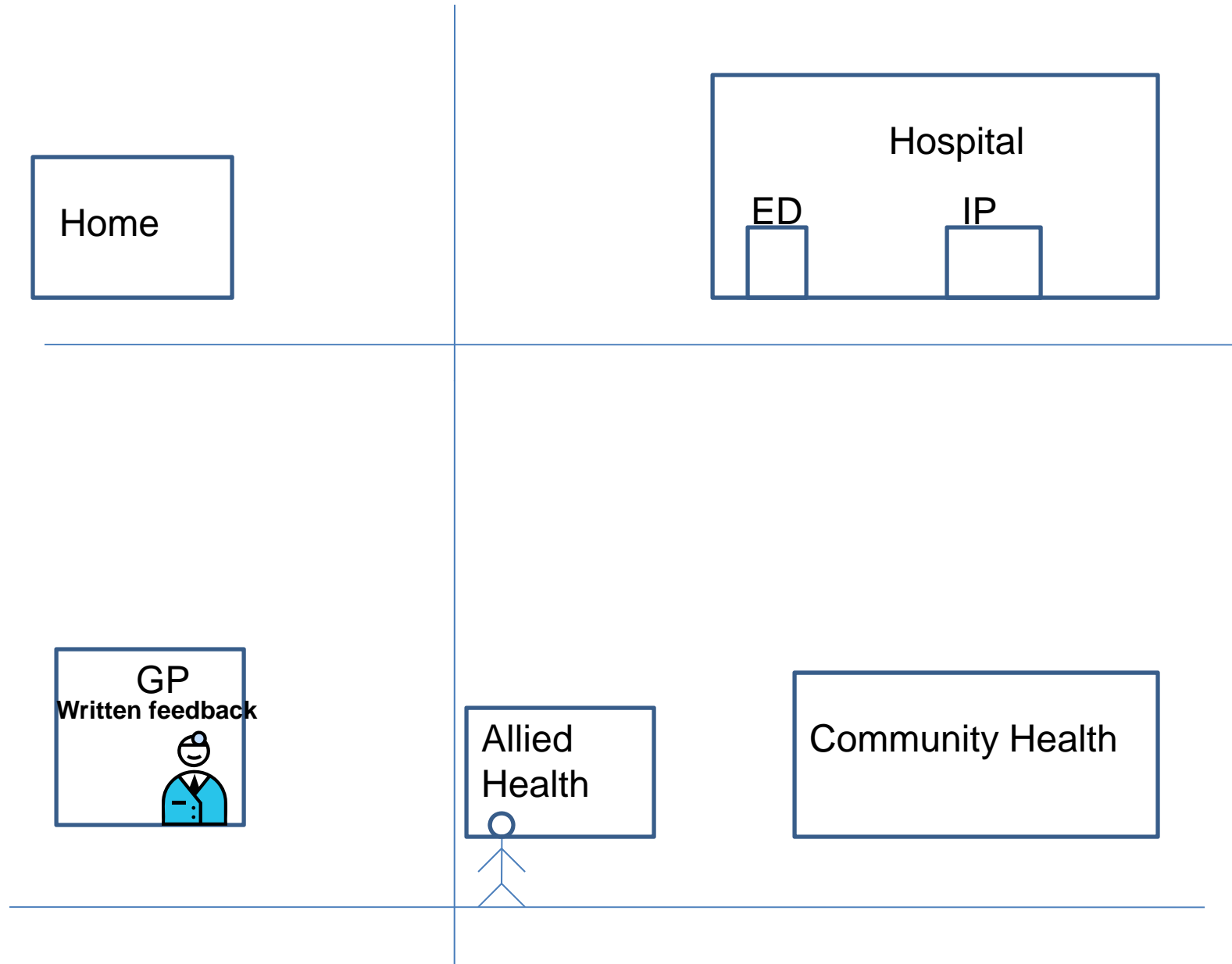
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