We’re with you every step of the way

Introducing CareComplete, a suite of programs that support you and your patients to better manage chronic and complex conditions.
# Contents

## CareComplete
- Empowering patients with chronic and complex conditions 4
- Why CareComplete? A big picture view 6
- What makes CareComplete stand out? 8

## CarePoint
- About CarePoint 10
- What is the evidence base for CarePoint? 13
- CarePoint case study 14

## CareFirst
- About CareFirst 16
- What is the evidence base for CareFirst? 18
- CareFirst case study 20

## CareTransition
- About CareTransition 22
- What is the evidence base for CareTransition? 25
- CareTransition case study 26
CareComplete
Empowering patients with chronic and complex conditions

Working in partnership with general practitioners, CareComplete delivers a range of integrated services that support patients with chronic and complex conditions across the care continuum.

Our model is based on evidence that people with long-term health conditions achieve positive outcomes when they and their families, community partners and health professionals are informed, motivated and working together.

CareComplete includes three programs

- **CarePoint**: An integrated care program for patients with the highest level of chronic and complex needs. **Duration: 2 years**

- **CareFirst**: A behaviour change program for patients diagnosed with a chronic condition in one of five key disease areas. **Duration: 6 months**

- **CareTransition**: A complementary program that enhances the hospital discharge process for patients most at risk of unplanned readmissions. **Duration: 30 days**
Rising rates of chronic disease, combined with an ageing population, have put more strain on our already stretched healthcare system. While Australians are living longer, they are living with more illness. Over half of all Australians have a chronic condition, and more than 40 per cent of those aged over 45 have at least two (Australian Institute of Health and Welfare, 2014).

Increasingly, general practitioners are managing these patients. Yet work pressures, lack of compensation and under-resourcing make it difficult for clinicians to incorporate integrated chronic disease management support into their schedules.

CareComplete addresses these barriers by providing additional support, training and resources within your practice.
What will CareComplete bring to your practice?

CareComplete programs focus on building capacity in your practice, allowing you to provide evidence-based chronic disease management services without increasing time pressures and workload on you or your staff.

The CareComplete programs provide:

• financial incentives for managing patients with chronic and complex conditions
• further financial support for registered health professionals to deliver specialised support services in your clinic
• professional development for registered health professionals in chronic disease management, with a focus on behaviour change
• access to an innovative online shared care platform that is clinically proven to improve patient outcomes. The platform allows your practice to easily communicate and collaborate with a range of healthcare providers and cuts through the red tape associated with chronic disease management.

How will your patients benefit?

More coordinated primary care has been shown to reduce hospital admissions and readmissions, shorten length of stay and decrease emergency department visits.

But beyond that, your patients will learn evidence-based self-management skills that have been shown to improve quality of life and outcomes.

Our CareComplete programs aim to increase a patient’s knowledge, skills and confidence in managing their own health. This is associated with positive health behaviours, better clinical outcomes, lower rates of hospitalisation and higher levels of satisfaction with services.

All CareComplete programs are free for the patient, and we will invest the resources to ensure your practice is supported and compensated.

Promising early results from our pilots

Preliminary results from our CarePoint pilots in Western Australia and Victoria show increased patient self-efficacy and patient activation, as well as increased medication adherence and stabilisation of conditions.

Early indicators from our CareFirst pilot in Queensland are also positive, with participants reporting increased knowledge of their condition, having reduced risk of hospitalisation and improvements in key measures such as blood pressure, BMI and alcohol consumption, when compared to baseline.

The pilots will continue to be rigorously evaluated by our university partners.

How does CareComplete fit into your practice?

CareComplete programs are GP-led and patient-focused. They allow you to offer best practice support services without the administrative burden and day to day management.

• CareFirst and CarePoint are delivered within primary care
• CareTransition complements the hospital discharge process and supports you in your patient’s post-hospital care.

The programs are designed to enhance existing chronic disease management practices in your clinic and do not require significant time or investment from you or your team.
What makes CareComplete stand out?

