Carrington Health case study

Care delivery models that integrate with specialist services

The Chronic Care Model element highlighted in this case study is **decision support**.

Developing condition-specific protocols and care pathways with other providers in the region is an effective strategy for supporting delivery of effective, efficient care.

Carrington implemented changes in diabetes and falls assessment program areas to integrate their services with specialist services.

Diabetes

Background

In 2008 Carrington Health (previously Whitehorse Community Health Service) developed a partnership with Eastern Health Endocrinology Department to improve services for people with diabetes.

Organisational reviews by both organisations pointed to a need for more effective, integrated, multidisciplinary care based in the community, as well as a need to respond to the current and pending financial pressure and increasing wait times for acute diabetes services.

What they did

After a review of their diabetes services, Carrington Health and Eastern Health agreed to work together to use the different funding streams that each of them had to provide multidisciplinary, community-based 'joined-up' healthcare within the limits of existing resources.

Working together, they developed the Integrated Diabetes Education and Assessment Service (IDEAS).

The service operates out of Carrington Health and the team includes an endocrinologist and registrar (from Eastern health) working directly with a diabetes nurse educator, podiatrist and community health nurse (from Carrington Health).

IDEAS provides:

- people with type 2 diabetes the opportunity to access integrated community-based diabetes specialist and allied health services in the one setting
- community-based follow-up of people with diabetes discharged from inpatient and ambulatory care services, including integrated referrals/communication pathways to other services (for example, general practitioners, community health)
- training in diabetes self-management and referral into other Carrington Health programs to provide support with other areas of their health and wellbeing
- coordination of care with other specialist services for people with diabetes related complications by:
  - linking with specialist practitioners in the community (for example, ophthalmologists)
  - operating in a coordinated and complimentary manner with existing ambulatory care services (for example, complex foot clinic, renal clinic, Box Hill Hospital endocrinology clinic)

IDEAS uses:

- standardised risk assessment tools to direct people with diabetes to the most appropriate setting for care. This may involve escalation of care from the community to Eastern Health and transfer of low-risk people presenting at Eastern Health outpatients back into the community
- a common assessment form used by all team members, including the short form of the PAID (Problem Areas in Diabetes – a standardised and validated tool)
- a common care plan to document the person's goals, the practitioners involved in their care, and progress towards their goals.

People receiving services provided by IDEAS are referred for assessment and support by their primary care provider or referred on following discharge from hospital inpatient or ambulatory services

The service is funded through Medicare Benefits Schedule-funded specialist medical services, and core community health-funded allied health professionals.

Eastern Health Hospital Admission Risk Program provided funding support to set up the service and provides ongoing administrative support.

Outcomes

Demand for specialist clinics at Eastern Health has increased by 51 per cent over the past three years. IDEAS provides an alternative model of care delivery, and is enabling redirection of approximately 33 per cent of Eastern Health diabetes outpatient referrals.

IDEAS has expanded and is now provided at two other community health services in the region and plans to further expand are in progress.

Funding provided by the Department of Health and Human Services has provided the opportunity to conduct two studies looking at the psychosocial and biomedical outcomes of adults with type 2 diabetes attending IDEAS relative to hospital-based outpatient diabetes clinics. Both studies were undertaken at four IDEAS sites, two community and two acute services sites. These studies were:

- a real-world, six-month, multi-site pilot randomised trial evaluating the impact of the IDEAS model relative to usual care at hospital-based outpatient clinics
- a cross-sectional study of patients attending IDEAS and hospital-based outpatient clinics.

The results indicated that IDEAS made real differences for people including:

- reducing HbA1c
- reduction in levels of diabetes distress
- improved sense of self-efficacy.

The results also showed that people who attended the community-based IDEAS were significantly more satisfied with their quality of care compared with those attending the outpatient hospital setting.

Quotes from participants in the study included:

- 'I am really happy with the professional standard of care and follow up with all areas. Having all my care providers for my diabetes at the same place is good – as each can access my file to see how I'm going.'
- 'I think the care plan is terrific. The doctor and other staff are involved in helping me and are supportive of my aims.'

Integrated Falls Assessment Service Model

Background

Over a 12-month period, one in three older people living in the community experience one or more falls, with rates even higher among those in residential care.

A fall has a significant impact on the person and those who support them.

Carrington Health decided to support a more proactive and preventive approach to falls prevention for older people in their catchment.

What they did

Carrington Health undertook a review of the evidence around effective falls prevention strategies and consultation with other services in the catchment.

The consultation and research identified the need for a community-based falls assessment service that would be readily accessible for older people who were concerned about mobility or balance issues or wanted to take preventive action to avoid these issues in the future.

An Integrated Falls Assessment Service was set up with funding provided by the Department of Health and Human Services in partnership with Inner East Medicare Local.

The service provides a specialist assessment service for older people experiencing problems with mobility and balance, focusing on prevention and early intervention.

The service is offered at Carrington Health and provides a comprehensive assessment with a geriatrician and a physiotherapist both employed by Carrington Health. The geriatrician consultation is funded via MBS and the physiotherapist funded by community health funding or MBS.

Regular multidisciplinary case conferences involving a physiotherapist, community health nurse and occupational therapist are conducted so that following assessment and, with the person's consent, ongoing care is discussed and appropriate referrals identified, including referrals to falls prevention programs and other services at Carrington Health.

With the person's consent their general practitioner receives a summary letter outlining the outcome of the consultation with the geriatrician and what action has been taken.

The service is also available via telehealth consultations for those in residential aged care funded through MBS. The telehealth consultation involves the general practitioner, geriatrician and facility staff and enables a full geriatric assessment to be undertaken without the resident having to leave their facility.

To receive this publication in an accessible format phone 03 9096 8618 using the National Relay Service 13 36 77 if required, or email partnerships.primary@dhhs.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Available at https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/chip-guidelines

(1610001)