

Coordinating Care for People with Complex Health Needs in General Practice



improvement foundation



Ros Rolleston RN
rwr@australiainmail.com

Learning Objectives

- Person centred care
- Flourishing teams
- Coordinating care
- Care plan
- Collaboration

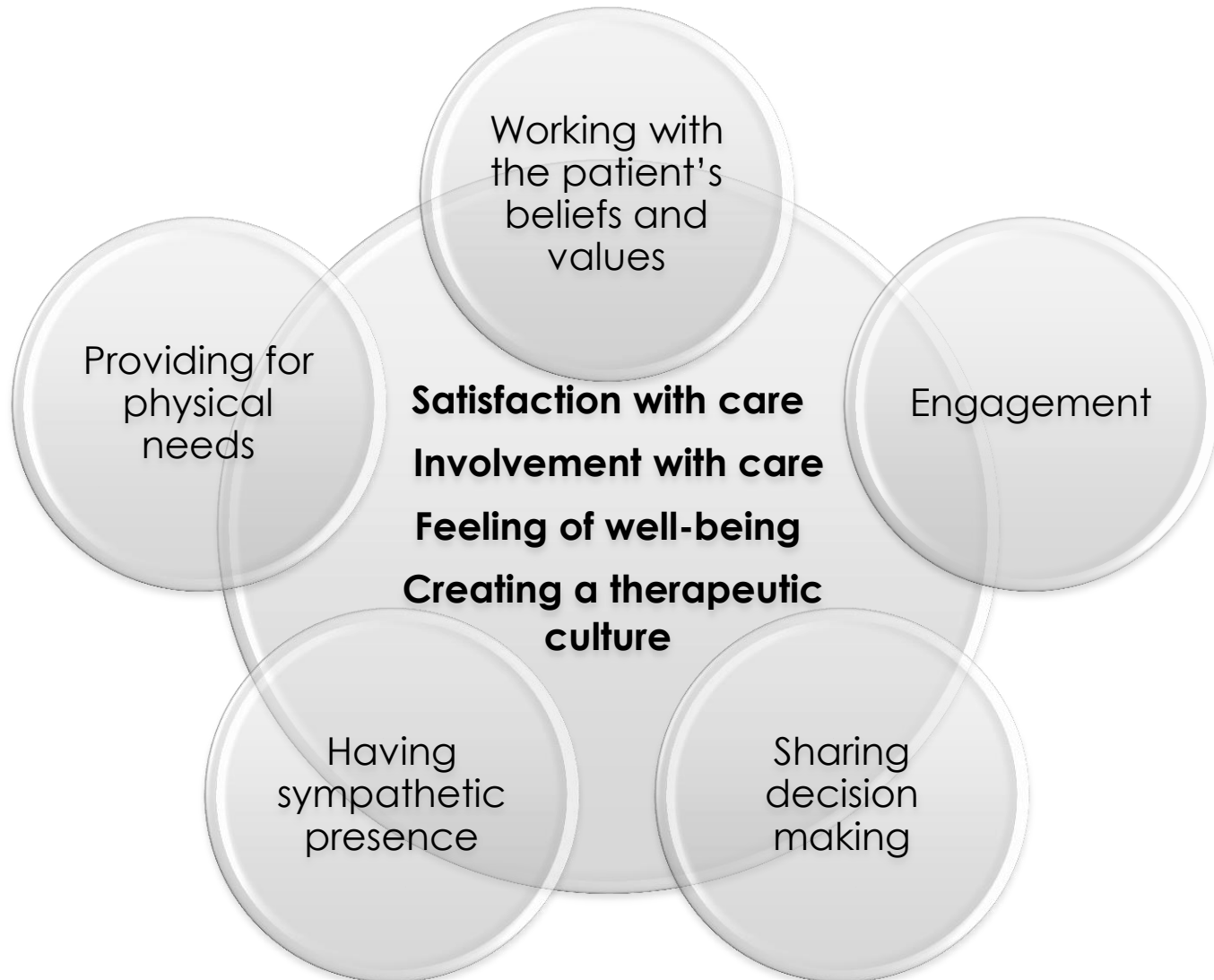


Goals of Person Centred Care

- Listen to the person
- Uncover the person's needs
- Discover their influences
- Encourage active participation
- Motivate behavioural change
- Develop long term relationships



Person Centred Model



Goals of Flourishing Teams

- Inclusive
- Valuing
- Participatory
- Productive
- Continually evolve

Flourishing Team Model



The Project

Coordinated Care

- Pathway of continuous care
- Regular contact with the person
- Shift approach from reactive to proactive
- Collaborative sharing of knowledge
- Integration of service providers
- Reduce hospital presentations

Qualities of Care Coordinator

- Experienced general practice nurse
- Knowledge of local resources
- Skilled communicator
- Relational & interpersonal attributes
- Leadership abilities

Team Meeting

- Discuss the coordination of people with complex illness project
- Agree on GP, GPN & admin roles
- Consider time requirements
- Plan triage response
- System for managing recalls
- Schedule evaluation



