# SHARED CARE

## WHAT IS IT?
## WHO IS IT FOR?
## HOW DO YOU DO IT?


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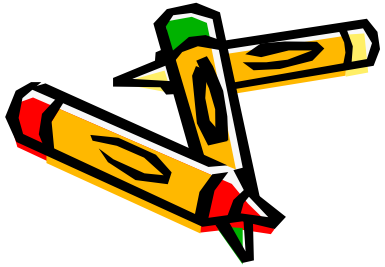
# WHAT DOES IT MEAN?

- SHARED

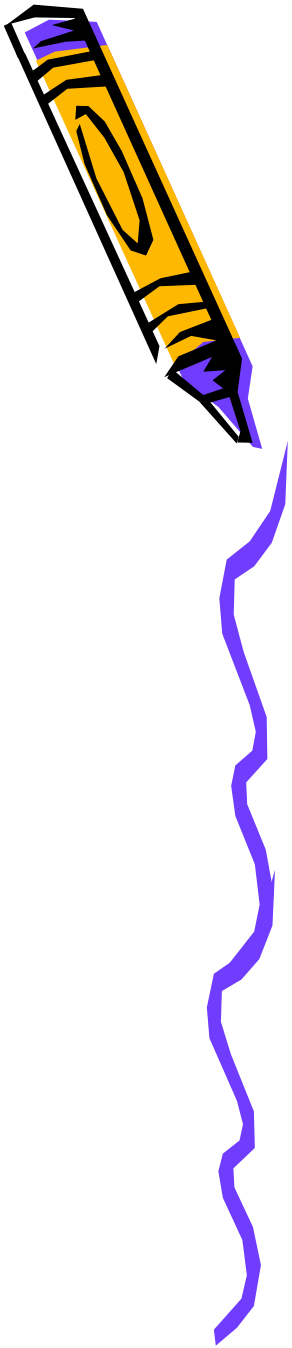
  patient, disease, Ix results, management, notes, from time of referral or time seen at hospital?

- CARE

  medical, psych-social, family, after-care, when does it start and when does it stop?



# WHO IS IT FOR?

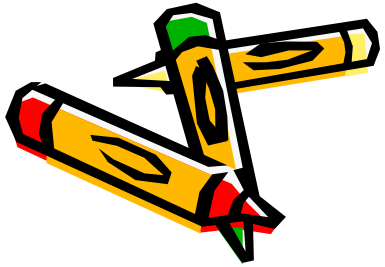


THE PATIENT?

THE GP?

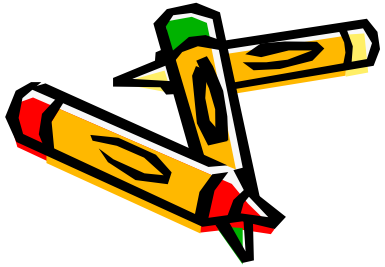
THE HEALTH SERVICE DRs AND NURSES? or

THE HOSPITAL?



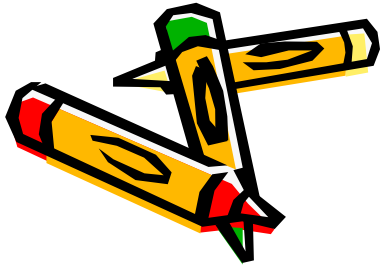
# WHY DO WE DO SHARED CARE?

