



Government of South Australia

Southern Adelaide Health Service

southern health

The Chronic Disease Community Program – Building Capacity for Change

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Outline

Context

- The case for change
- **Chronic Disease Community Program (Hospital avoidance)**
- Outcomes after 2 yrs

Building Capacity for Change

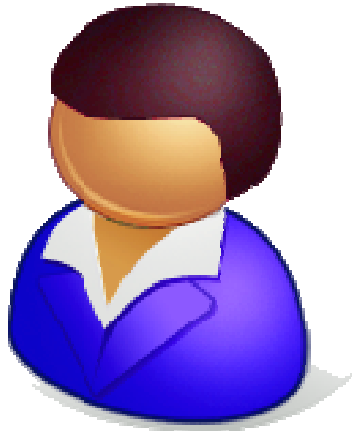
- Liaisons and change team
- Accredited provider panels
- Self management
- GP engagement – working with divisions
- Concurrent work ABHI and GP Plus initiatives
- New components

Aims

SA Govt funded hospital avoidance strategy:

- Reduce rate & no. of unplanned hospital admissions
- Improve population & individual health outcomes
- Service reform – systems approach
- One strategy on continuum from acute to PHC

Case study – the need for change



COPD
Smoker
↓ physical activity

COPD advice given by resp nurse
Ref to Allied Health in hospital

Discharged into community

Multiple
Admissions
(2x 6/12)

Continued smoking, reducing physical functioning,
recurrent exacerbations, less socialisation, anxiety & depression

Chronic Disease Community Program Eligibility

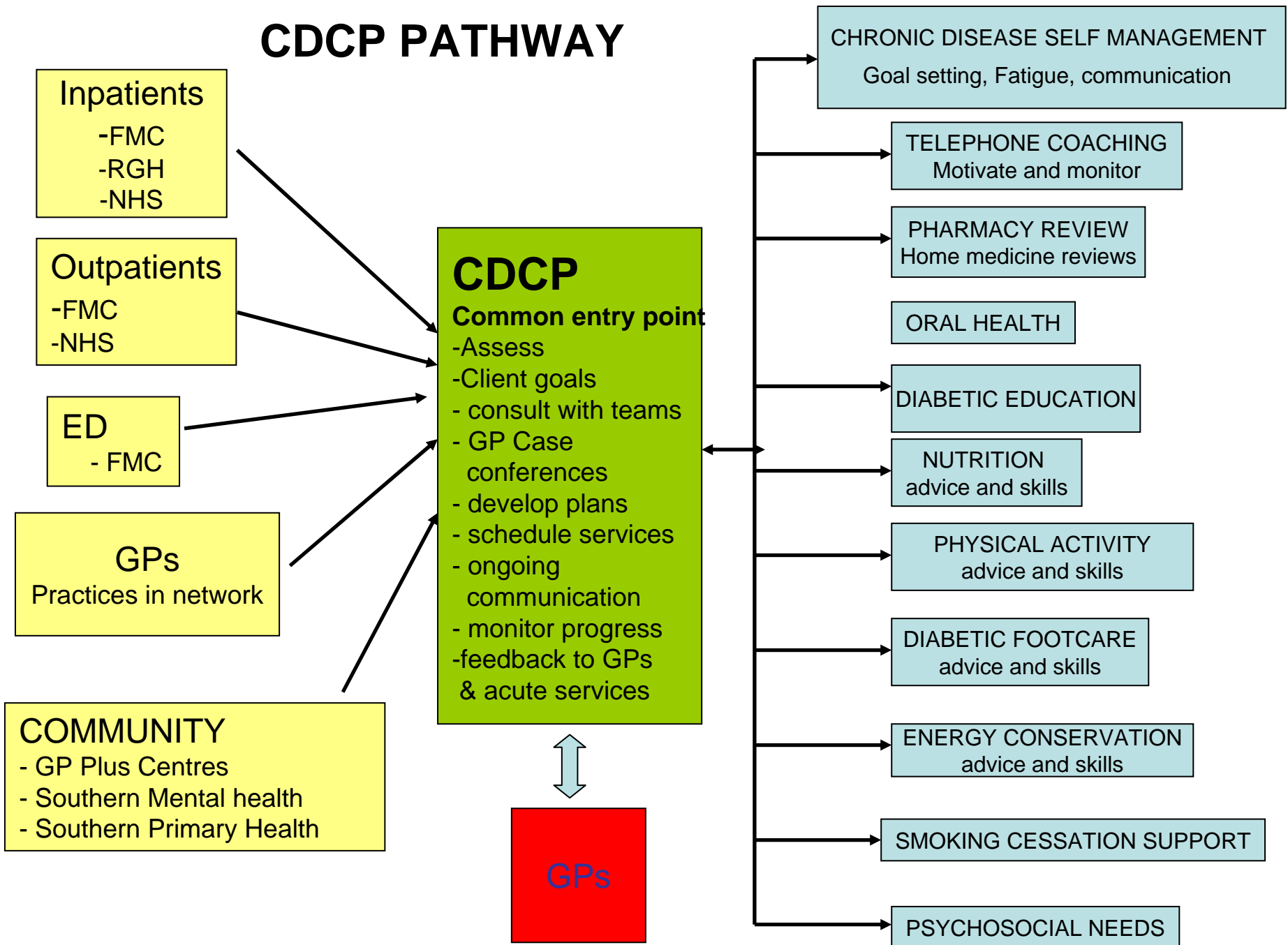
- 1^o diagnosis of COPD, Heart failure/Unstable Angina, Diabetes or as co-morbidities
- complex needs requiring multiple coordinated services
- been admitted or at risk of future hospital admissions – (at least one target risk factor out of normal range)
- want to change lifestyle behaviours/ participate in self-management

