Mid North Coast Seasonal Demand Coordinated High Intensity Patient Care Initiative (CHIP) program recommendations

Program improvement

1. Involve general practices in program planning to increase its relevance to their business and patient care models.
2. Create a stronger awareness campaign for clinicians, general practices, and patients to promote program understanding and uptake.
3. Include evaluation measures in the program design, clearly link measures to specific program aims and strategies, and appraise the suitability and sufficiency of measures before implementation.
4. Address barriers to information sharing between general practices and MNCLHD services prior to program implementation, including referral systems and strategies to coordinate shared patient care.
5. Ensure sufficient prospective payments to general practices for protected time to implement and deliver the program.
6. Start program earlier in the year to incorporate influenza vaccination clinics.
7. Have a longer service delivery time period to increase patient care coverage and enable better assessment of program outcomes.
8. Assess patient motivations and preferred frequency of contact, and encourage clinicians to tailor the model of care to these characteristics.
9. Increase clinician access to resources for patient care.
10. Prioritise strategies to engage GPs in program delivery.

Program extension

1. Extend program access to other high risk patients (including sick, frail, Aboriginal, those with mental health issues, and those not engaged with GP).
2. Develop strategies for ICDM teams to link patients to general practice services.
3. Include social workers and other allied health or psychosocial care providers in program delivery.
4. Extend protected time payments to include nurse and allied health participation in case conferences and to enable home visits.
5. Provide protected time and resources to assist general practices in embedding the model of care as standardised practice for at risk patients.
6. Consider improved and prioritised linking of patient cohort to psychosocial care and other external services.

Program evaluation

1. Reduce the number of evaluation tools, or increase protected time payments to cover time needed to complete or assist patients in completing these.
2. Ensure secure electronic messaging systems are operational before service delivery, and its data is routinely collected.
3. Incorporate all elements of the model of care in the evaluation tools.
4. Collect rates of refusal and reasons.
5. Use patient identifiers in data collection.
6. Improve accessibility of PREMs/PROMs questions and data collection devices, and provide clearer instruction on the purpose and use of these tools.
7. Conduct patient interviews to generate qualitative information from a patient perspective.
8. Evaluate patient and clinician/staff appraisal of the program with reference to the systems of implementation at the service level.
9. Provide resources to support internal service evaluation (in addition to PDSAs), with the aim of improving program implementation and patient outcomes.
10. Consider ways to include and extract information from service record systems, or provide an online data collection portal that can be completed after each activity.