Brisbane North PHN Future Models of Care

High level Report

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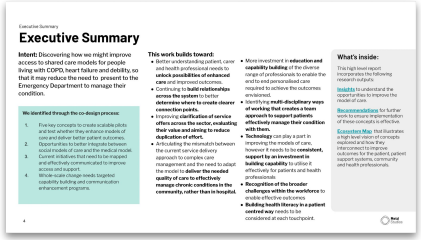
31 March 2022

Meld Studios

Contents

How to use this report & accompanying artefacts



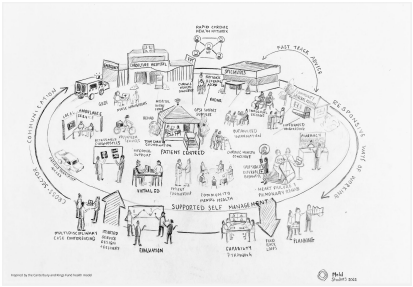
Executive Summary

If you want the short version read page 4.

It describes what we discovered and what this work builds towards.

Insights, findings & recommendations

This is the longer read - it unpacks the executive summary, accompanied by selected qualitative data.

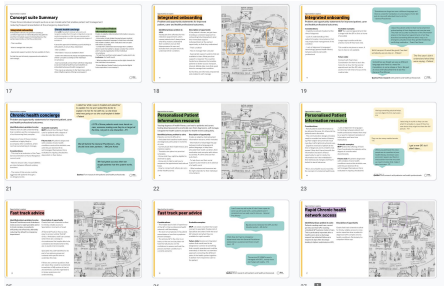


Care Model Ecosystem Map

This is a visualisation contextualising the different care models uncovered in our research and existing models around Caboolture catchment area.

This has been developed as a representation of what we heard with a focus on connection across sectors and disciplines.

Created with the three conditions in mind, it could be adapted for other health conditions.



Concept Capture

Look at these if you want to dig into the individual concepts. It includes a concept description, the genesis of the concept (problem to solve) considerations and scalable pilot examples and supporting quotes (patient and health professionals).

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Executive Summary

Intent: Discovering how we might improve access to shared care models for people living with COPD, heart failure and debility, so that it may reduce the need to present to the Emergency Department to manage their condition.

We identified through the co-design process:

1. Five key concepts to create scalable pilots and test whether they enhance models of care and deliver better patient outcomes.
2. Opportunities to better integrate between social models of care and the medical model.
3. Current initiatives that need to be mapped and effectively communicated to improve access and support.
4. Whole-scale change needs targeted capability building and communication enhancement programs.

This work builds toward:

- Better understanding patient, carer and health professional needs to **unlock possibilities of enhanced care** and improved outcomes.
- Continuing to **build relationships across the system** to better **determine where to create clearer connection points.**
- Improving **clarification of service offers across the sector, evaluating their value and aiming to reduce duplication of effort.**
- Articulating the mismatch between the current service delivery approach to complex care management and the need to adapt the model to **deliver the needed quality of care to effectively manage chronic conditions in the community, rather than in hospital.**
- More investment in **education and capability building** of the diverse range of professionals to enable the end to end personalised care required to achieve the outcomes envisioned.
- Identifying **multi-disciplinary ways of working that creates a team approach to support patients effectively manage their condition with them.**
- **Technology** can play a part in improving the models of care, however it needs to be **consistent, support by an investment in building capability** to utilise it effectively for patients and health professionals
- **Recognition of the broader challenges within the workforce** to enable effective outcomes
- **Building health literacy in a patient centred way** needs to be considered at each touchpoint.

What's inside:

This high level report incorporates the following research outputs:

Insights to understand the opportunities to improve models of care, how they might intersect.

Recommendations for further work to ensure implementation of these concepts is effective.

Ecosystem Map that illustrates a high level vision of concepts explored and how they interconnect to improve outcomes for the patient, patient support systems, community and health professionals.

Section 1

Project Background

How this project came to be

Brisbane North PHN in partnership with Metro North Health received funding from the Commonwealth Department of Health and the Queensland Department of Health to lead the Complex Care Models for Frequent Presenters to Caboolture Emergency Department.

The project aims to improve access to shared care with primary health care and care coordination for those people living in the Caboolture hospital catchment area, who frequently present with:

- COPD (Chronic Obstructive Pulmonary disease)
- Chronic heart failure
- Debility.

Originally the focus was on:
Bringing together health professionals, consumers and carers and other key stakeholders to learn about their current needs and behaviours to re-imagine future models of care to better meet those needs.

Meld Studios was engaged to lead the co-design process to better understand needs, identify opportunities, and prototype concepts that could progress into the next phase; detailed design and development.

Phase 1 was undertaken between **11 January - 31 March 2022.** This discovery phase focused on understanding **what was desirable from different perspectives, so that possible options for improvement could be identified.**

Note: the original plan to undertake some of the consumer and health professional engagement face to face shifted due to Covid.

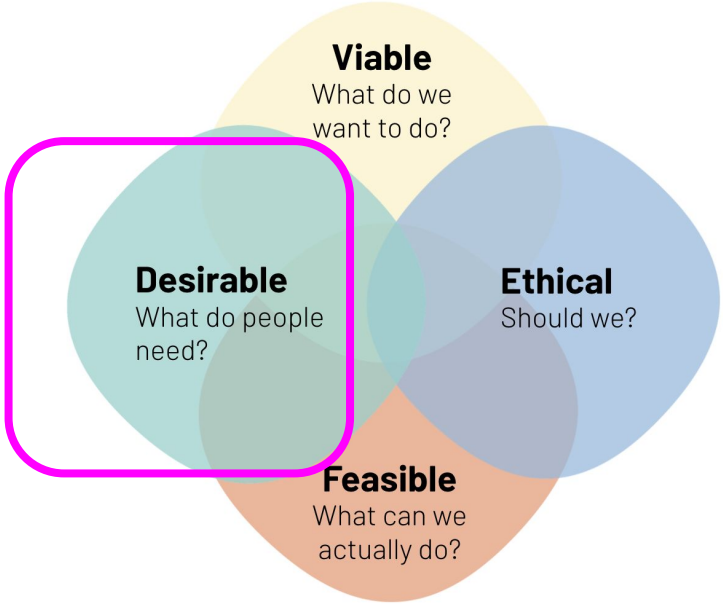


Image above: Desirable, Feasible, Viable and Ethical diagram

Research approach

The research approach focused on **building basic understanding** of current models of care, what's working well and where are the challenges, which need to be addressed to improve outcomes for the target groups.

