



# Chronic and Complex Disease Program Bulletin 1 – July 2001

## Message from

### Area Director of Clinical Services

*I am very pleased to be announcing some of our achievements in the management of chronic and complex disease in the South East Health community. As many of you will know, we have always had a good infrastructure for community health care and now we are adding to this commitment some focus on disorders not traditionally prioritised.*

*I see this initiative as another 'step' in our organisational journey to "Good Health Care, Better Health" and I urge you to continue to participate in making a difference!*

**Dr Lynette Lee**

### Enquiries/Comments to:

Clinical Services Policy and Planning Unit  
South East Health  
PO Box 430  
Kogarah NSW 1485  
Phone: (02) 9947-9845

## Overview

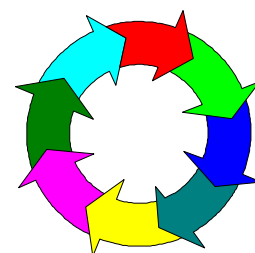
*Welcome to the first Bulletin of the Chronic and Complex Disease Program for South East Health. Future updates will be provided on a six-monthly basis.*

*The Chronic and Complex Disease Program is an integral component of the Government Action Plan for Health (GAPH), which is a State-wide initiative designed to bring significant improvements to the NSW health system. The Chronic and Complex Disease Program focuses on improved and coordinated care for NSW residents with chronic disease. Target chronic diseases are cardiovascular disease, respiratory illness and cancer.*

*With funding of \$6.6m over three years, South East Health has initiated seven programs addressing Aboriginal Health, Asthma, Congestive Cardiac Failure (CCF), Chronic Obstructive Pulmonary Disease (COPD), Cancer, Diabetes, and Nursing Homes. All programs have established relevant Area and local governance groups.*

*Key aims of the programs are to better co-ordinate hospital and community services, to reduce urgent and unplanned admissions, and to improve the quality of life of patients and carers. Involvement of clinicians, executives, community practitioners and consumer representatives is a key element in the process to help ensure an integrated and well-rounded approach to chronic disease management in the Area.*

*Reports on individual projects are provided inside.*



## **CHRONIC DISEASES AMONG ABORIGINAL PEOPLE**

South East Health has over 5,000 residents who identify as being of Aboriginal or Torres Strait Islander descent. Of these, just under 2,000 reside in the Randwick and Botany local government areas. This program seeks to improve their quality of life through a local community-based coordinated model of health care that will include risk factor management and health care intervention to reduce the burden of chronic disease.

Consultations have been held with community members and GPs. Aboriginal community members and local Aboriginal service providers and medical practitioners have been invited to join the implementation committee. Refurbishment of the Arrunga Centre at La Perouse has commenced and clinics will be held there.

Applications have been called for the position of Aboriginal Health Education Officer to run the clinic, provide chronic disease management education with clients and carers, and facilitate access to other chronic disease initiatives. This Officer will be part of the Generalist team of the Community Health and Aged Care Program and will work closely with the other Aboriginal Health Education Officers already employed in the Area.

**Chair:** *Professor Tony Broe  
Chair, Aged Care, SEH*  
**Contact:** *Meg Basser 9382-8177*

## **COLLABORATIVE CARE FOR CONGESTIVE CARDIAC FAILURE (CCF)**

This program aims to improve the quality of life of CCF patients, carers, and families, and to improve disease management, which will lead to reductions in crisis presentations to hospitals. Main elements include co-ordinating cardiac rehabilitation, enhancing education to patients and GPs, and developing and adapting relevant guidelines and pathways to improve the quality and standard of the service delivery.

A multidisciplinary management model, centred on senior nursing staff, is being implemented across four major hospitals in SEH. Four senior nursing staff and a project officer have been appointed to the project across the Area.

The clinical management structure to support the implementation has been established at all sectors in the Area, and a review of the current service provision for CCF patients has been completed in two sectors. Data indicate that services have put great effort into chronic disease management by providing specialist physicians, pharmacists, social workers, physiotherapists and occupational therapists to CCF patients. Each CCF patient using hospital services during the auditing period of 12 months received interventions from an average of 2.4 clinician groups, and the increased number of clinicians involved reduced the average length of stay in the hospital. Of these cases reviewed, 98% have an identifiable GP, but information on the level of collaboration between GPs and hospitals needs to be reviewed further.

