



## Summary of Chronic and Complex Care Projects

Submitted by South East Health, 2000

Total Pool: \$2.2m

### AIMING FOR ASTHMA IMPROVEMENT

**Chair:** Dr Richard Henry

**Support:** Lucy Chen

**Funds:** \$135,000

The program is in keeping with the latest review of the six-step asthma management plan. Educational in nature, it will employ asthma educators to extend the asthma management program to schools, and follow up ED presentations, hospital admissions and discharges re quality use of medications and asthma management. Funding will be directed towards clinical nurse educator salaries and supporting infrastructure.

### CONNECTING CANCER CARE

**Chair:** Dr David Gorman

**Support:** Colleen Leathley

**Funds:** \$645,000

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;
- | Empowering cancer patients and their carers through education about disease management and service access;
- | Quick response support for unplanned presentations of palliative care patients to Emergency Departments;
- | Enhancing clinical oncology and palliative skills of community health staff and GPs through clinical education and information sharing; case conferencing and clinical protocol development;
- | Developing appropriate databases and care guidelines to inform care provision and enhance care continuity.

## **COLLABORATIVE CARE FOR CONGESTIVE CARDIAC FAILURE**

**Chair:** Dr Roger Alan

**Support:** Lucy Chen

**Salaries** \$545,000

The program aims to improve quality of life of CCF patients, carers, and families, and improvement in disease management which will lead to reductions in crisis presentations to hospitals. The Coordination on cardiac rehabilitation, patient and GPs education on medications, and development and adaptation of guidelines and pathways to improve the quality and standard of the service delivery are proposed by the program working group.

An information system to flag, monitor, and evaluate the service utilisation and outcomes of the group of patients will also be developed during the early phase of the program.

## **COPING WITH COPD**

**Chair:** A/Prof David McKenzie

**Support:** Lucy Chen

**Funds:** \$540,000

The proposed program aims to provide cardio-pulmonary rehabilitation and patient education as key strategies in the prevention, detection, treatment and rehabilitation of patients with COPD. The other key element will be enhanced co-ordination of patient care in the community.

The 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 manager, PAROS nurse or community health nurse. Participation in ongoing community exercise rehabilitation programs will make it possible for health workers to identify patients in difficulty. 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 can also assist linkages to other community services, such as Home Care Packages, as many COPD patients are housebound and severely disabled by their illness.

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

**Chair:** Dr Gideon Caplan

**Support:** Meg Basser

**Funds:** \$140,000

This program largely operates on the lines of a “Hospital in the Nursing Home” model and transcends the heart, lung and cancer dimensions. It is targeted largely at nursing home residents who are transferred to Emergency Departments for exacerbations of chronic or end stage diseases such as cancer, heart failure, respiratory failure and dementia. It aims to provide specialist aged care medical support to GPs, nursing home staff and families to manage residents within nursing homes and hostels, and to reduce presentations to Emergency Departments and admissions to hospital. The program will provide standardised, health practitioner supported care to allow appropriate residents to remain in their “homes” for episodic chronic disease exacerbation, and terminal phase care of chronic diseases. Funding will be directed towards salaries and supporting infrastructure.

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

**Chair:** A/Prof Lesley Campbell

**Support:** Nicole Cockayne

**Funds:** \$120,000

The main aim of this project is to better manage podiatry services 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 to assist in the foot-care of their patients.

## **MANAGING CHRONIC AND COMPLEX DISEASE IN ABORIGINAL PEOPLE IN SOUTH EAST HEALTH**

**Chair:** Prof Tony Broe

**Support:** Meg Basser

**Funds:** \$75,000

Program to empower Aboriginal people in the La Perouse Community to better manage incidence and risk of heart failure, respiratory illness and cancer within their local community. The model will support Aboriginal Health Workers and identified GPs to facilitate care for exacerbation of heart and lung disease and cancer in the community, and to prevent unnecessary or crisis Emergency Department attendance and unnecessary hospital admission. Funding will largely be directed towards salaries and supporting infrastructure.