- IMPROVE HEALTH OUTCOMES (of course)
- Keeps patients out of hospital
- OPTIMISING USE OF SKILLS
- Access for patients
- CHOICES FOR CARE
- Share resources
- EFFICIENCIES
- Ensure best practice
- HOLISTIC APPROACH
- It's fun



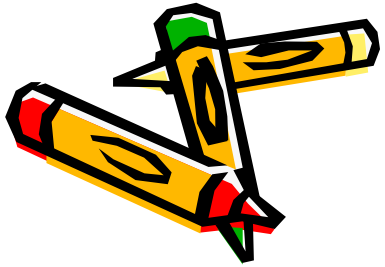
# What AHS asks for:

- 'We want GPs to give us the latest Path results they have'
- 'We want GPs to see the walking well for Pre-admissions'
- 'We want GPs to do the work-up before the pt. comes to hospital'
- 'We want to discharge patients from our service'
- 'We want GPs to look after the stable chronic patients'
- 'We want GPs to know what we do'



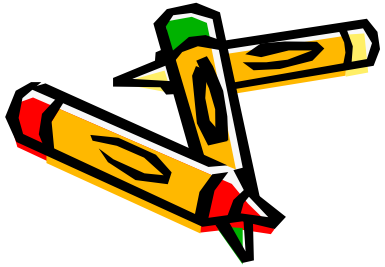
# Let's rephrase those questions:

- 'Our Service has this much capacity, if we worked with the GPs we could increase our capacity'
- 'How do GPs work with this type of patient and what can our service do to support them?'
- 'We send GPs all this stuff and GPs send us all this stuff. What do we all really need?'



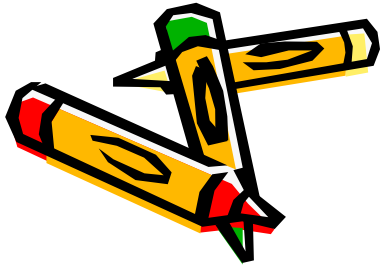
# I encourage shared care clinicians to:

- Get to know your GPs
- Talk to GPs about 'patients'
- Try and decrease paperwork
- Find out how a GP likes to receive communication
- Find out if GPs want education and how they would like it

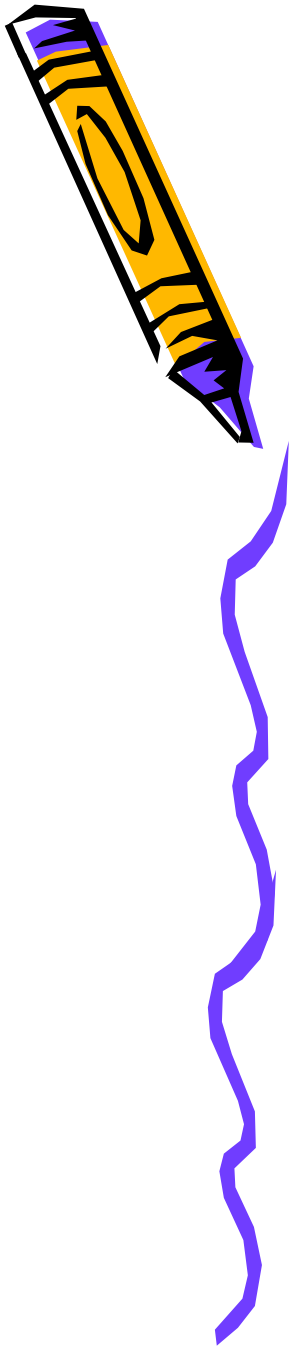


# It works if……

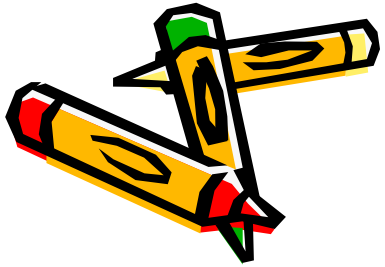
- It works if the clinical specialists are behind it
- It works if GPs like the work and feel supported
- It works if there is agreement on how to deal with unstable patients
- It works if communication is a priority
- It works if the system is managed
- It works if clinicians are kept informed



# One size never fits all



- Hence no guidelines
- Instead we have a chance to work creatively
- Jump at the chance to design a shared care program
- Get feedback from the GP Division on the feasibility
- Be sure you are clear on what AHS is trying to achieve
- Get to know GP speak
- Look for efficiencies / be aware of limitations
- Make sure everyone who is interested has been invited to the planning



# How then?

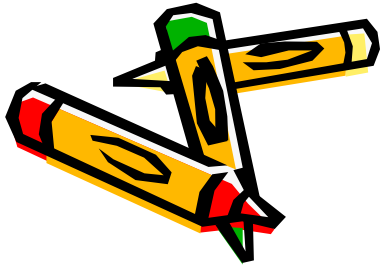
*Step one*: What does your service provide?
How does your service work?