To support the co-design process, a **Core Design Team** was established at the kick-off of the project. The team consisted of Project sponsor, Project lead, Engagement lead and key staff to support and guide the two Meld designers with key context, decision making to ensure the approach continued to meet the needs of the diverse range of stakeholders. The team met weekly to check in on progress and sense check emerging findings and adapt methodology with changing conditions.

A final **Playback** was delivered with a large number of stakeholders invited to go through a high level overview of the approach and emerging findings, which they were invited to provide feedback.

Methodology

The methodology was based on a rapid co-design process to ensure potential users, were involved in designing the future care model concepts. There was a shift in research approach from face to face to online due to Covid.

Methods used involved a mix of: desktop research, semi-structured interviews, generative co-design and testing sessions with cross sector health professionals and patients living with complex chronic health conditions.

Semi-structured Interviews included qualitative 'natural inquiry' to understand behaviours, mindsets and the way people currently navigate and manage chronic health diagnosis. We also explored patient and health professionals expectations and aspirations.

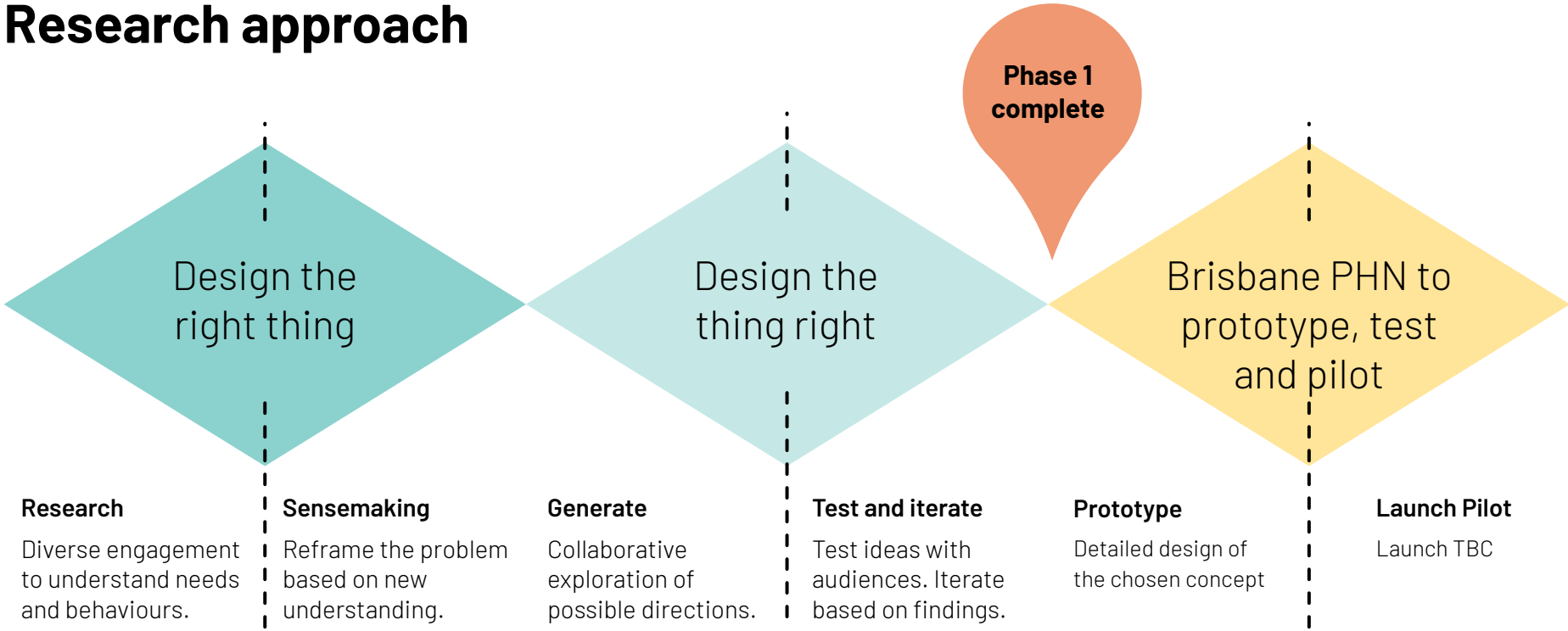
Co-design and testing sessions to better understand the needs, ideas and issues of a broader range of health professionals. Once concepts were mocked up, testing sessions allowed health professionals to dig deeper into how their ideas may be translated.

Analysis and synthesis of the research revealed:

- Insights to shape the understanding and connection between current initiatives and how they can better be engaged with to increase awareness and application.
- Opportunities to enable self-management for patients and and enhance responsive service when health events are triggered.
- Recommendations to undertake further work to explore these opportunities and determine the optimal ways to improve outcomes for patients and health professionals.
- Mindsets to help make decisions along the way that align with the consumer and health professional desires, needs, aspirations and challenges.

Participants included a range of health professionals including, GPs, Specialists, ED doctors, nurse navigators, Team Care Coordinators, Allied health professionals, Ambulance, Practice Managers and patients.

Research approach



Project snapshot

15

Background documents review

5

In-Depth Health Professional stakeholders participated in 5 hours of 1:1 in-depth interviews
11-12 January 2022

4

Frequent Presenting patients
at Caboolture Emergency Department.
25 February & 2 March, 2022

3000+

Qualitative Data Points gathered analysed and synthesised to generate insights
January - March, 2022

15

People engaged across disciplines and sectors in 3 hours of generative co-designing workshops
17 March, 2022

14

Concepts generated 5 refined & prioritised.
24 March, 2022

Section 2

Overarching Insights & Opportunities

Insights & Opportunities

We identified five desirable concept opportunities for further exploration to address the needs of health professionals caring for patients with complex health conditions and reducing the number of patients presenting at the Emergency Department.