Time

- Some people need to talk a lot
- Extended time for care plans, reviews & 10997
- Collaboration with GP
- Loads of paperwork
- Telephone calls
- Discussion with AHP

Education

- Medical Home
- Erhlich et al. 2012, *'Spanning boundaries and creating strong patient relationships...'*
- Coordinated Veterans Care

The Care Plan

Fred

- 84 yo, lives with wife
- COPD, AF, T2DM, MD
- Metformin, ACE, Ca Antagonist, statin, Digoxin, Warfarin & puffers
- Presents for INR – 2.7
- Experiencing breathlessness, SpO₂ – 95%
- 3 ED presentations in past 2 months, discharged each time



Fred

- Inferior myocardial infarction presenting as acute pulmonary oedema
- Comes in for INR post discharge, with his wife
- Now also on Frusemide & Nitro spray
- Unsure when to use his puffers
- Anxious about his breathing
- Angry at home
- Licence suspended



Questions...

- What support might be available for Fred?
- How can you prevent further ED presentations?

Fred

- ED presentation for breathlessness
- Wife rings in distressed, change in medications
- What do you do?



Person Centred Assessment

- Comprehensive biopsychosocial needs assessment
- Goal based care
- Encourage self management
- Improve health literacy
- Promote wellbeing



Mental Health & Wellbeing

- Daily routine
- Sleep patterns
- Relationships
- Depression & anxiety screen?
- Do we need help here?

1 in 4 OF US
will experience
mental health
Problems
in our Lifetimes.

Cardiovascular

- Lipid profile is normal
- HbA1c – 7%
- Medications
- Is an ECG indicated?
- Who might be able to help Fred?



Renal Protection

- eGFR – 50, protein in urine
- What are the aims of management?
- How can we best achieve these?
- Do we need help here?



COPD

- Exercise tolerance
- Identification of symptoms
- Management of symptoms
- Who can best help Fred?



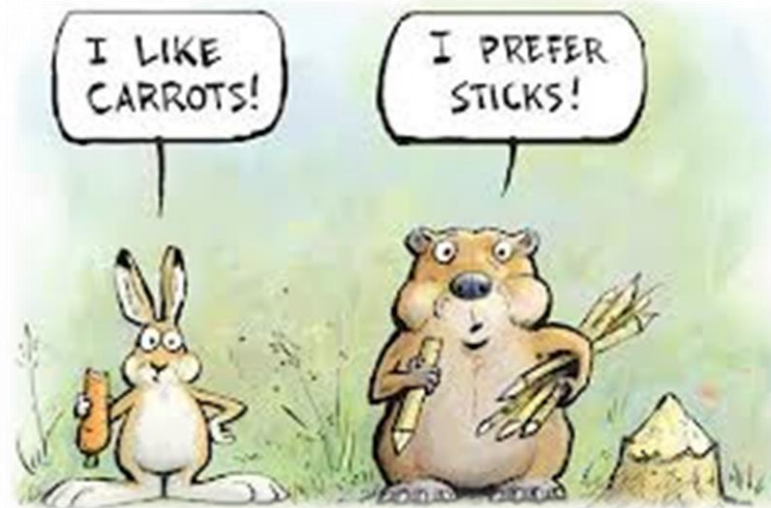
Potentiating Self Care

- Gentle & persistent encouragement
- Continuing education
- Engaging family in care



Motivational Interviewing

- Priority
- Importance
- Readiness
- Confidence
- Tools



Peron Centred Goals

- Confidence in managing his breathing
- Weigh himself x2 each day
- Walk his dog each day



Continuing Care

- Regular contact every month
 - Practice visits
 - Home visit
 - Telephone contact
- Fred can ring practice at any time

Prevent Hospitalisations

- Accessible care coordinator
- Improved self management
- Early recognition of changes
- Facilitate GP review
- Influenza & pneumococcal vaccination

Management of Exacerbation

- COPD action plan
- When to use Nitro spray vs SABA
- Triage process

Advanced Care Directive

- Process of consultations
- Home visit
- Transparent conversation with family
- Dedicated discussion with GP

The Collaboration

Team Care Arrangement

- Wife
- GP & GPN
- Respirologist, cardiologist & ophthalmologist
- Heart failure & COPD nurse consultants
- Podiatrist, optometrist, pharmacist

Coordinating Care

- Get a copy of ECG & bloods from ED
- Send TCA invitations
- Ring the pharmacist
- Talk to the COPD nurse
- Arrange home visit

CDM Folder

- Engages person
- Person a role
- Person responsibility
- Up to date health history
- Collaboration tool



Case Conference

- GP
- Care coordinator
- Other care provider

Fred

- Bilateral escharotomies
- Not yet mobile
- Rehab objective is to discharge home
- Who do you collaborate with?



Palliation

- Identify Fred's needs
- Negotiate with family
- Ensure ACAT assesment
- Ensure home assessment



Questions...

Acknowledgements

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