Winter Strategy

This model of care incorporates different elements of all the 2019 Winter Strategy projects. The model can be adapted to fit your practice patient population and interests. You can pick and choose from the options below or develop your own.

Identify and recruit eligible patients

- SPDS champion to identify patients using PenCS CAT4
- Appointment confirmed with patient consent

Pre-Consult with Nurse

- Review patient history and collect missing information
- Conduct baseline clinical assessment
- Conduct baseline survey
- Provide education
- Administer vaccination

Consult with General Practitioner

- Screening and Chronic Disease Management
- Medication Management
- Referrals

Post-Consult with Nurse

- Conduct progress clinical assessment
- Conduct progress survey
- Provide education

Care Navigation

- HealthPathways
- Non-medical options

With thanks to Brindabella Family Practice, Equilibrium Healthcare, Gerringong Family Medical Practice, Junction Street Family Practice, Kiama Medical Practice, Meroo Street Family Practice, Queen Street Medical Centre, Sapphire Clinic, Sapphire Coast Medical Practice, Ulladulla Endoscopy and Medical Centre and Windang Beach Family Medical Practice.

COORDINARE

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Winter Strategy

Identify and recruit eligible patients

Chronic Conditions	• Asthma • COPD • Diabetes (HbA1C >7%)
Vulnerable populations	• Aboriginal or Torres Strait Islander patients • Veteran Gold Card holders with chronic conditions at risk of unplanned hospitalisation • Patients that were due or overdue according to the National Immunisation Program
Recruitment method	• Phone call from either reception or clinician • SMS with instructions sent to phone for more details • Mail invites with information pack • Face to face if eligible patient presents to practice

Pre-Consult with Nurse

Review patient history	• Review of Pneumococcal and Influenza immunisations • Review of last hospital admission and specialist reports • Review of Smoking, Alcohol, Nutrition and Physical Activity • Collect information for GP health assessments or care plans if applicable
Conduct clinical assessment	• Spirometry • ECG
Conduct survey	• Patient experience survey • Patient Activation Measure (PAM) • COPD assessment test (CAT)
Provide education	• Provision of educational material • Review of condition management • Review of medication compliance • Goal setting and preventative measures
Administer Vaccination	• At General Practice, RACF or during home visit

Consult with General Practitioner

Screening and Chronic Disease Management	• Finalise Health Assessment • Finalise General Practitioner Management Plan (GPMP) • Finalise Team Care Arrangement (TCA)
Medication Management	• Domiciliary Medication Management Review (DMMR) • Residential Medication Management Review (RMMR)
Referrals	• Specialist • Allied health • Pathology • Medical Imaging

Follow-Up Consults with Nurse

Conduct clinical assessment	• Spirometry • ECG
Conduct survey	• Patient experience survey • Patient Activation Measure (PAM) • COPD assessment test (CAT)
Provide education	• Provision of educational material • Continuing education on condition management • Continuing education on medication compliance • Goal setting and preventative measures • Shared Medical Appointments

Care Navigation

HealthPathways	• Management and treatment options for common medical conditions • Information on how to refer to the most appropriate local services and Specialists
Non-medical options	• Link patient in with appropriate community services and health related activities • Encourage participation with social clubs and support groups • Book services to assist with Activities of Daily Living