These are the building blocks (diagram) to enable an integrated model (social and medical).

The service spectrum from the ideal of the patient being enabled to self-manage themselves through complex chronic health conditions all the way to a fully assisted health management approach, when needed.

These mindsets are the foundation to enable self-managed, wholistic, adaptive, patient centred care:

Health professionals need to be:

- Responsive to individuals needs and circumstance

- Connecting with others to empower the patient to self-manage

- Integrating across the system (health and social) to deliver a team based approach to patient's care

- Working with deep humility to leverage collective expertise in service of meeting patient needs

Diagram above: Enabling building blocks

Foundational mindset

To enable any of these concepts to enhance patient outcomes and unlock the potential of working better together, it proposed that some shared mindsets are valuable. These mindsets have not specifically been tested, however were gleaned through the co-design sessions.

Responsive

Tailoring care to patient needs.

Listening and watching for cues to show that the approach is not working, and adapting when needed.

Adopting a continuous learning approach that considers the type of relationship and the amount of information that the patient can digest at the different stages of learning about their condition.

Partnering

Across the spectrum of relationships to enable quality care for patients with complex and chronic health conditions, including:
-Health professional to health professional
-Patient to health professional
-Health professional to community professional
-Health Professional to carer (formal or informal)
Need to embrace more of a team approach to care and honour the different strengths that each part of the broader team offers

Integrating

Seeing the importance of connecting the medical and social models of care and understanding that for a patient the social elements are crucial to managing their condition effectively

Empowering an integrated approach across the different disciplines to increase consistency and reduce silos and duplication of effort

Exploring opportunities to undertake follow ups through integrating with other parts of the system in a way to potentially reduce anxiety and increase confidence in their ability to manage their condition(s)

Humility

To keep the patient at the centre of health care, professionals need to foster a mindset of humility.

This is an opportunity to learn together and although there maybe tried and tested methods to treat a patient, there also needs to be an openness to shift approaches when it does not suit a patient's circumstances.

Capability of the health professional is enabled to ensure a patient centred approach.

Systemic Challenges

Although this project is focused in the Caboolture area, a wide range of systemic barriers were raised throughout the research, that may impede progress for this project and ultimately limited the outcomes required.

Limited cross-sector communication means there is a lack of feedback loop and knowledge sharing.

This leads to:
-Patient frustration about needing to tell their story accurately and continuously for numerous different health professionals.
-Health professionals frustration that they cannot seamlessly respond to their patient needs.
-Pieces of the patient health story are at risk of falling through the cracks and treatment is not as responsive as needed.

Lack of consistency across digital systems means it is difficult to get a clear picture of the patient in a timely fashion.

This leads to:
-Fractured patient health records that puts a lot of pressure on the patient
-Double handling of key information
-Duplication of effort
-Risk that the appropriate level of care is not provided, as the health professional on hand does not have all the appropriate information about this patient, to enable them to support them effectively

Inappropriate funding models to manage complex conditions means health professionals are not able to spend the time need to deliver quality care.

This leads to:
- Lack of time to support the patient effectively

-Inappropriate sequencing to match the cadence of care required to effectively manage chronic complex conditions

-Mismatch between care of patient and design of health system

Workforce shortages in key areas means there are limited staff with the skills and experience need to deliver the care needed for people with chronic conditions.

This leads to:
-Health professionals not able to attend to patients in the critical time out of hospital
- A lack of knowledge about how to handle these type of conditions with the required integrated care model
-Lack of experience in the intricacies of dealing with chronic conditions, which increases the recommendation to go to ED
-Burnt out and overloaded health professionals

Current state mapping

Core to consider when developing any of the concepts

Throughout the co-design process, there were a range of current initiatives outlined that are designed to better support patients through their chronic condition journey.

Some of these include:

- Nurse navigators
- GEDI
- GPSI (GPs with Special Interests)
- Team Care Coordination
- RADAR (Residential Aged Care District Assessment and Referral Service)
- Virtual ED
- Hospital in the home
- Rehab services
- Not-for profit programs (e.g. Heart foundation)

There is a strong need to better map these programs showing how they currently work together, and how they could better connect to deliver better outcomes.

Since all health professional are busy, the translation of current initiatives, who is eligible, how people access them and opportunities for them to better connect is crucial as a foundation for any other concepts to flourish. This needs to be undertaken in a way that is easy to digest and usable and useful to translate through to improving patient care.

Enabling functions

Crucial to enable key shifts to improve outcomes

To activate key initiatives and services to work according to their intent, there are a range of core functions that need to be carefully considered and supported.
These include:

- Capability building
- Cross-sector Communication
- Evaluation
- Digital tools

These functions needs to be designed with the target audiences in mind and not create additional confusion or congestion, rather help open up pathways for patients staying healthy.

Some topics that have arisen through the process are:

- increasing diagnostic capability of healthcare professionals
- targeted campaign that highlights understanding of the three conditions and what's already available to support them
- tools that could enhance the ability to track patients health baseline

At a higher level, participants recognised the need to reset and reimagine funding models, governance structures, workforce strategies, communication campaigns and digital strategy to effect whole-scale change. These are are not within the scope of this project, however they are acknowledged as some of the biggest challenges to enabling more patient centred quality care.

Section 3

Concept Overview

Opportunities to explore

Concepts Overview

This visualisation shows a desirable integrated system, where these complex patient needs are met through the coordinated and collaborative efforts of all providers, irrespective of sectorial, organisational or geographic boundaries. It contextualises several of the concepts generated during this project within a desirable integrated health and social services Caboolture ecosystem.

This project kicked off by discovering insights from an end to end linear process and during the process of testing evolved the vision into an ecosystem shape, as so much of the health journey for these patients is cyclical and the intervention touchpoints overlap throughout their health journey.

Several concepts seen in the visualisation on this page were generated over the course of the discovery phase, informed by patient and health professional insights and desktop research. Five of these concepts (seen highlighted and coloured coded) were then selected to be refined further, and presented to health professionals in subsequent concept testing workshops.

The original brief was focused on frequent flyers into the ED. It became evident through the research, that the set up phase for patients (i.e. within the first 6 months) was crucial to embed new behaviours
and give them the best chance of
self- managing their condition.

