Victorian Chronic and Complex Care Program

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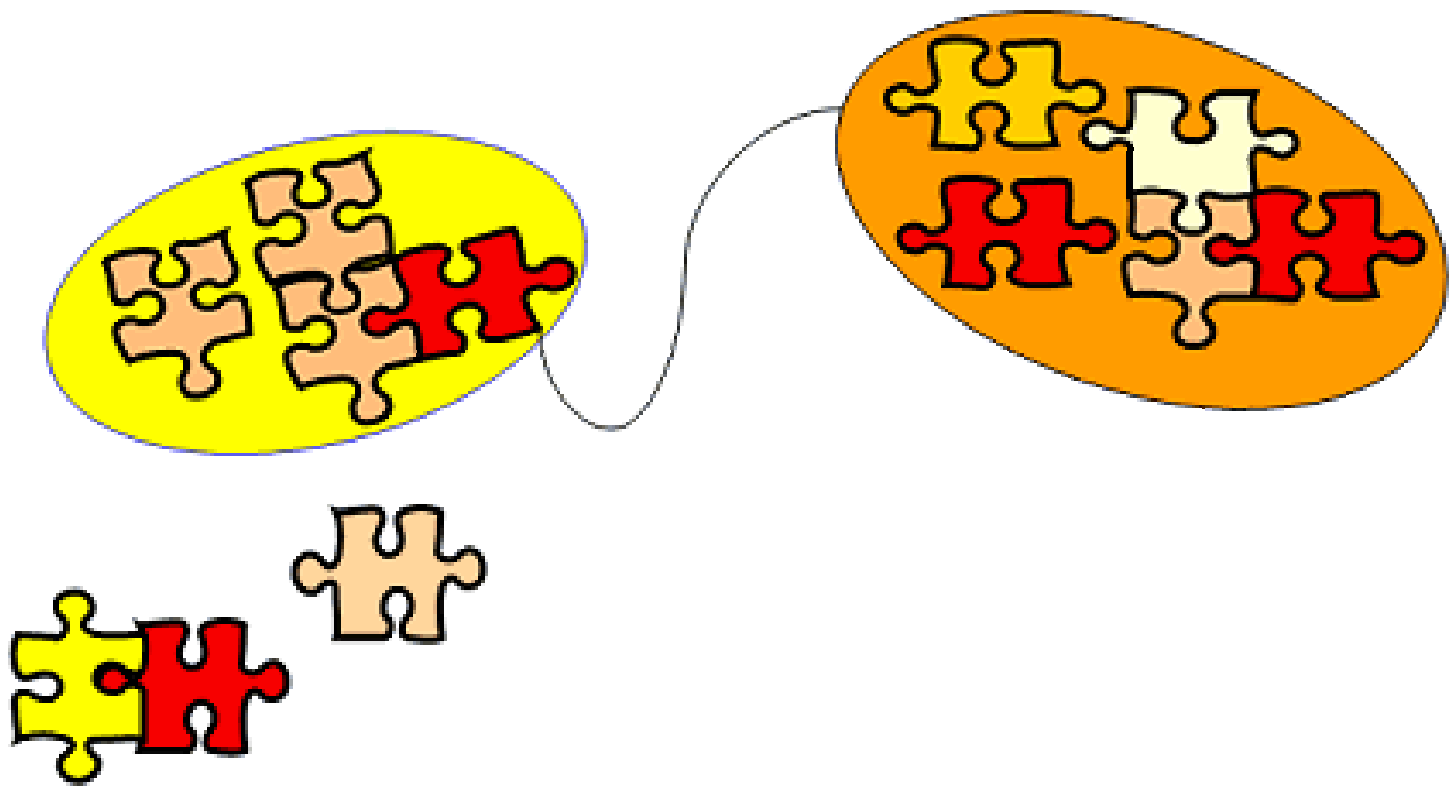
Monday 20 June 2005

Mainstreaming HARP

- Implement the Victorian Chronic and Complex Care Program
- Develop the diabetes model of care
- Promote advance care planning and remote patient monitoring
- Enhance communication between hospitals, community agencies and GPs