*Step two*: Do you work with GPs?
How do you work with GPs?

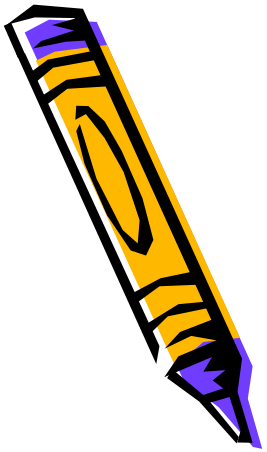
*Step three*: What do you want to achieve?

*Step four*: This is how GPs work, how can we link with GPs?

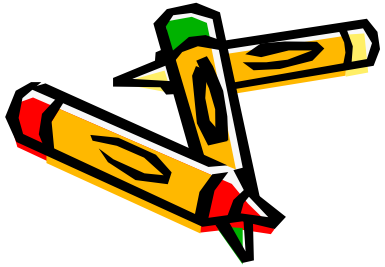
*Step five*: We need to find out how many GPs will be interested and how we can work together?



# How do you work with the "other side"?

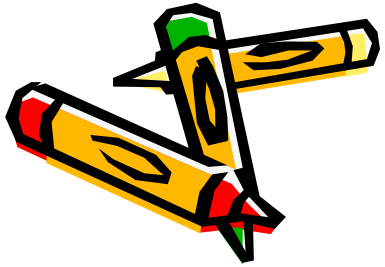


- LINKED = Info provided when asked; you ask when you need it
- COORDINATED = Info flows routinely in both directions
- FULLY INTEGRATED = use a common record as part of daily joint practice and management

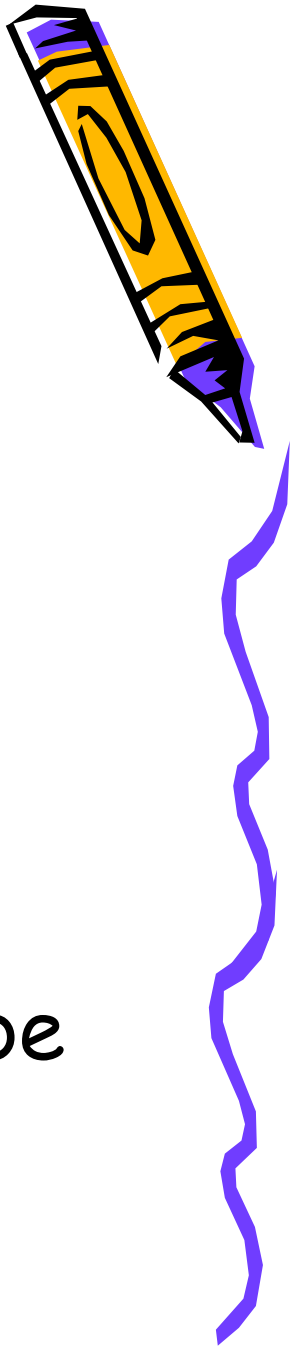


# The multiple personalities of Shared Care

- Antenatal
- Mental health/GP
- D&A
- Hepatitis C
- APAC/GP
- Palliative Care
- Clozapine



# WHAT KEEPS US GOING?



- Team work
- Creative thinking
- Bob the builder philosophy
- Bouncing energy
- It is fun
- The networks enable problems to be easily sorted