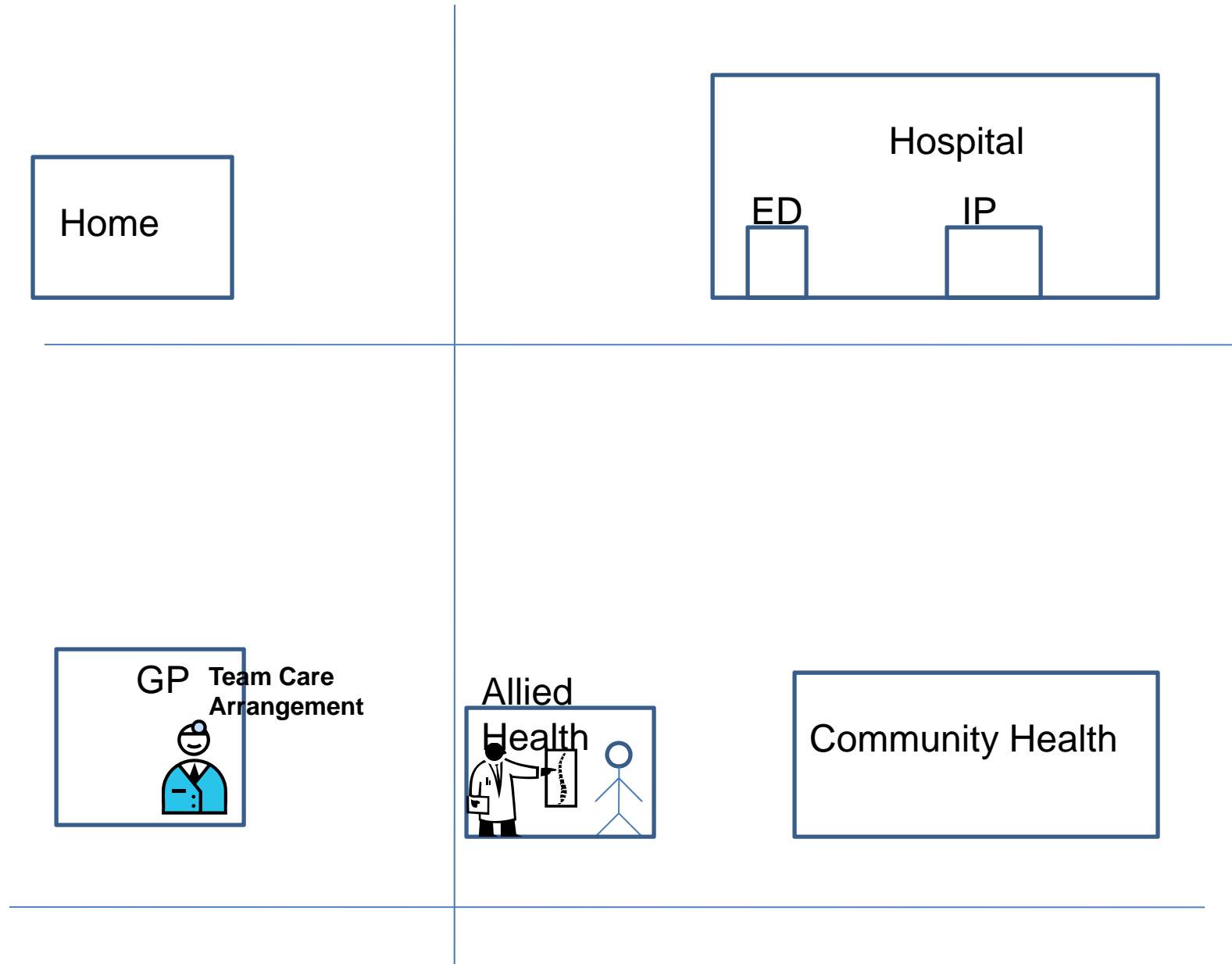
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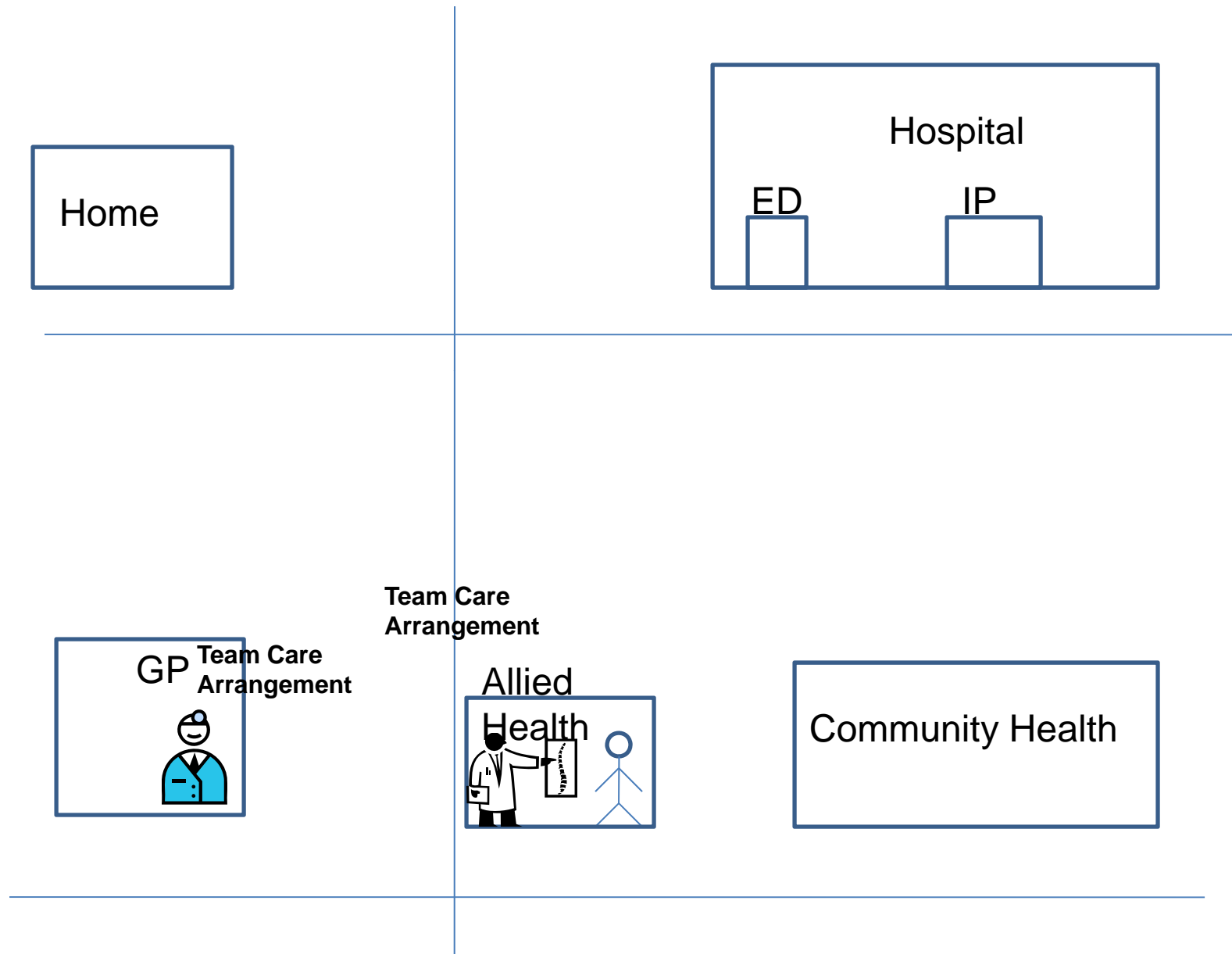