Hence, the focus on the first three concepts is based around enhancing education for patients, their carers and health professionals to enable the successful establishment for self-management.
The following two concepts are connected, one a lower scale of the other, both serving the deep need for improved connectivity between multidisciplinary health professionals in the social and medical ecosystem to deliver responsive care to patients.

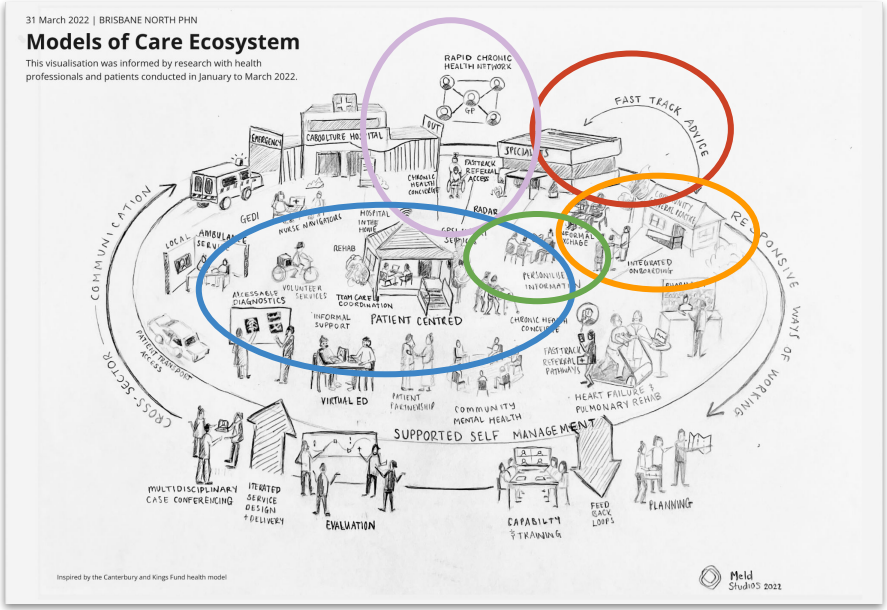


Image: This visualisation contextualises several of the concepts generated during this project within an integrated health and social services Caboolture environment. The structure of this model was inspired by the Canterbury Health System Vision, which was inspired by the Kings Fund visualisation.

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Opportunities to explore

Integrated onboarding

Identified primary problem to solve

Inadequate time afforded for when someone is learning about their diagnosis.

Commonly this information may be shared at hospital or in a standard scheduled GP appointment.

Due to the lack of time, not having someone to help translate the information for them, patients don't always have what they need to understand their condition and can feel disempowered to own and activate their care plan and truly understand their condition.

Patients maybe in shock and emotionally distressed, so that don't actually digest the information provided.

Description of opportunity

Creating a consistent approach to onboarding/inducting patients (and their immediate support individual/team) at the earliest opportunity, so that they understand:

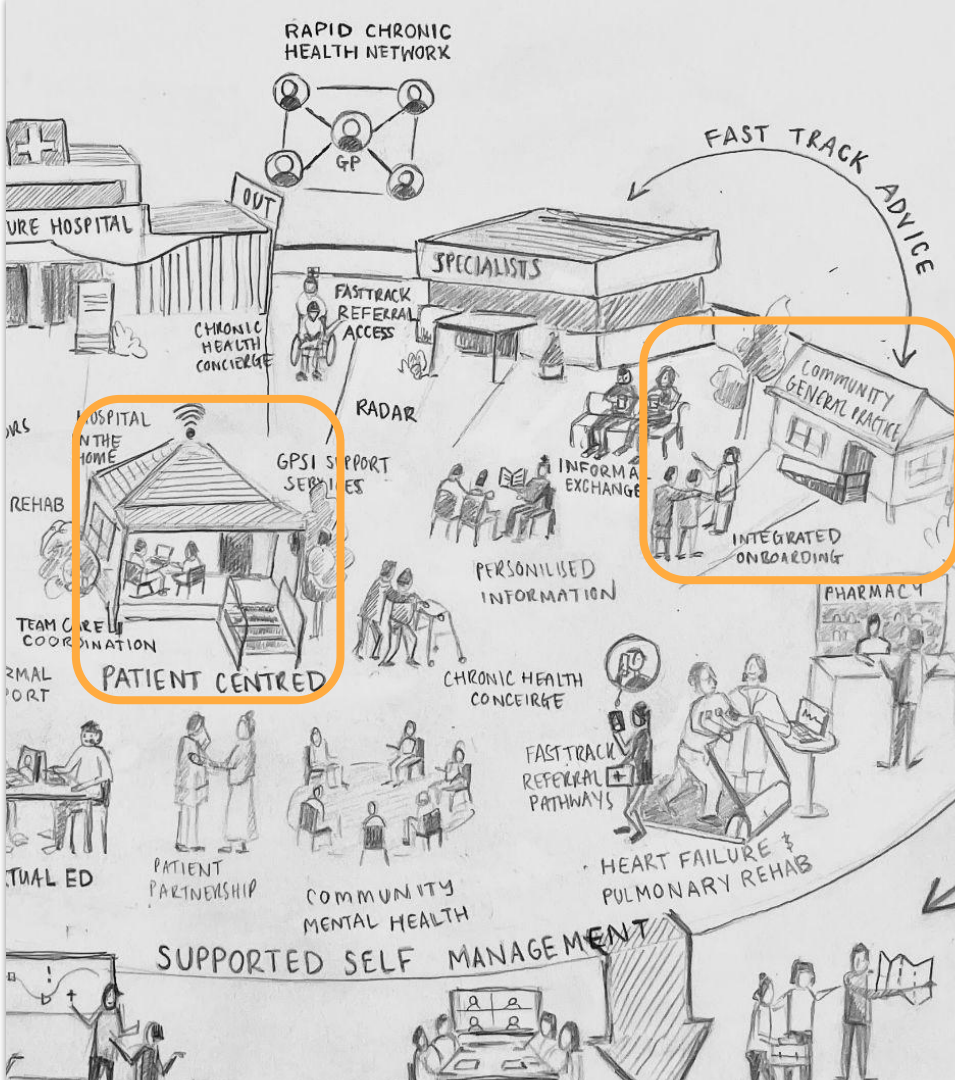
- their condition

- how to manage their care plan

- appropriate support systems that are available to them.