Evidence-based and rigorously evaluated

The CareComplete programs are underpinned by evidence-based guidelines for specific conditions. They have been designed according to international best practice, incorporating key features identified in robust analyses of programs that successfully reduce hospitalisation rates and improve outcomes in high risk patients.

The CareComplete pilots are being evaluated in association with the School of Public Health and Community Medicine at the University of NSW (CareFirst), and the Boston Consulting Group and the University of WA (CarePoint).

Unique funding model makes CareComplete available to more patients

CareComplete is funded by a public/private model that is open to governments, Primary Health Networks and private health insurers who wish to make the programs available to the patients in their communities who are most at need. The programs are then offered free of charge to patients.

CareComplete is available across most Australian states and territories. Payments to practices are made based on patient enrolment, completion of the program and achievement of clinical outcomes.
An integrated care program for patients with the highest level of chronic and complex needs
Coordinated care that empowers

CarePoint is a GP-led program that focuses on proactive care for your patients with complex needs, supporting them to navigate through the complicated and fragmented health system.

This program aims to avoid hospital admissions by providing an integrated service in your practice where care coordinators work collaboratively with GPs to ensure patients have access to all the services they need.
A coordinated approach
A dedicated Care Coordinator connects your patient to other service providers and community resources, while keeping you up-to-date every step of the way. When you refer your patient to allied health professionals, the Care Coordinator will follow up to make sure everything goes as planned and all information is fed back to you. This allows your patient to access comprehensive support, while you remain at the cornerstone.

Supporting patients with complex needs
CarePoint is available for patients with chronic or complex conditions who have a history of hospitalisations, particularly visits to an emergency department for problems related to their diabetes, asthma, heart failure or chronic obstructive pulmonary disease.

Integrated care
A Care Coordinator works with you and your practice staff to help patients navigate the complexities of the healthcare system and access the support and resources they need. This includes new and existing health and home care services.

Once enrolled, the patient meets their Care Coordinator, usually at the patient’s home, to develop or update an existing care plan and coordinate support. You are then consulted to discuss, finalise and sign off on the care plan, ensuring it is aligned with the patient’s needs and your goals for their care management.

A personal Care Navigator provides additional telephone support for patients.
What is the evidence base for CarePoint?

CarePoint is based on international best practice evidence which demonstrates substantial reductions in hospital admissions and average length of stay when a coordinated multidisciplinary approach is used.

A systematic review of 29 randomised trials including more than 5,000 patients with heart failure found that interventions which used a coordinated multidisciplinary approach could reduce hospitalisations by 25 per cent.\(^1\) Another study found 50 per cent fewer hospital days and 45 per cent fewer admissions per 1,000 patients when a coordinated approach was used.\(^2\)

Moreover, a robust analysis of programs to reduce hospitalisation rates\(^4\) in high risk patients found that successful interventions have several common features, including:

- a mix of face-to-face visits and follow-up calls
- open and frequent communication between care coordinators and providers
- using behaviour change techniques and motivational interviewing to improve medicine adherence and self-management.

In Australia, a large scale intervention using a coordinated multidisciplinary approach, along with tailored telephone support, reduced hospitalisations in veterans by approximately 20 per cent.\(^5\) Likewise, an intervention in Victoria showed 35 per cent fewer emergency department attendances and 53 per cent fewer emergency admissions.\(^6\)

CarePoint is built on this framework.

Support to implement strategies to reduce falls

Following the home visit, Belle’s OT recommended several strategies to reduce falls, which were discussed and then fed back to her GP and implemented by her Care Coordinator. These included:

- referral for council-funded personal care support to help conserve energy and minimise falls risk due to fatigue
- a walking frame to support mobility and reduce falls risk
- equipment to improve safety while getting in and out of bed.

Funding was provided by community services and additional health providers. Belle’s GP received reports and feedback from the Care Coordinator throughout the process.

Staying out of hospital

Belle rang her Care Coordinator to say she had a temperature and no appetite, and thought she should go to hospital because she had no way to get to her GP. Belle’s Care Coordinator consulted with her GP who arranged for a practice registrar to visit Belle at home that day. She commenced antibiotic therapy for a UTI and further investigations were scheduled as an outpatient.