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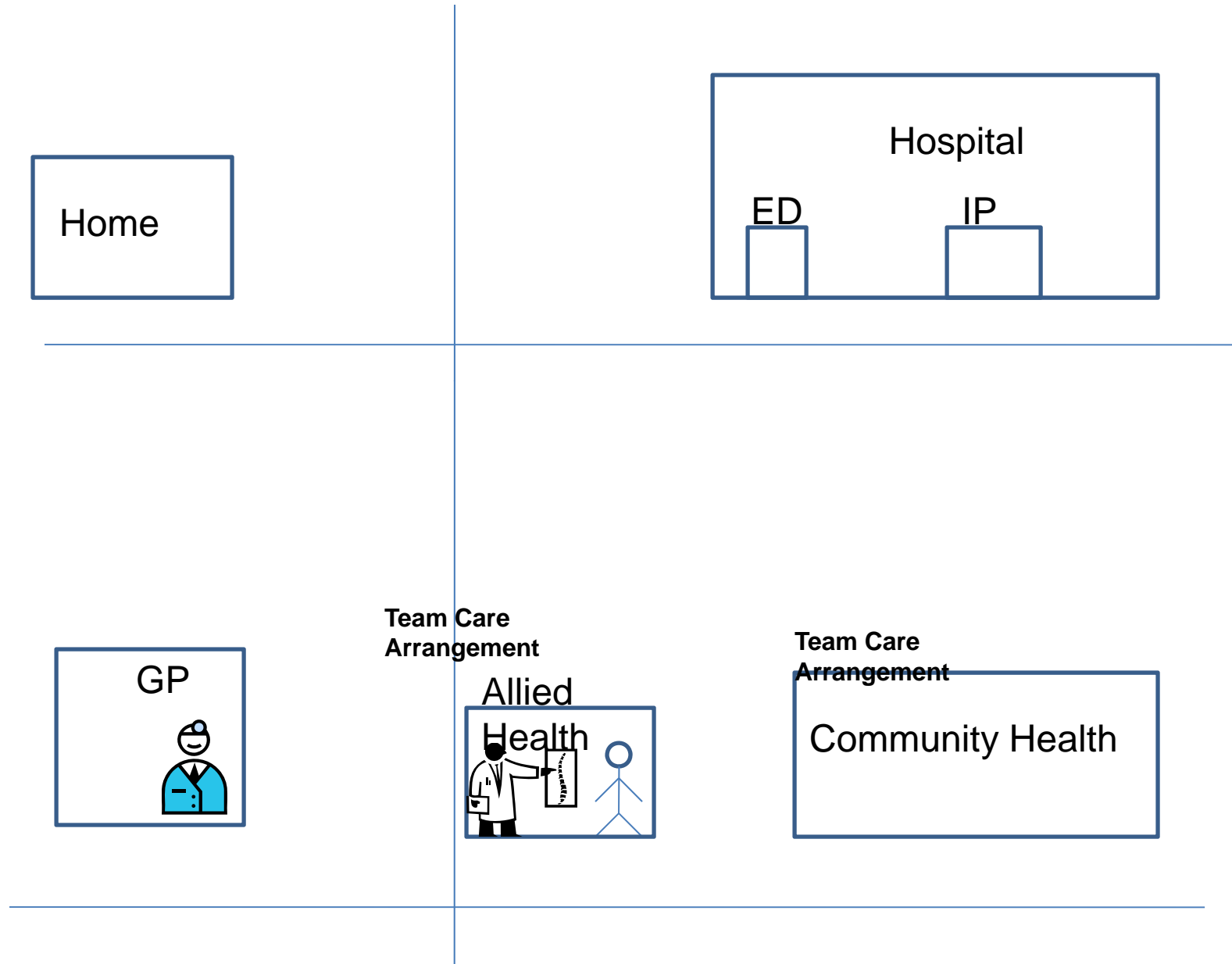
