Care of People with Chronic Illness

The incidence of chronic illness and disease is increasing steadily. This is driving a significant increase in health care demand with approximately half of all admissions to SCHHS facilities being for chronic disease. By 2052/53, without changing the way this patient group is cared for, it is estimated that there will be admitted patient growth of 116%. A large proportion of these admissions are considered avoidable. The HHS has an important role, with its partners, to both reduce the incidence of chronic disease in the population and ensure care provided to patients is given in the most appropriate setting.

Current Service Provision

Chronic disease management is provided primarily in the community setting with further management at the acute facilities as patients’ conditions progress. Care is required across the continuum and includes prevention, screening, diagnosis, acute and ongoing medical care, surgery, rehabilitation and palliative care.

Scope of Chronic Diseases

For the purpose of this paper, the definition below applies. It has been adapted/expanded from the Queensland Health Chronic Disease Strategy (2005-15). These conditions were identified as they pose a significant burden in terms of morbidity, mortality and health care costs, and are amenable to preventive measures.

- Coronary heart disease and heart failure
- Stroke
- Type 1 and 2 diabetes mellitus and gestational diabetes
- Renal disease
- Respiratory disorders: chronic obstructive pulmonary disease, asthma, sleep disordered breathing, lung cancer (exception of acute stages) and cystic fibrosis
- Chronic mental illness eg, depression and anxiety
- Cancer
- Musculoskeletal: arthritis, osteoporosis
- Persistent pain

Palliative care and ensuring people with a chronic disease have early and appropriate access has been identified as an integral component in chronic disease management.

Potentially Avoidable Admissions

Avoidable admissions indicate chronic disease in the community and hospital admissions that could be avoided with changes in chronic disease management.

The graphs below show the extent of potentially avoidable admissions of SCHHS residents compared the Qld. While general SCHHS has similar or lower rates, the volumes do indicate the potential opportunities to reduce admissions through alternatives to hospital care.

Female - avoidable admissions per 100,000 standardised population

Rheumatic heart disease
Hypertension
Iron deficiency anaemia
Anaemia
Convulsions and epilepsy
Congestive cardiac failure
Angina
COPD
Diabetes complications

Data Source: Health Indicators Addendum 2011, SCHSD, Addendum to the Health Indicators Report, Sunshine Coast and Cooinda Health Service District 2007

Sunshine Coast Hospital Health Service Chronic Disease Framework

The framework (Figure 1) provides an overview of the continuum of care in management of patients with chronic diseases.

The framework has been developed in response to the need to move the HHS priority from acute sector management only to a focus on decreasing disease progression to reduce the need for acute admissions.

The framework is based on the following approach:

- Services need to provide consultation, education, support and training for consumers and staff
- Services should cover the entire SCHHS, for all age groups and across the whole continuum
- All services need to provide education focusing on improving lifestyle and coping mechanisms, programs for risk minimisation strategies, early intervention plans and diversion of patients (where appropriate) from the acute / hospital sector.

Services to be developed in partnership with the primary care sector and Medicare Locals to prevent disease progression/ exacerbation and avoid hospital admissions.

Chronic Disease Service Delivery Model

Chronic disease management is not the sole responsibility of any one organisation, and a collaborative effort is required to improve the care of these patient groups. In particular most early and ongoing care is provided by GPs.

The preferred model is based on the Community and Primary Health Service model. It covers 3 tiers of increasing complexity for non-admitted services and emphasises a collaborative approach to care with support by GPs and acute hospital admissions where necessary. (Refer to the Community and Primary Health Services summary.)

Service Transition Priorities 2012 -2016

The short term priorities for the management of chronic disease are to redirect services and patients from acute settings to the community.

2012 - 2014

- Increase range of specialist outpatient services in GHS and CHS in renal medicine, cardiology, diabetes, stroke, respiratory medicine, mental health and palliative care services.
- Develop an integrated diabetes and heart disease service at NGH.
- Develop integrated MDT complex chronic disease clinics for patients with multiple chronic conditions at NGH and GHS.
- Expand the ‘Diabetes Shared Care Model’ with general practitioners/ Medicare Local across the health service.
- Develop and implement a comprehensive services plan for addressing Aboriginal and Torres Strait Islander health inequities.
- Strengthen care coordination model to include musculoskeletal and chronic mental health specialists.
- Pilot a community-based chronic disease care centre for respiratory disease in GHS.
- Increase pulmonary rehabilitation programs and reconfigure locations in CHS, NGH, Maroochydore, Noosa and GHS.

2012 – 2014 continued

- Develop multidisciplinary community diabetes team including credentialed diabetes educators.
- Implement a gestational diabetes mellitus program at NGH.
- Increase community MDT programs at GHS and CHS for children and adolescents identified at risk of chronic disease and child healthy weight assessment teams.
- Implement allied health cancer, lymphedema and survivorship planning in community hubs.
- Make the best use of the workforce through investment in nurse practitioner and advanced scope of practice allied health professionals.
- Develop an integrated diabetes and heart disease service at NGH.
- Develop integrated information systems between service providers such as acute sector, community and general practitioners to facilitate transfer of clinical and non-clinical information for the coordination of patient care.
- Investigate developing in partnership with Medicare Local, self-management education programs.

2014 - 2016

- Develop ‘Community Care Chronic Disease Centres’ for adults, children and adolescents in the speciality areas of diabetes, respiratory and renal disease selected NGH, CHS and GHS hubs (subject to critical mass).
- Develop additional shared care models with general practitioners/ Medicare Local eg respiratory conditions.
- Develop nurse practitioner/advanced health professional led chronic disease clinics within the community for respiratory and diabetes services.
- Develop strategies that focus on early identification of disease progression in partnership with Medicare Local eg chronic disease screening to reduce complex treatments and Estimated Glomerular Filtration Rate (eGFR) for Kidney Disease (CKD).
- Establish a Hospital in the Nursing Home program and pilot a chronic disease model within residential aged care facilities (RACF).
- Develop integrated information systems between service providers such as acute sector, community and general practitioners to facilitate transfer of clinical and non-clinical information for the coordination of patient care.
- Investigate developing in partnership with Medicare Local, self-management education programs.
**Figure 1**

**Sunshine Coast Hospital Health Service Chronic Disease Framework**

Care of CD patients will be provided in a number of settings with providers such as GPs and the SC Medicare local focusing on prevention and intervention at the early disease phase. Community services focus on self-management and care coordination across the primary and pre-hospital phase with the acute sector adopting a MDT approach to management when disease has progressed or exacerbated.

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- Screening/assessment diagnosis & plan
- Care plan
- Monitor by phone / individual
- Not OK Not Self Managing
- Care plan
- Ongoing monitoring
- Admission & acute management
- Discharge Planning

Should be concentrating here to decrease hospital admissions

Currently concentrating here