Services

Program brings together services funded by both state and commonwealth - comprehensive package of care addressing:

- specific risk factors - slow down progression of disease e.g. physical activity, high blood pressure, HbA1c, smoking, nutrition
- self-management strategies models and approaches e.g. Home exercise programs, relaxation skills, energy conservation, Stanford Lorig / Flinders Partners in Health CDSM
- evidence based approaches to chronic disease management: clinical guidelines; audit; research (RCT - M Vale)

CDCP PATHWAY



Case study – the change



COPD, Smoker
↓ physical activity

COPD advice – Resp nurse
Ref to Allied Health in hospital

Referral
CDCP

- GP team involved
- Ax of needs
- Case conference for action plan
- Schedule services
- Pharmacy

Discharged into community

- PT for home ex, br ex
- NRT
- Telephone coaching
- HMR
- Oral health

Walking regularly, & in ex prog,
Considering pulm rehab, stopped smoking,
Improved adherence to action plan with medication review; able to eat healthy diet with new dentures
No further admissions to hospital

Results

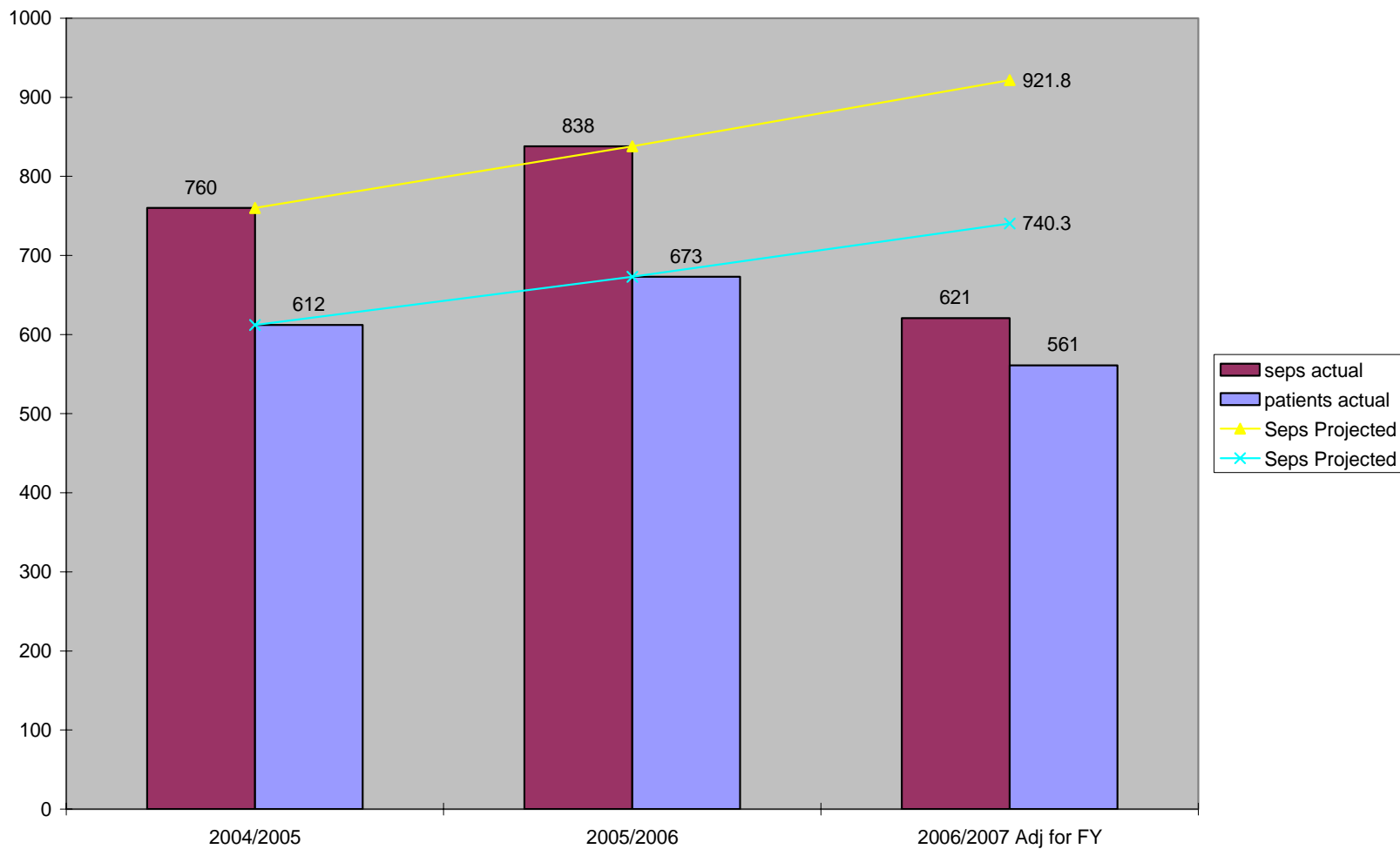
- **Enrolled: 475**

COPD – 305; Diabetes – 91; CHF/ unst angina – 79

- **Reduction in individual admissions by 67 %**

126 people - number of admissions for chronic condition compared 12 months prior & during/ post program works equally well for people living in low and high socio economic areas; particular benefit for older people

- **Trend - decreasing COPD admissions to FMC 06/07 by 63% compared to prev yr**



Building capacity for change

- Change team
- Evaluation
- CDCP Liaison role