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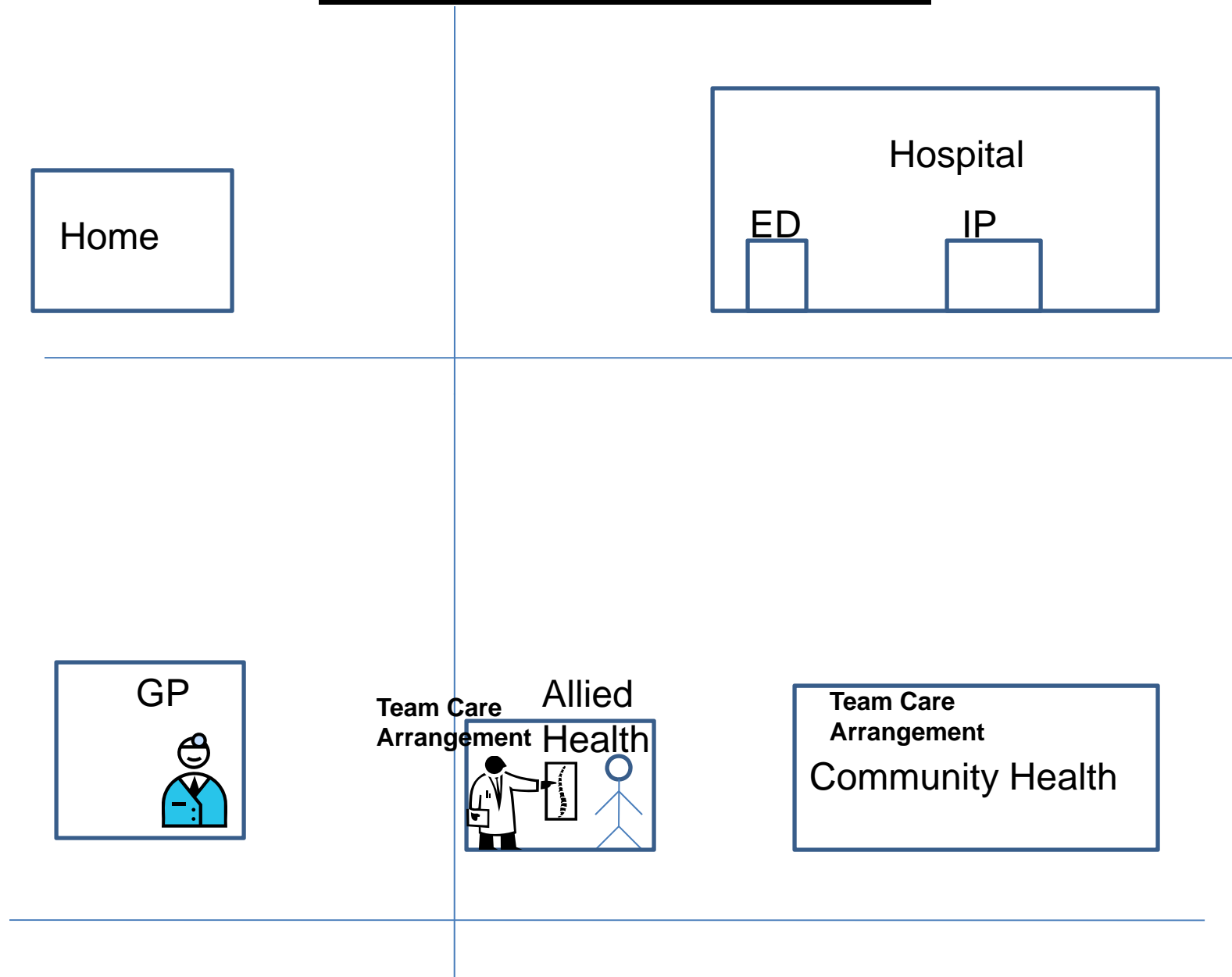
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