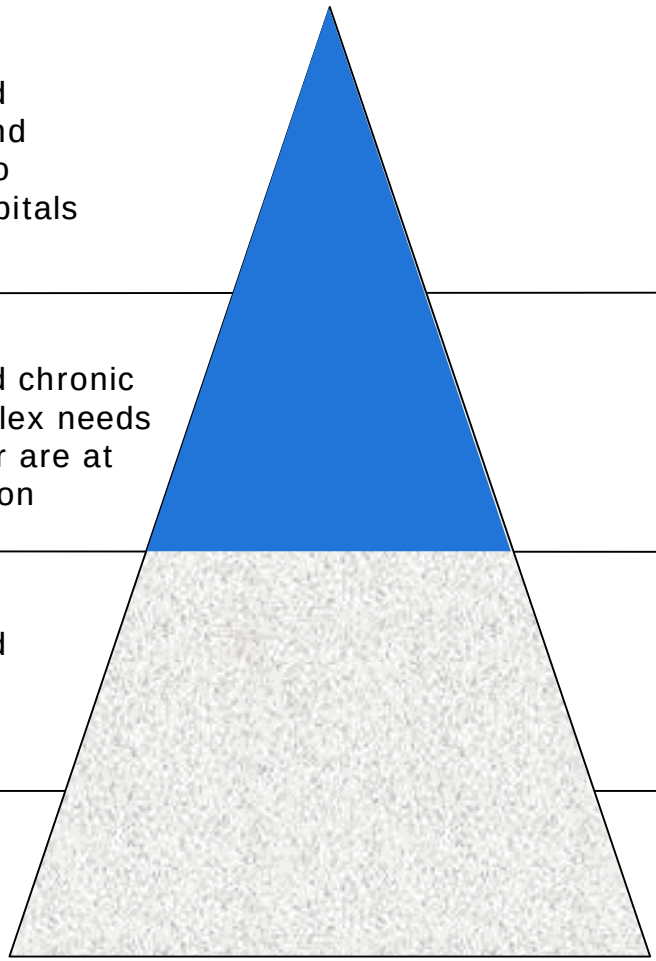
Projects ⟹ Program



Victorian Chronic and Complex Care Program

- Strategic Directions
- Governance
- Accountability
- Guidelines

Victorian Chronic and Complex Care Program



Level 1
People with defined chronic diseases and complex needs who frequently use hospitals

Intensive case management
- Tertiary prevention
- Enrolled patient population
- Case management
- Specialist medical and GP management
- 24 hour rapid response including outreach
- Additional services where appropriate

Level 2
People with defined chronic diseases and complex needs who use hospital or are at risk of hospitalisation

Community based coordinated care
- Secondary and tertiary prevention
- Enrolled patient population
- Care coordination including care planning
- Access to multidisciplinary team care
- 24 hour telephone advice

Level 3
People with defined chronic diseases and/or complex needs

Usual care
- GP care
- Self-management programs
- Access to mainstream community services
- Generic telephone advice