The database for the project is at the final testing phase, and will be implemented by the end of September. Data will provide information on the service utilisation and outcomes of the patients registered in the project.

Standard CCF management guidelines have been developed and endorsed by the Area, and two Division of GPs have provided strong support for their implementation.

**Chair:** *Dr Roger Allan, Chair, Heart Health  
Clinical Reference Group, SEH*  
**Contact:** *Lucy Chen 9947-9853*

## **AIMING FOR ASTHMA IMPROVEMENT**

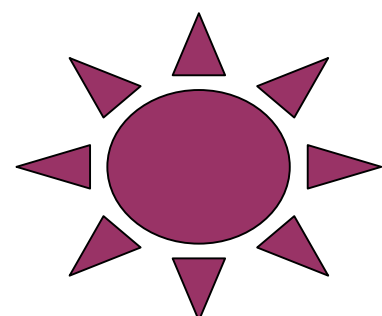
This program is in keeping with the latest review of the national Six-Step Asthma Management Plan. Educational in nature, the program focuses on asthma prevention in children.

Our program will engage asthma educators to extend the asthma management program to schools, and to follow up Emergency Department presentations, hospital admissions and discharges regarding the quality use of medications and asthma management. It will also introduce standardised clinical practice guidelines across the Area, and strengthen links between hospital and community based services.

A written Asthma Management Plan has been shown to improve asthma control, and the program aims to ensure each child discharged from our services has a Plan which has been negotiated with his/her doctor. This will enable self-management at the onset of asthma problems and help avoid the need for ED attendance and hospital admission.

Local and Area project implementation groups have convened, and three asthma educators have been recruited. Standard asthma management guidelines and an action plan, supported by the Area Emergency Department Service Committee, are being piloted at Sydney Children's Hospital. An Area-wide standard educational material for clinicians and carers will be finalised in August.

**Chair:** *Professor Richard Henry, Head Paediatrics,  
Sydney Children's Hospital*  
**Contact:** *Lucy Chen 9947-9853*





## CONNECTING CANCER CARE PROGRAM

Consistent with the aims of the Chronic and Complex Care framework, this program is largely a 'bridging' and educational program, linking hospital and community services to facilitate coordinated care to people with cancer. Main elements include:

- Community based care for cancer management linking patients, carers, cancer services, community health services and general practitioners;
- Education about disease management and service access to patients and carers;
- Quick response support for unplanned presentations of palliative care patients to Emergency Departments;
- Clinical education and information sharing; case conferencing and clinical protocol development;
- Databases and care guidelines to inform care provision and enhance care continuity.

While it was initially intended that a uniform program would be implemented across the Area, it became apparent that as local sectors had different infrastructures and needs, a more flexible program, within the aims of the framework, was required. St George, Sutherland and Prince of Wales are adopting a similar model, based on a Cancer Outreach program. St Vincent's is seeking to develop Area-wide, Web-based clinical protocols in oncology, which can be accessed by clinicians, GPs and possibly patients. An over-riding palliative care database will foster better information regarding presentations to EDs and admissions.

To date, Area and local implementation groups have been established and hold regular meetings. Clinical nurse consultants have been appointed at St George, Sutherland and Prince of Wales hospitals. The Clinical Protocol group is seeking to recruit a pharmacist and project manager, and it is expected the Palliative Care database will be fully operational by July 2002.

**Chair:** *Dr David Gorman, Director, Palliative Care Southern Sector, SEH*

**Contact:** *Colleen Leathley 9947-9845*



## COPING WITH COPD

The COPD program aims to provide pulmonary rehabilitation and patient education as key strategies in the spectrum of care of people with COPD. Another key element is enhanced co-ordination of patient care in the community.