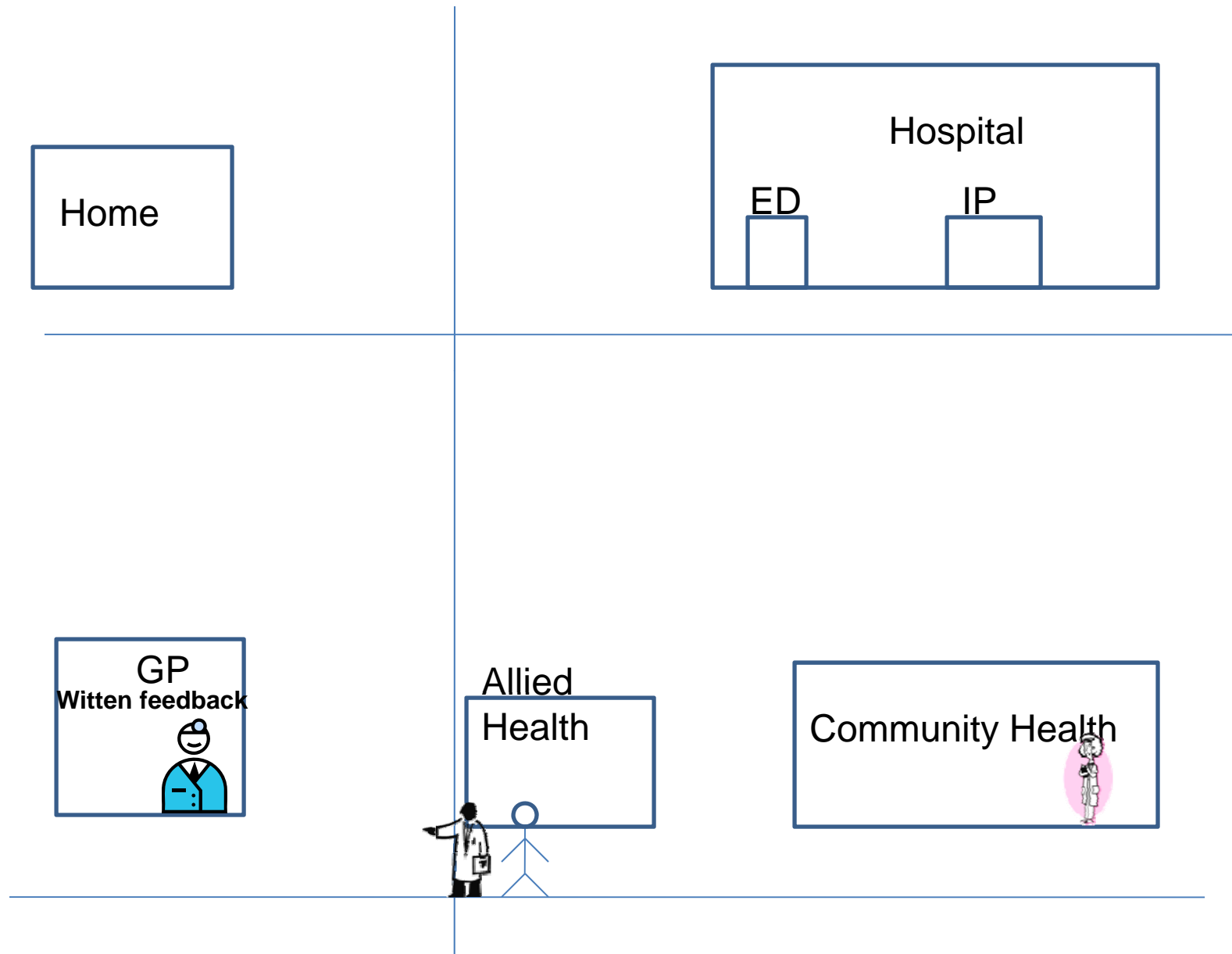
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