Level 4
Whole population

Primary Prevention
- For example:
- Obesity reduction / smoking cessation

Strategic Directions

Objectives

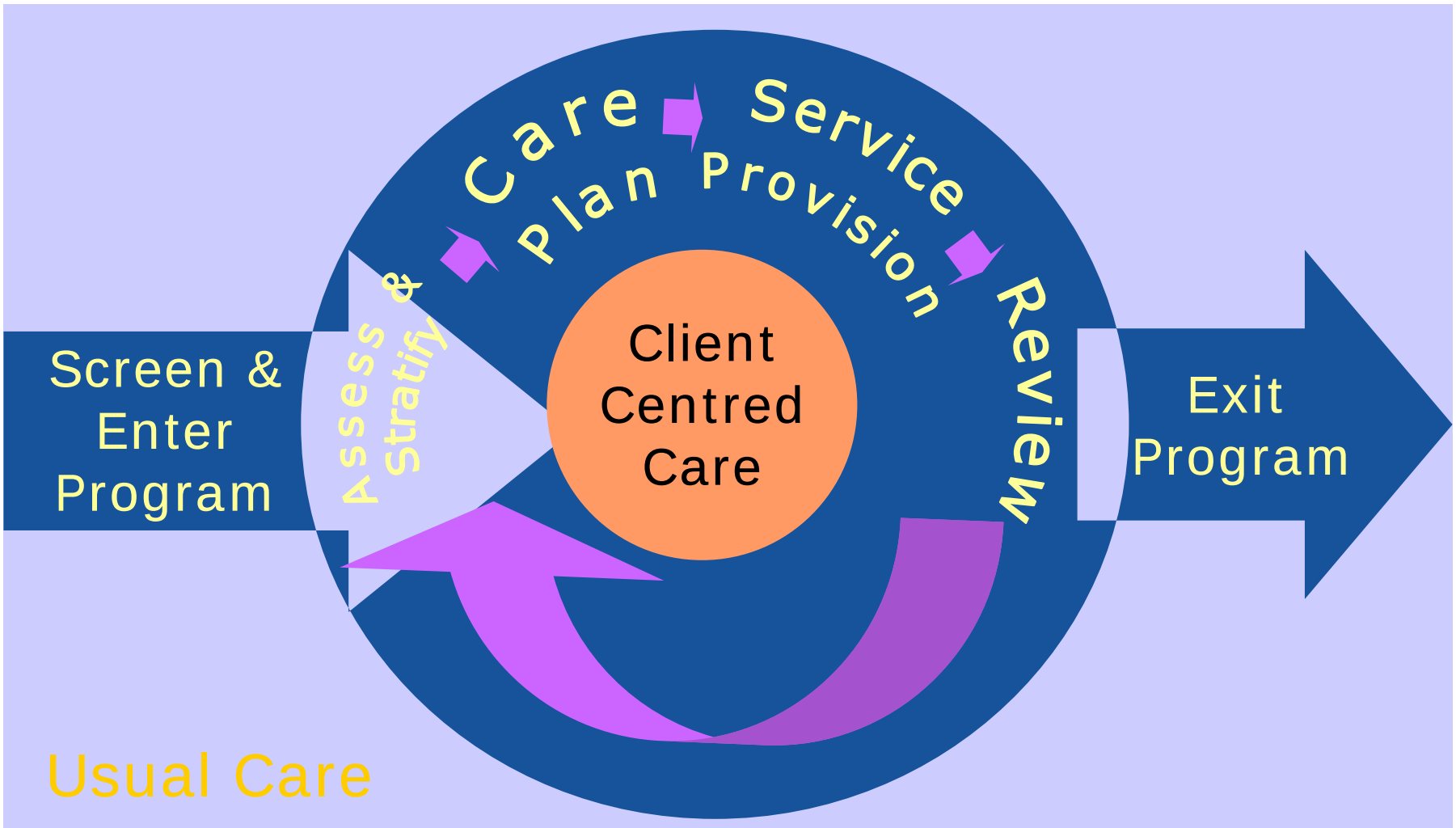
- Improve patient outcomes
- Integrate care within and across sectors
- Reduce avoidable hospital admissions and ED presentations
- Provide equitable access to healthcare

Target Population

Photo courtesy of Melbourne Easy Breathers

Principles

1. Patient focus
2. Carer involvement
3. Collaboration
4. Integration
5. Leadership
6. Workforce Development
7. Evidence based practice
8. Quality


Screen & Enter Program
Assess & Stratify
Care Plan
Service Provision
Review
Client Centred Care
Exit Program
Usual Care

Governance

- VCCCP Reference Group
- Guidelines
- Leadership
- Local Alliances
- Accountability

Guidelines

- EQuIP Framework
- Structure
  - Program Guideline
  - Rationale
  - Minimum requirements

Guideline Examples

- Defined point of access
- Assessment and Stratification
- Education and self management
- Flexible funding
- 24 hour contact
- Role of the General Practitioner

Key Priorities

- Improve health outcomes for people with chronic and complex care needs
- Mainstream on the basis of evidence
- Develop strong accountability mechanisms
- Community / hospital collaboration

Next steps

DHS

- Consultation draft of Program Guidelines
- Formally communicate direction
- Establish the VCCCP Reference Group
- Conduct workshops with the sector
- Release of final guidelines

Sector

- Provide feedback on Program Guidelines
- Nominate Program contact person
- Develop or review Local Alliances
- Develop Terms of Reference
- Develop a Program Implementation Plan

Further Information

Guidelines available on

- www.health.vic.gov.au/vcccp
- Information kit