- Accredited provider panels
- Linking sectors
- GP engagement – working with divisions
- Extending capacity
- Concurrent work ABHI and GP Plus initiatives; new components - telehome monitoring

Change Team

- “Boundary spanners”
- Learning other sector’s business to build in shared benefit
- Skills in working with consumers and providers at all levels and backgrounds
- Engaging new areas
- Developing new aspects, troubleshooting, feedback re outcomes

Coordination - Liaison & Coaches

- Dedicated liaisons & telephone coaches
- Integral role to program and outcomes
- 2.4 FTE – screening, scheduling, monitoring & coaching, feedback
- Tel coach manages 16 -18 people per FTE
- Developmental role
- Link person between acute and GP teams, plus service providers

Evaluation framework

Robust Qualitative & Quantitative analysis to convince.....

- Impact on hospital utilisation rates
- Risk factor measures (HbA1c, BP)
- Number of people on GPMP/TCA care plans
- AQoL; self efficacy and goal achievement
- Process eg Discharge Summaries/ timing; recall and monitoring
- University Industry Collaborative Research Grant-modified RCT for COPD
- Before and after studies

Accredited panels of service providers

- Purchasing and collaborative arrangement: assure services meet safety & quality criteria.
- Panels - CDSM & Allied Health - Local services and links
 - **Private**
 - **NGO**
 - **State funded (SPH and GP Plus)**
- Quality, training, feedback loops & data
- Consistency of service & messages
- Increased capacity to provide specialised services eg AH, anxiety & depression & better location access
- Shared responsibility and benefits