- what practical support is required.. This could be trialed as a funded allowance that enables patients to better access transport, internet, mobile data, tools that assist them to manage their condition.

So that they are informed, empowered and enabled to self-manage.



Opportunities to explore

Integrated onboarding

Considerations:

- Cognitive overload of patient at the time of diagnosis

- Lack of understanding of the patient's broader circumstances that may impact their management of the condition

- Lack of alignment in language / terminology/ general health literacy between patient and health professional

Scaleable examples:

MVP Try a second appointment that is longer with the GP in clinic or home (if possible)

Longer appt could be with the practice nurse (if they have one).

This could be via phone or zoom, if face to face is not available.

Future state

Connect with Team Care Coordination for them to be in the home for an hour for the second appointment and the GP calls or zooms in for 15 mins to focus on the medical side.

Sometimes we forget we save a different language and there is a need for translation, in some shape or form. We just at a loss with allocated time to do this. - General Practitioner

I asked the patient (whilst in their home) what their understanding of their diagnosis and care plan was. They had not accurate recollection of the information shared in that important appointment, in fact they described something different which may, in an emergency situation mean they get life threatening conflicting medication. - Team Care Nurse

With transport it would be good if we had somebody we can rely on - Patient

The first year I didn't understand what they were saying - Patient

Sometimes we forget we save a different language and there is a need for translation, in some shape or form. We just at a loss with allocated time to do this. - - General Practitioner

Quotes: From research with patients and health professionals

Opportunities to explore

Chronic health concierge

Identified primary problem to solve
Patients have trouble understanding their condition and the consequences of not honouring their care plan. It can take time to digest this information. Many go through stages in processing the diagnosis and can feel overwhelmed in the process.

Diagnosis of one of these complex conditions is highly likely to accompany other conditions, which can feel overwhelming to manage.

Description of opportunity
Walk **with** the patient, being an advocate and translator, leading them through an integrated social and medical ecosystem, so that they are empowered to self-manage their care plan with appropriate degree of assistance

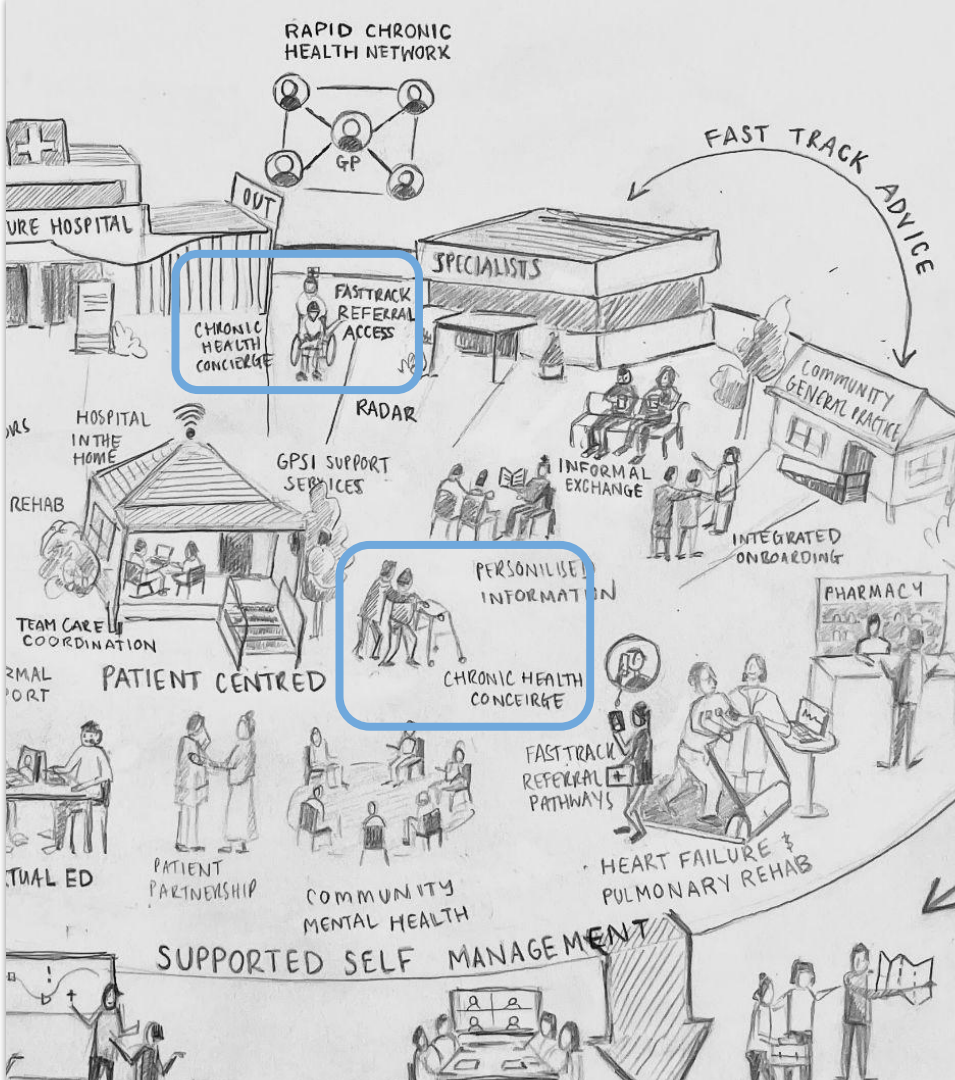
A proactive approach to following up and checking in with patients, to ensure they understand:

- their condition

- information / resources available to them

- assist in the behavioural change and applied learning of their care plan according to their individual circumstance

- how to practically connect them with their integrated social and medical health team and establish an embedded behavioural health management.



Opportunities to explore

Chronic health concierge

Considerations:

- This may be an extension of the Team Care Coordination or Nurse Navigators current remit.

- Need to ensure roles / responsibilities are clear between different existing functions and programs.

- The name of this service could be explored with patients through a co-design process.

Scaleable examples:

MVP: Extend the offering of Team Care Coordination for patients with a degree of care allocated discretionarily.