Belle recovered at home, and is now aware of the support that is available to her, including urgent GP appointments and after hours visits. Her Care Coordinator explained CarePoint to Belle and her husband and provided supporting brochures and fridge magnet reminders which were prominently placed in their home.

A collaborative partnership

Belle’s GP was informed about her falls history, and reinforced the recommendations of the OT and physiotherapist and suggested a neurological review. Her care was led by her GP with her Care Coordinator ensuring continuity through the process.

“I want to feel more comfortable and safe at home, and be aware of what services I can call on.”

Case Study: Belle

Belle is a confident and organised 81-year-old woman. Belle has osteoarthritis, osteoporosis, bilateral knee joint replacements and recurrent urinary tract infections (UTI). Belle spends most of her day in bed. She lives with her elderly husband.

Fast-tracked occupational therapy home assessment

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Patient’s name and photo have been changed for privacy purposes.

Risks identified during OT home visit

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Case Study: Belle

Belle is a confident and organised 81-year-old woman. Belle has osteoarthritis, osteoporosis, bilateral knee joint replacements and recurrent urinary tract infections (UTI). Belle spends most of her day in bed. She lives with her elderly husband.

Fast-tracked occupational therapy home assessment

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Risks identified during OT home visit

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Risks identified during OT home visit

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Risks identified during OT home visit

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Risks identified during OT home visit

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Risks identified during OT home visit

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Risks identified during OT home visit

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Risks identified during OT home visit

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.

Risks identified during OT home visit

Belle’s Care Coordinator was able to organise an urgent occupational therapy (OT) home assessment within three days of referral, fully funded by CarePoint. This is particularly significant since the wait-list to see a community occupational therapist in Belle’s city was 8–12 weeks.

Risks identified during OT home visit

Before she enrolled in CarePoint, Belle’s doctor was not aware that she had fallen several times recently. Belle had previously fractured her wrist and also suffered frequent urinary tract infections. However she rarely discussed the UTIs with her GP, instead waiting until her symptoms progressed to the point where she needed to go to hospital. All of these risks were identified during Belle’s home visit with the OT, and were reported to her doctor by the Care Coordinator.
A behaviour change program for patients diagnosed with a chronic condition in one of five key disease areas
Support to encourage lasting change

CareFirst participants receive extensive support to increase their self-management skills, including:

- a new or updated self-management care plan informed by evidence-based guidelines for specific conditions, but individualised to reflect their current status and health priorities
- a series of health coaching sessions delivered by registered health professionals
- a series of phone calls from a dedicated Care Navigator to help them keep track of healthcare appointments, medication and health goals
- healthy living and disease specific support materials and access to online resources
- access to a health advice line.

CareFirst is GP-led, patient-focused and delivered by specially trained registered health professionals. Patients are also encouraged to work with allied health professionals and specialists.

Capacity building: Upskilling for registered health professionals within your practice

CareFirst recognises the important role registered health professionals play in patient wellbeing. Your clinic’s registered health professionals will receive:

- professional development training in chronic disease management, healthy lifestyle coaching and behaviour change methodologies
- support to help deliver best practice primary healthcare services, including dedicated sessions with patients to address their chronic and complex needs
- financial support to deliver these services.

The program can be supported by an existing registered health professional from your clinic, or someone from the CareComplete team can operate from your practice as required.

Supporting practice teams from start to finish

A GP Liaison Officer will work with you and your practice staff to identify which patients are eligible for the program.

Once a CareFirst patient is enrolled, an initial appointment for a face-to-face assessment is scheduled with both you and a registered health professional. Their individual program is then developed and the patient is guided through their CareFirst plan.
During calls with a Care Navigator, participants may be transferred to a health advice line if they need to speak with a nurse. Participants will also be provided with the number of the health advice line in their information kit.
What is the evidence base for CareFirst?