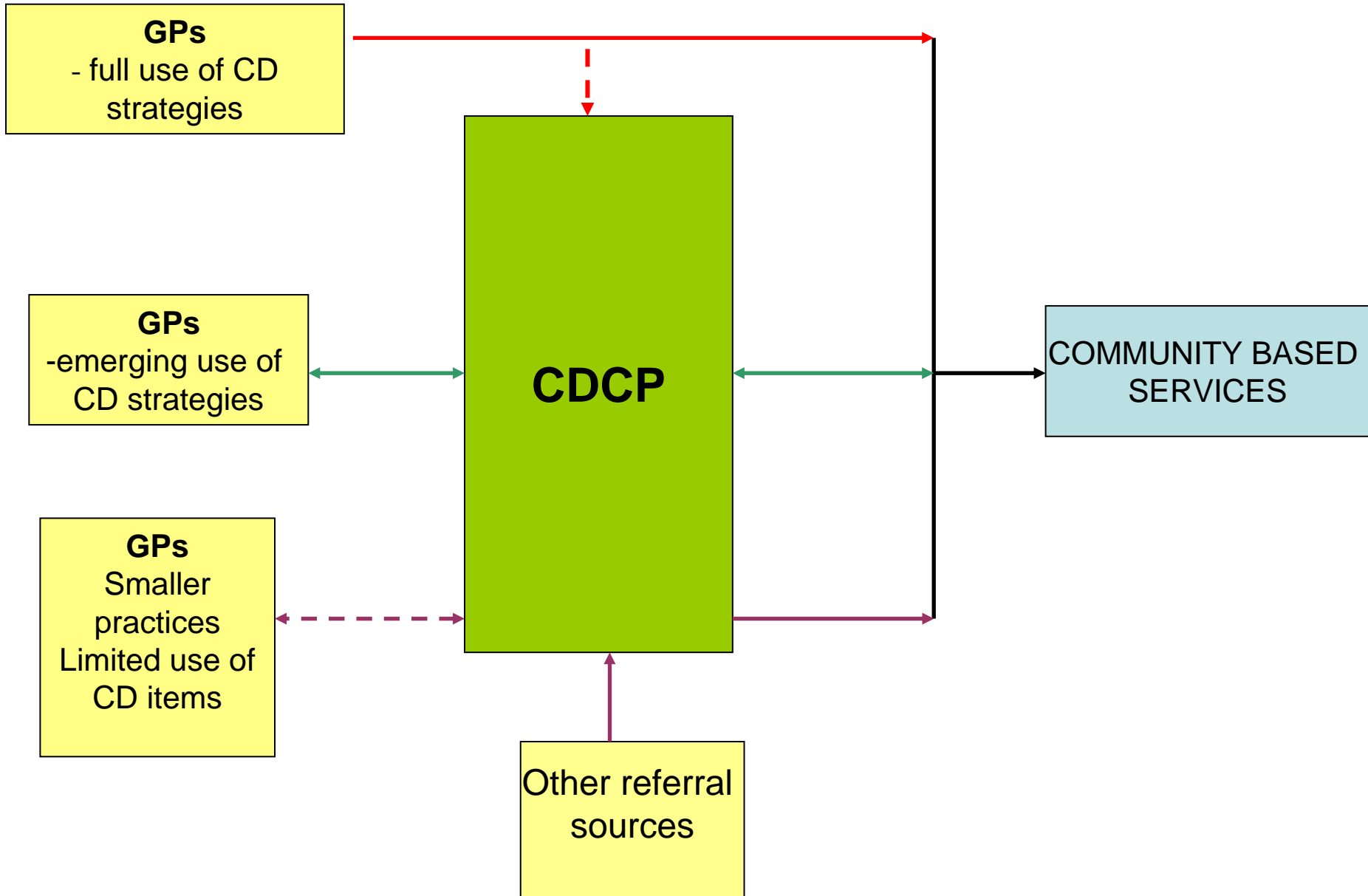
Linking sectors- the glue

- Accredited providers – common referral forms, correspondence format, timeframes and evaluation
- Development of other service agreements with Dental and Pharmacy
- Risk factor ongoing education – consistency, currency, local communication links
- CAHE evaluation of risk factor education program
Clearly articulated paths roles / functions/ info flow-
right time, right place, right service
- Domiciliary services linked in to support strategies

GP engagement

- Early involvement
- Addressing their issues - had to be easy & simple to use; good business sense; evidence based
- Making it the easiest choice
- Utilising known systems- their frame of reference
- GP case conferences with acute (Medicare item)
- Provide info in *care planning framework* - Medicare items maximised
- Build GP team capacity to use local services with confidence
- Working with diversity – flexibility & consistency

CDCP working with GPs



Extending capacity

- Use CDCP platform to expand to complex age related conditions - frailty
- Increase choice of providers for services / geography; supported by workforce development
- Broaden services: disease specific CDSM; ATSI focus; tele-home monitoring
- Linked to ABHI - Lifestyle advisors
More Risk Factor Program development
- GP Plus Health Care Centres - self-management, lifestyle and risk factor programs / PNs supports long term care planning