Future state

All patients diagnosed with complex chronic health conditions receive this holistic care, until they are deemed fit to self-manage themselves.

This is evaluated in ongoing checkpoints dependant on their status.

I called her while i was in hospital and asked her to explain it to me and i asked the doctor to explain it to her for me with me, so she knew what was going on so she could explain it better - Patient

LOTS of these patients need more hands on care, someone making sure they're on target all the time, not just in one interaction. -P3

We left behind the General Practitioners...they should have been partners. - MeCare Nurse

We had great success when we taught patients how the system works. - P1

Quotes: From research with patients and health professionals

Opportunities to explore

Personalised Patient Information resource

Varying degrees of health literacy can lead to patients and carers feeling disempowered to practically own their diagnosis, self-manage, navigate the health system and plan for health events adequately.

Identified primary problem to solve

Patients can find it difficult to:

- Articulate their baseline health status and diagnosis particularly in moments of crisis
- Communicate their health history and medicine regime
- Translate care plans into practical schedules
- Know what they might be eligible for and how to apply
- Know who to talk to and how to sequence the appointment and referral loops.
- How to connect with others who on a similar health journey

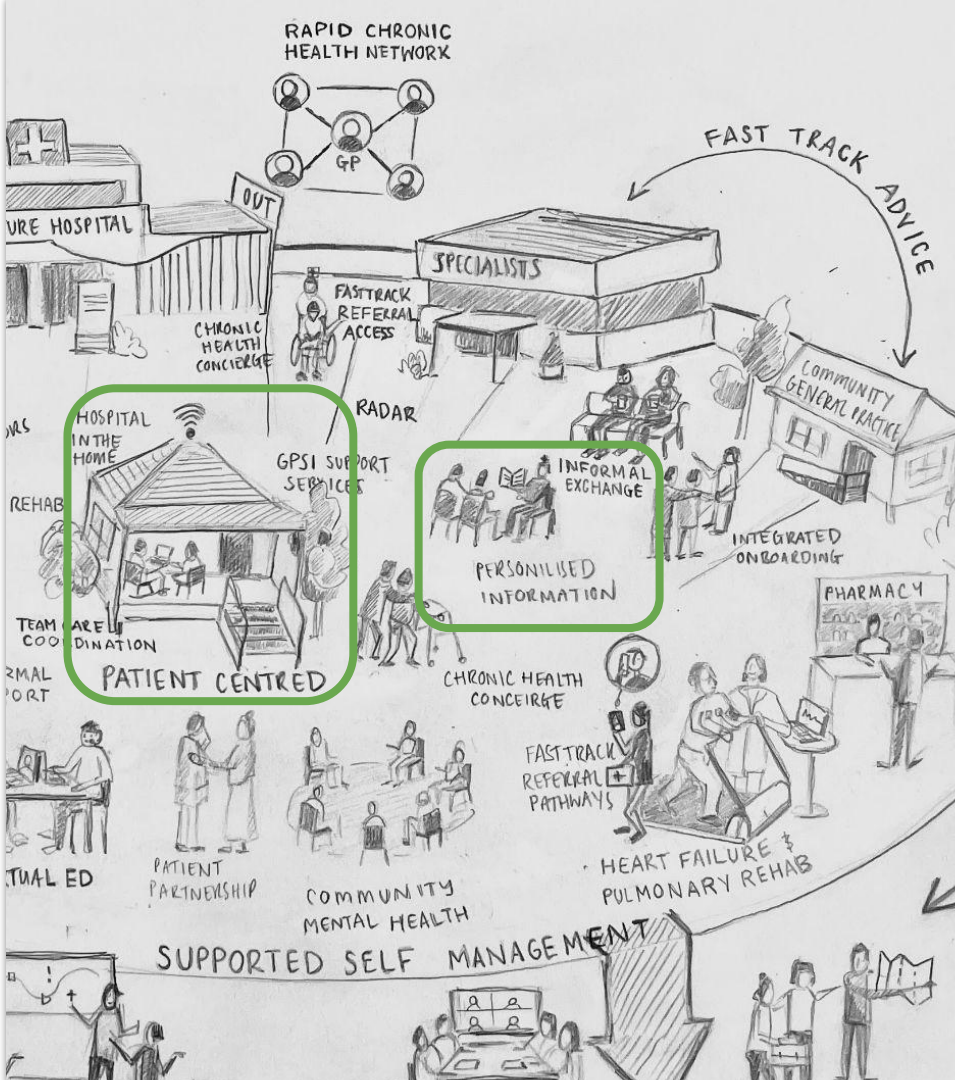
Description of opportunity

Create an adaptive tailored patient information resource, which includes:

- Information to help bridge the gap between medical language and patient language, to help them articulate their health condition, their medication and care plan with others accurately. At a time and pace that suits them.

- To help them and their social support to plan what to do in advance of a health event

- What numbers and resources are the right channels for their individual circumstance



Opportunities to explore

Personalised Patient Information resource

Considerations:
- Not all patients want information to be delivered this was, It's offered at the patient/carers discretion
- The communication design principles need to consider low levels of literacy e.g Plain english and universal visual cues like, traffic light instructional cues.
- Cognitive overload of patient at the time of diagnosis and in a health crisis means if they don't have time with the information and aren't offered opportunity to ask for clarity the information won't be embedded in their behavioural changes and they'll default to learnt behaviour.

*This is not a health record as such, more like the concept of a maternal health folder.

- Lack of alignment in language / terminology between patient and health professional means there may be a need for tailored translation of information, which has time implications

Scaleable examples:
MVP for this concept is a individually curated printed resource. This could be scale from existing resources, to undertaking a co-design process to ensure it meets the majority of patient and health professional needs

Future state
A digital version accessible via App or Desktop, as an option.A folder that is modular based, so it can be targeted to the individual circumstances.

Having something physical helps, so I can digest it at my own pace. - P4

I also bring in my kit so they can see what I'm actually on, cause if they're a new doctor they might not have the full picture. - P3

They use too many medical words. - P1

I got a new GP, but I didn't listen...P2

When you peel back the onion, people are in a position of poor health literacy and lower socio- economic reasons put them in that position from the very start, we need to bolster that, make it easy to access. - P1

Quotes: From research with patients and health professionals

Opportunities to explore

Fast track advice

Identified primary problem to solve
General Practitioners and Ambulance need access to rapid specialist advice to treat complex care patients efficiently and effectively ultimately reducing the default to emergency department.