CareFirst is based on the widely adopted Chronic Care Model (also known as the ‘Wagner Model’) developed by the MacColl Center for Healthcare Innovation, which identifies six key elements for improving care of people with chronic illness.¹
Six core elements for improving chronic care:¹

1. Stronger links between providers and community-based resources
2. Prioritising chronic care in the payment structure
3. Support for patients to develop skills and confidence to manage their condition better
4. Specialised training for staff to support self-management goals and assist with follow up
5. A framework based on evidence-based guidelines
6. Computerised systems to facilitate compliance with guidelines, provide feedback and improve planning for patient care.

This model has informed successful chronic disease management interventions in the US, UK² and Australia.³ CareFirst incorporates all six of these core components.

Supporting self-management

Additional evidence supports the use of self-management strategies that are central to CareFirst. An analysis of 29 international trials including over 5,000 patients found that chronic disease management programs that systematically used evidence-based guidelines, self-management strategies and multidisciplinary care reduced hospitalisation by up to 25 per cent in patients with heart failure.⁴,⁵

Providing patients with tools, knowledge and support to take control of their condition is key to high-performing chronic care programs.⁶,⁷ A systematic review in Australia found that the most effective interventions offered self-management support, including educational sessions and counselling, combined with multidisciplinary teams involving registered health professionals.³

References:
Key changes

Following her medication review, Marg commenced a new diabetes medication which stabilised her HBA1c levels.

After consulting with the dietician, Marg made changes to reduce her carbohydrate intake and portion sizes.

Coaching sessions have given Marg a better understanding of her conditions and more confidence in managing them.

Along with her formal personal training sessions, Marg began using an exercise video at home (which was provided by her trainer).

Results

• Marg has already lost more than three kilograms.

• She is now consistently making healthy food choices and eating smaller portions.

• Marg has gone from no activity at baseline to 240 minutes of exercise each week, with ongoing plans for organised physical activity.

• Marg’s risk of hospitalisation (measured by the HARP tool) has dropped from 20 (med-high) to three (low).

“I finally have the right care team around me – I have lost weight and my waist measurement is down. I am very happy!”

Interventions

After enrolling in CareFirst, Marg received a medication review, attended three consultations with a dietitian and engaged with a physiotherapist, ophthalmologist and podiatrist. She had coaching sessions with the registered health professional to learn self-management skills. She also began personal training, including organised pool sessions to help with movement-related pain.

“I want to lose weight so I can be more mobile and healthy.”

Case Study: Marg

Marg is 69 and has been diagnosed with asthma, coronary heart disease, type 2 diabetes and osteoarthritis. She has a BMI of 37.
A complementary program that enhances the hospital discharge process for patients most at risk of unplanned readmissions
CareTransition

CareTransition eases the transition from hospital to home to help prevent future hospital admissions.

Hospital patients are often bombarded with information and instructions for the post-discharge period. This can be overwhelming, especially when they are already dealing with the stress of their recovery. Meanwhile, GPs are not always aware that their patient has had an unplanned admission until much later, and may not be kept up-to-date about key information such as what new medicines a patient has been started on. CareTransition helps in these scenarios.

A CareTransition Coach is assigned to support patients in the critical post-discharge period when further health issues are most likely to emerge. A CareTransition Coach works with your patient to ensure they make and attend follow-up appointments with you.

CareTransition also helps you support your patient’s post-hospital care by providing discharge information and plans directly to your practice.

How does CareTransition work?

CareTransition focuses on improving a patient’s ability to manage their own recovery and ongoing conditions. Where possible we contact eligible patients before they go to hospital to provide information on how they can prepare better for their hospital stay and recovery. All patients receive assistance with discharge planning and the early post-discharge period.

Once the patient is discharged, a CareTransition Coach visits them at home to help them set a health goal and develop an action plan to achieve it over the next 30 days.

This patient-centred approach involves:

- identifying personal and medical goals that are important to the patient
- helping the patient develop systems to manage their medication more effectively
- increasing a patient’s knowledge and understanding of warning signs that indicate a worsening of their condition, and how to respond if they occur
- connecting patients back to their GP and other doctors.

What is included in the program?