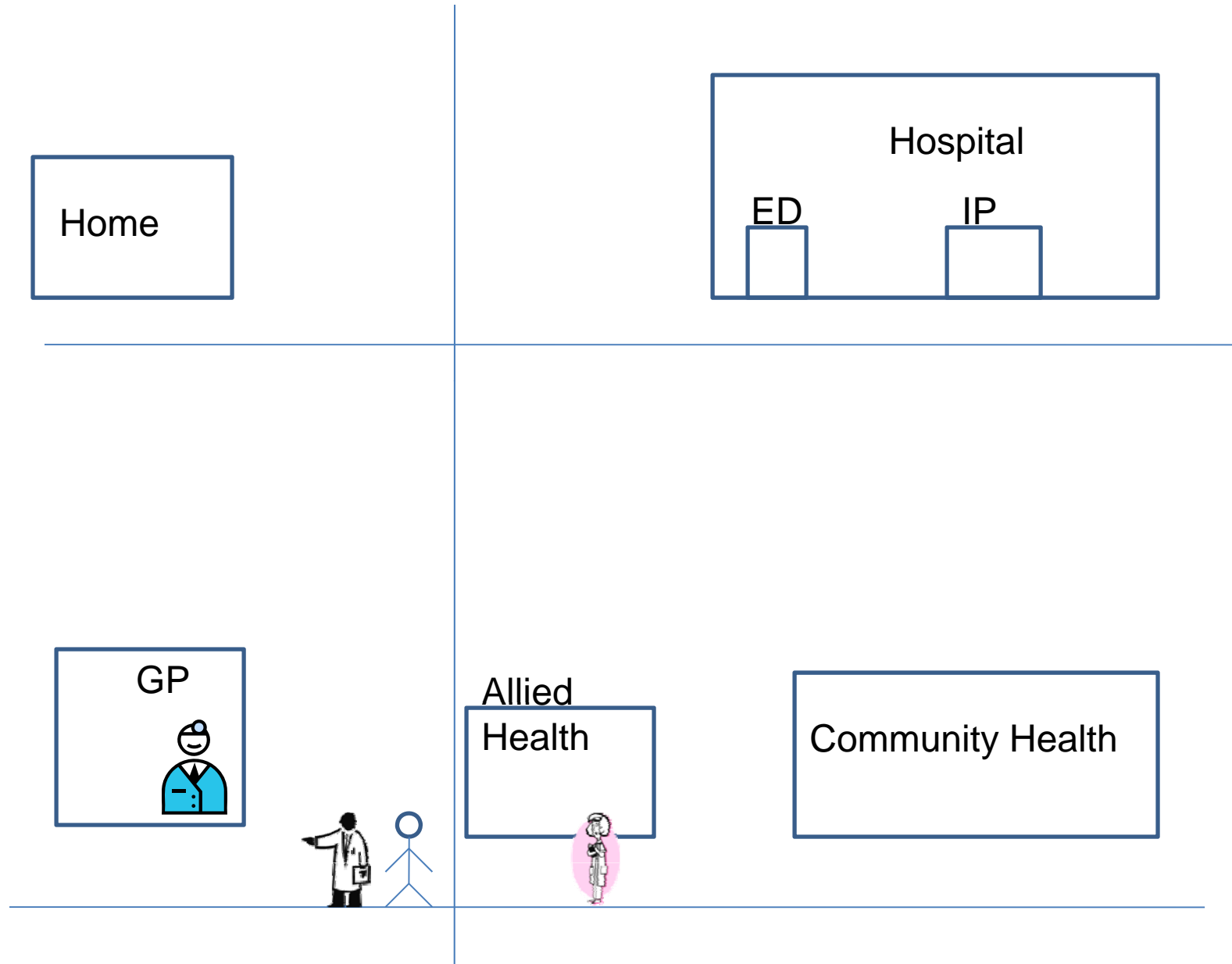
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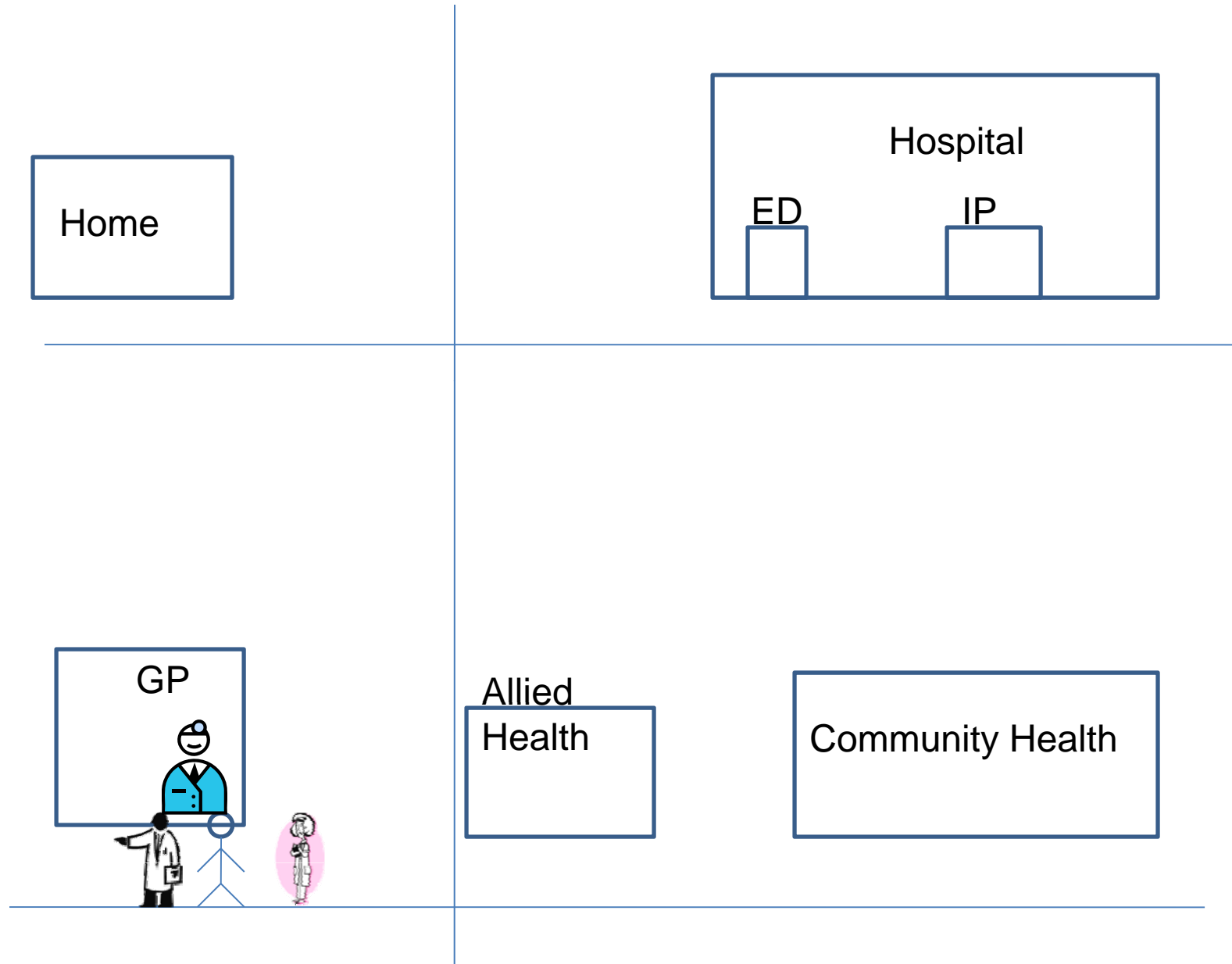