When a patient is with them the ability for the GP or Ambulance to check in with a Specialist, may reduce the need for the patient going to ED.

Description of opportunity
Create fast track channels to allow for timely, reliable access to Specialists in moments of need.

Have a clear, easy to access number that GP clinics / Ambulance staff can contact when there are a change in circumstances that maybe able to be considered and treated where they are, to avoid a trip to hospital.

Key Specialist staff identified to be part of an advisory group and rostered with specific time to undertake this task.

If there are common questions that are raised, they could be curated and turned into a FAQ section of the kit, and seminars could be organised to increase awareness and understanding.

Opportunities to explore

Fast track peer advice

Considerations:
- This maybe due to lack of experience of the GP or their professional health network is still developing
- The level of complexity in the patient exacerbates or how their symptoms present changes
- The primary GP in the clinic is on leave, so the one on duty does not have the full picture, nor the confidence to assess and treat the person and their condition as it currently presents

Scaleable examples: MVP is to share a number that could connect to specialist. Create a list of Specialists and share it with the local GP network and when they are available for rapid consults.

To support this it would be useful to create opportunities for GPs, Ambulance and Specialists to meet, connect and build relationships and capability together.

Future state Develop an integrated system that would need to be designed (or connect to something that currently operates and could be extended), so that this is a seamless approach connecting the different parts of the health system together to deliver more responsive care to the patient.

I can't come up with a plan if I don't have a peer to come up with a plan with....some patients aren't compliant and we really need to discuss - General Practitioner

Big disconnect between the GPs and the Hospital system - ED doctor

I think they don't go to emergency department when the General Practitioner relationship is sustained and there is built trust. - P1

The service AT HOME is poorly managed with GPS....mostly hours don't align with reality. - P4.

Quotes: From research with patients and health professionals

Opportunities to explore

Rapid Chronic health Network

Identified primary problem to solve

Patients needing rapid care, particularly when they cannot get into see their GP, in the existing scheduled GP business model of care.

This is particularly important after a health event, when a discharge request has indicated follow up is required 3 days after discharge leading to higher readmissions at ED.

Many GP clinics can't find appointments for 3 weeks, let alone within 3 days.

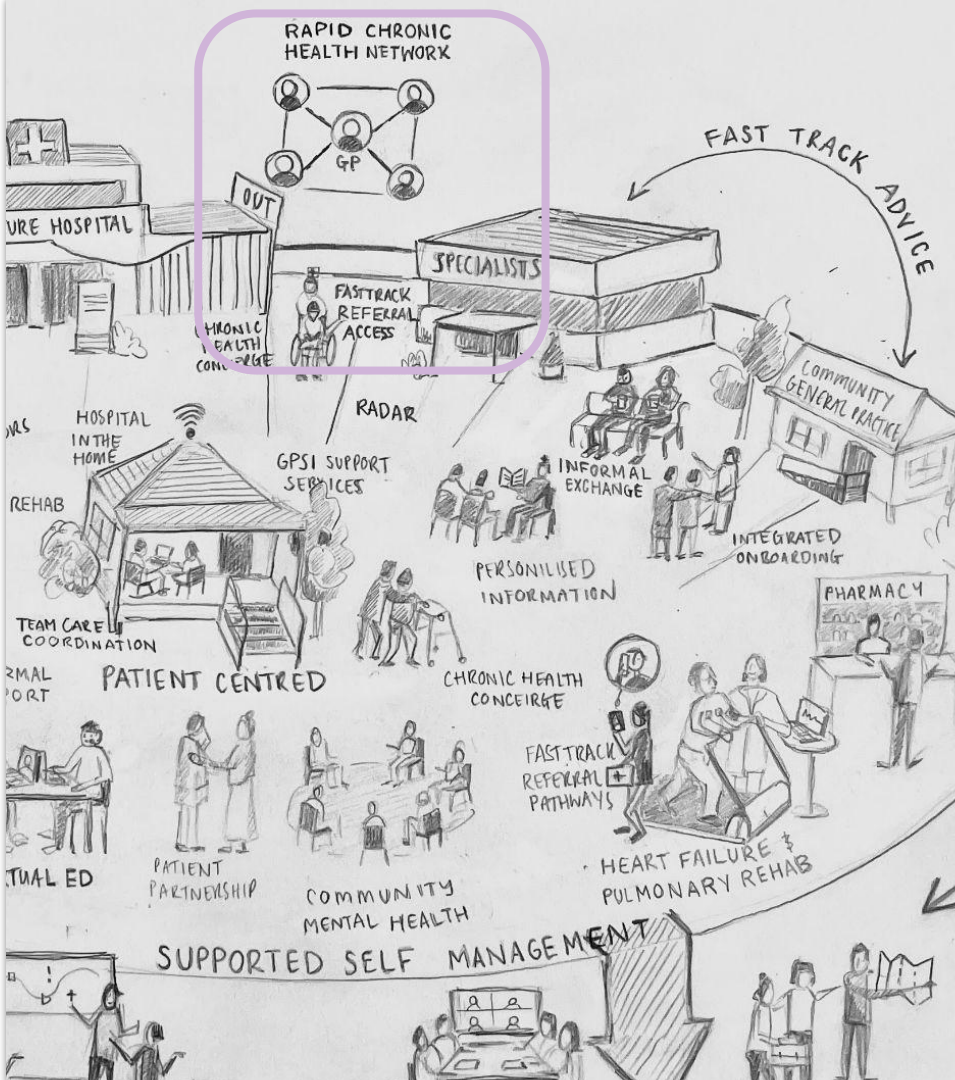
Description of opportunity

Create a network where GPs, Specialists, Nurses work together to provide 'buffer' care, until they can see their primary GP / team.

This would engage in the current clinics and utilising resources in more of a collective care model.

This is particularly needed for outpatient follow ups.

Although this could connect with Virtual ED and Team Care Coordination or Nurse Navigation programs, there maybe a need to still see a GP. This concept would allow for a 'backup' GP, when needed.



