

# Patient Care Coordination

## GP Links Bundaberg Patient Care Coordinator: John Gamlin

The role of Patient Care Coordinator is to facilitate improvement in coordinated care of patients with chronic disease. In particular, this program focuses on patients with Chronic Obstructive Pulmonary Disease (COPD) and Chronic Cardiac Disease, however patients with heart failure are excluded from the program.

Patient Care Coordination is an initiative of the Bundaberg Hospital's Avoidable Hospital Admissions Committee and partners with GP links to improve coordination and management of the care of patients with chronic illness.

Working closely with General Practitioners, the Patient Care Coordinator promotes better outcomes for patients, and helps reduce the need for patients with chronic illness to present to hospital.

The project utilises an integrated case management model of care to help identify and provide coordinated care to those patients with chronic disease, who are identified as being at risk of avoidable presentation and admission to hospital. The Patient Care Coordinator works with the patient, GP, multidisciplinary health team and external service providers to plan and coordinate care, and enhance patient access to services. Patient care coordination seeks to deliver better outcomes for patients and reduce unplanned hospital presentations and admissions among the target cohort.

The Patient Care Coordinator receives referrals from key hospital stakeholders and General Practice, and conducts a comprehensive assessment of the patients' health and social needs, while facilitating a management plan in consultation with a multidisciplinary health team. In addition, the Patient Care Coordinator also provides ongoing monitoring and support to patients to assist with ongoing management of chronic disease.

The Patient Care Coordinator:

- Works with and for the patient
- Enhances patient access to services
- Actively involves and empowers the patient
- Coordinates community services

The Patient care Coordinator can assist General Practice with the management of patients by:

- Working with GP's to provide support and follow-up for patients having difficulty managing their COPD or chronic cardiac disease and associated problems
- Assisting patients to comply with their General Practitioner Management Plan (GPMP) and /or Team Care Arrangement (TCA)
- Assisting with coordination and follow-up of community services
- Liaison with hospital departments to streamline care.