The CareTransition program offers comprehensive patient follow up and discharge support services for 30 days after discharge. It includes:

- a home visit by a CareTransition Coach to help patients through the transition period
- follow-up phone calls from their CareTransition Coach for ongoing support
- an information pack with a CareTransition booklet and a Personal Health Record to help the patient keep track of their health conditions, medications and any appointments they have scheduled with their doctor.

Who is CareTransition for?

CareTransition is designed for patients with medium-to-high risk of an avoidable readmission after discharge from hospital. Eligible patients are identified by a predictive analysis based on their medical history.
Improves the continuum of care

**Patient enrolment and pre hospital contact**

- **Planned admission**
  - identified at pre-admission
  - predictive analysis performed

**Pre hospital**

- **Planned admission outbound call (-3 days)**
  - confirm eligibility
  - enrol member
  - organise home visit
  - pre-hospital education

**Patient ID/entry**

- **Unplanned admissions**
  - identified at admission or during hospital
  - referrals from GPs

**Admission**

**Post hospital**

- **Planned admissions discharge call**
  - confirm discharge has occurred
  - set time for home visit

**Transition coaching**: Member sets personal goal for transition

**Discharged instruction**: Review and coaching

**Medication**: Medication review and coaching

**Red flags**: Condition/symptom management review and coaching

**Outbound call (day 10)**

- **Goal review**
  - medication self-management
  - condition/symptom management
  - attending health service

**Outbound call (day 30)**

- **Program review/exit call**
  - connect back to GP

**Unplanned admissions outbound enrolment call**

- confirm eligibility
- enrol member
- organise

**Post hospital visit**

- **Enhanced early follow up services**

**Post hospital**

- **Primary care follow up**
  - Prepare patient follow-up visit with their GP

**Day 1**

- **Discharge**

**Day 2**

**Day 7**

**Day 30**

**Exit**
What is the evidence base for CareTransition?

CareTransition is based on a rigorously evaluated program developed by the University of Colorado which complements the existing discharge process and supports patients to take an active role in their care.

The program (Care Transitions Intervention) has been evaluated in two randomised controlled trials with about 850 people. Participants in the intervention were significantly less likely to be readmitted to hospital, and the benefits were sustained for five months after the end of the one-month intervention period.1,2

The program has since been implemented by over 900 organisations in 44 states in the United States. Other studies have shown significant drops in 30 day readmissions rates3,4 as well as 60-day and one year readmissions.4

An analysis of programs to reduce readmission in high risk patients found that support during the transition period after hospitalisation was a key component of successful interventions.5

Other reviews support the effectiveness of interventions aimed at improving medication management to reduce hospitalisation rates.6,7

Geoff is an 89-year-old man who is recovering after having a carcinoma removed from his left eye. He lives alone in a two storey house.

Geoff says he has been feeling like a zombie, going blank and pale as though he is disappearing from his body.

These episodes occur every day, stopping him from daily activities, and have been so severe that passers-by have called an ambulance on more than one occasion.

A holistic approach

Although Geoff was referred to CareTransition after his eye surgery, he told his CareTransition Coach that he was particularly concerned that his overall medication regime could be contributing to his poor quality of life.

Geoff has been taking more than 20 medications, including five different blood pressure medications. He takes all of his medicines together at breakfast at around 7am.

Case Study: Geoff

Taking action:

At the urging of his CareTransition Coach, Geoff and his family organised:

- a home medication review
- an appointment with his GP, who helped him schedule an earlier appointment with his cardiologist due to concerns he was over-medicated.

Results:

Geoff’s cardiologist recommended he stop taking one of his blood pressure medications (Hydralazine). Geoff now understands the risks and benefits of each of his medicines, and is monitoring his blood pressure at home every day.

The change in Geoff’s medication regime and how he takes them had an immediate effect on his wellbeing. In the first few days Geoff said he was already feeling great. He no longer felt like a zombie and had already had coffee with a friend. He has added back in daily activities including bookkeeping and exercise.

“I feel like I have my life back again. Since leaving hospital I no longer feel drowsy all the time.”
Your patients’ privacy is important to us
Medibank takes privacy and data security very seriously. Our CareComplete programs are designed according to stringent privacy regulations, and patient confidentiality is always upheld.