Opportunities to explore

Rapid Chronic health network

Considerations:
- This maybe due to lack of experience of the GP or their professional health network is still developing
- The level of complexity in the patient exacerbates or how their symptoms present changes
- The primary GP in the clinic is on leave, so the one on duty does not have the full picture, nor the confidence to assess and treat the person and their condition as it currently presents

Scaleable examples:
MVP Create a network of health providers that can support people with chronic health conditions. If a patient cannot get into their GP within the needed time, there is a clear list of clinics that the practice manager could try to get an appt.

Future state
A fully integrated collective care program targeted to chronic health patients.

Create a system that could tag a patient and other clinics could see that, and book them into an appointment in a responsive way.

Longer term, maybe a different business model that solely focusing supporting people with chronic health conditions.

We left behind the General Practitioners...they should have been partners. - MeCare Nurse

The patients need to have a GP practice plan that isn't doctor swapping but that there is possible to have a relationship with more than one GP or NP - Practice Manager

We need a buffer the GP can't always be available. - Practice Manager

I go to a family GP, it can be hard to get into - P3

Quotes: From research with patients and health professionals

Section 4

Recommendations & Next Steps

Further work to do..

Noting this was a rapid co-design piece of work, there are a range of recommendations, to ensure good practice and better outcomes.

Continue utilising a co-design approach

1. **Test concepts** with consumers / patients focused on frequent flyers who do not demonstrating that they are following a clear care plan AND circling back to those who have already been participants in earlier research.
2. Translate the concepts into more **detailed designs with health professionals and consumers.** Focus what can be trialed in the next 12 months.
3. Continue a **cycle of testing and iteration throughout the design and delivery process** of any of the concepts.
4. Ensure a good **cross-section of health professionals** are incorporated into the process (especially ambulance and other professionals that connect with patients at a range of touchpoints outside of the scheduled system).

5. Engage with methods that match the intention of the research. This should include **multi-method research approach. Contextual inquiry** is a method that is important to activate for this type of work. Shadowing key health professionals, so that an authentic consumer / patient and health professional end to end journey is outlined. This way of working uncovers more genuine opportunities for change that may have greater impact.

6. **Business Model Jam** - Opportunity to bring together key stakeholders to reflect, re-imagine and re-engineer business models to enable a more holistic, patient centred model.

Recognise the importance Social Models of Care as integral

In all research, the importance of **social models of care** (or sometimes known as social prescribing) was raised as key to effectively managing a patient's condition. This includes formal (i.e. registered program) and informal (i.e. family or close friends) support systems. There is a need to move beyond these areas of care seen as 'nice to have'.

Explore ways to identify and formalise existing models of care that can be leveraged to support the medical model of care, to create better patient outcomes.

More focus needs to provided to key target groups that don't have these social systems (formal or informal) in place, so that they can be identified and a clear action plan is established to ensure they don't fall through the cracks.

Be clear about the indicators (formal or informal) that show someone is at risk of not have the necessary support to afford then to self-manage.

Partnering for collective impact - unlocking team potential

Understanding human behaviour change, with patients and their lifestyle habits that may need to shift, and with health professionals in the approach to working in the chronic complex care space is central to any genuine progress for this project.

To support health professionals in this endeavour, recognising many are overworked already, different ways of working in more of a multidisciplinary, partnership model may need to be further explored.

This could build on case conferencing approach, however there is a need to broadening who is engaged, how they are engaged and honouring the contributions each discipline brings to the table. To support this work a broader capability building program with effective communication using effective channels is required.

Recommendations for the website

Feedback from final playback

Hi, some interesting content in the presentation will the slides be sent out after this meeting?

11:23:50 From Archana Mishra to Everyone: Heart Failure and pulmonary rehabilitation services - different modalities (home based, virtual, centre based) should be included as well

11:36:18 From Mark Scott to Everyone: Ambulance is currently showing interest in getting copies of management plans available to the crews, just needs to be flagged to an address as their system is address based.

11:38:21 From james to Everyone: Virtual ED offers excellent fast track advice and rapid further networking. Could this be extended to allow ambos to call for this cohort of patients.

11:39:56 From Mark Scott to Everyone: VED is currently talking about being forward facing (able to talk directly to patients). There is strong resistance from the consultants working in VED. They see that there is a need for patients to deal with their primary health providers first.

11:40:18 From Archana Mishra to Everyone:opportunity for Rapid Access Clinics with links to Virtual ED, GPs, HITH (Hospital in the Home)

11:45:59 From Archana Mishra to Everyone: Nurse Practitioner led clinics for heart failure and COPD that will help bypass ED

11:48:54 From Mark Scott to Everyone: But how does someone access the clinic?

11:49:04 From 142 Glynis S to Everyone: Great presentation! Would appreciate hard copies of the concepts as there was a lot of information exchanged.

11:49:54 From Steph Huxley to Everyone:There is some work happening to allow referrals to pulmonary rehab through GP Smart Referrals too

11:54:56 From Melanie Dubbelde to Everyone: I have currently identified 62 programs/models/initiatives that are current and more that are on the horizon for this cohort of patients. Looking at all the options!!!

11:57:26 From Mark Scott to Everyone: We often get patients sent to ED by GPs who don't know how to get someone in to a timely OPD. Frankly, neither do I. So we end up having to ring the inpatient teams to find out. Would be nice if there were clear boundaries as to who qualifies for which clinics and with what priority, and what tests are helpful before they get there. Like heart failure -- any Efc below x%, NYHA class y, exercise tolerance less than z meters = cat 1, different x, y, z for cat 2.... Please ensure has echo less than 6 months old, and MPS/EST/or angio within past 2 years...

11:57:42 From CranitKL to Everyone: Agree with James, those who lack social supports , also those who have low health literacy & no transport...

11:59:09 From Sean Lowry to Everyone: Spot on Mark - Clinical Prioritisation Criteria and Healthy Pathways articulates all of these min. patient work ups required for a referral to be eligible for a specialist outpatient clinic. Uptake and adherence to the CPC and Pathways is still a work in progress. Needs a big push.

12:02:12 From Suzanne to Everyone: Great work team! Really great to see the outcome of all the work

Thank you

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