We’re with you every step of the way

CarePoint is an integrated care program for patients with the highest level of chronic and complex needs

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.

Coordinated care that empowers

- Home-based services to support patients managing their chronic conditions and lives at home
- Lifestyle counselling to improve self-management, motivation and adherence to plans
- A Care Coordinator who helps manage patients’ holistic care needs
- A call centre based team that helps patients navigate appointments and logistics
- Health coaching
- 24x7 nurse hotline
- After hours support for questions and advice when required
- GP and patient
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.1,2 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.3

Moreover, a robust analysis of programs to reduce hospitalisation rates4 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
- 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.
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.

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.”
Integrated Care Services takes privacy and data security very seriously. Our CareComplete programs are designed according to stringent privacy regulations, and patient confidentiality is always upheld.

References:

For further information please call the CarePoint team on 1300 650 742 or visit www.carecomplete.com.au