Nurse and allied health-driven education and self-management components at the major hospitals will include instructions and protocols for rapid access to appropriate specialised care in the event of exacerbation as an alternative to presentation at an Emergency Department. Patients will have a written treatment plan instructing their medication changes, the indications to consult their GPs, and how to notify their case managers, PAROS nurses or community health nurses. Participation in ongoing community exercise rehabilitation programs will make it possible for health workers to identify patients at risk. The access to a multidisciplinary management team will allow early detection of deterioration, and exposure to smoking cessation messages. Community based nurse and physiotherapist involvement will also assist linkages to other community services such as Home Care Packages as many COPD patients are housebound and severely disabled by their illness.

Area and local implementation groups have been convened. The "Easy Breathing Program" in Prince of Wales, "Healthy Heart and Lung Program" in Sutherland, and "Respiratory Outreach Program" in St George have started referring patients. Three project staff have been appointed at the facility level. The database for the project will be implemented in October 2001. Two facilities have launched their project to local GPs, and received a very positive response. The current focus of the project is to implement the Area-wide admission and discharge forms, and COPD discharge plan, which have been endorsed by the Area Lung Health Reference Group.

**Chair:** *A/Prof David McKenzie, Chair, Respiratory Health Clinical Reference Group, SEH.*

**Contact:** *Lucy Chen 9947-9853*

## **DIABETES FOOTCARE – A COMPREHENSIVE DIABETES COMPLICATION REDUCTION STRATEGY**

The main aim of this project is to increase involvement of all staff in footcare for people with diabetes in the Area, so as to deter development and exacerbation of foot-related problems which often lead to amputations and long bed-stays in hospital. Funding will provide for an Area Coordinator to link existing services, educate clinical staff and carers about foot care, and collect relevant data. Limited funds will also be available to sites for podiatry and related services to assist in the foot-care of their patients.

The target population is adult residents of South East Health who have diabetes and existing or potential foot problems. Area and local implementation groups have been convened, and recruitment of the Coordinator is underway.

Podiatry assessment forms have been developed for the screening of patients 'at risk' and this process has commenced in two sectors. Staff in each sector have been equipped and trained in the use of updated podiatry tools and there has been an increase in the number of podiatry sessions available each week. Sectors have also established a network for liaison with other service providers within and outside of the Area and contact has been initiated with the Divisions of General Practice.

**Chair:** *Prof Lesley Campbell, Director Diabetes Centre, St Vincent's Hospital*  
**Contact:** *Nicole Cockayne 8382-2021*

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## **CHRONIC DISEASE MANAGEMENT IN NURSING HOMES: A COLLABORATIVE APPROACH**

This program targets nursing home residents who present to Emergency Departments for exacerbations of chronic or end-stage diseases such as cancer, heart failure, respiratory failure and dementia. Over the 1999/2000 financial year, there were 1,865 admissions of Area nursing home residents to hospitals via the emergency department, a rate of 49.5 admissions for each 100 nursing home beds in the Area. Of these admissions, 91% were to hospitals in South East Health. Respiratory, cardiology and orthopaedic diagnoses were the most common causes of admission.

The project aims to improve the quality of life of residents and to reduce medical care provided inappropriately to them. The development of Advanced Care Directives and treatment algorithms to allow consenting patients with end-stage illness to be managed in their nursing homes, are key components of the program. Comprehensive clinical assessment, multidisciplinary case-conferences and involvement and education of key stakeholders are also key components of the program.

Two different approaches to the program are operating across the Northern and Southern sectors of the Area. The northern sectors' initiative cooperates with the Post Acute Care Service at Prince of Wales Hospital. A clinical nurse consultant, to be recruited, will provide in-service education for nursing home staff and negotiate Advanced Care Directives with residents, relatives, staff and medical practitioners on admission to the nursing homes. In the Southern sectors, in comparison, the emphasis is on comprehensive geriatric assessment of residents in the nursing home and post assessment negotiation of the care plans. Clinical staff have commenced on the literature review and initial data collection to facilitate detailed service planning for the project.

**Chair:** *Dr Gideon Caplan, Director, Post Acute Care Services, Prince of Wales*  
**Contact:** *Mea Bassar 9382-8177*