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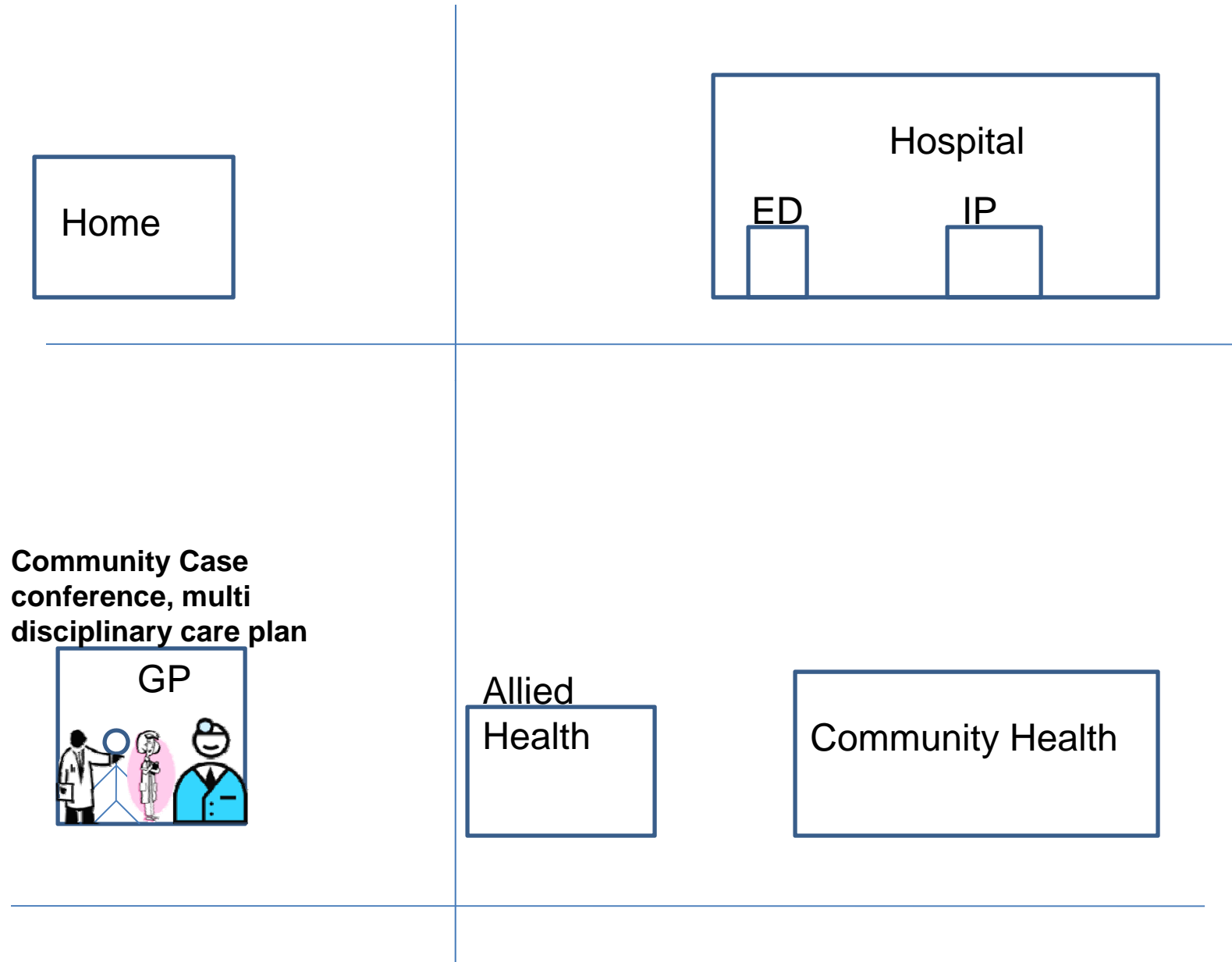
GP and Community Integration



GP and Community Integration



GP and Community Integration





WentWest

Thank You