

NSW Chronic Care Program: Phase Two 2003–2006

Executive summary

Strengthening health care for people with chronic illness



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Foreword

Chronic diseases cause significant distress and burden for people with the illness and their family and carers. Chronic diseases also account for a significant number of potentially avoidable emergency department presentations, hospital admissions and readmissions. With the ageing of the population, this burden will increase.

Phase one of the NSW Chronic Care Program (2000–2003) was an innovative period for NSW. The Program was responsible for facilitating 60 priority health care programs statewide that aimed to enhance the care provided for people with chronic illness, improve their quality of life and that of their carers and reduce hospital presentations. The focus was on the priority areas of cardiovascular and respiratory disease and cancer.

The first phase of the NSW Chronic Care Program was notable for its many achievements and successes, with over 56,000 bed days avoided. The Program also highlighted barriers to implementation of chronic care and began to identify solutions to overcome these.

We are delighted to announce phase two of the NSW Chronic Care Program (2003–2006), which will provide the opportunity to build on the initiatives and lessons learned during phase one. Key components of phase two include establishing new governance arrangements including the overarching Chronic Care Implementation Committee, new Clinical Expert Reference Groups and continuing the Chronic Care Program Managers Forum. Implementing the Clinical Service Frameworks, a major initiative from phase one, will comprise a significant component during phase two, with the Chronic Care Collaborative supporting their implementation during 2004.

Developing robust and sustainable models for chronic care, with strengthened links with primary health care including general practitioners and community organisations will be a strong feature during phase two. Enhancing care coordination, care planning and review and multidisciplinary care for people with chronic illness will be key features throughout phase two. Developing the chronic care funding model and addressing workforce issues to support and enhance chronic care will also be addressed. Working with the Commonwealth to develop the National Chronic Disease Strategy, and other significant national chronic care initiatives will provide valuable policy frameworks to guide chronic care nationally.

We are excited to be involved in the NSW Chronic Care Program, phase two, and look forward to tackling the many issues and challenges to improve the care provided for and quality of life of people with chronic illness in NSW.



Professor Ron Penny

Chair, NSW Chronic Care Program



Executive summary

This document

The purpose of this document is to outline the key issues in gearing the NSW health system to meet the challenge of improving the care provided to people with chronic illness in phase two of the NSW Chronic Care Program.

The document is aimed at senior managers, policy makers, clinicians involved in providing care for people with chronic illness, and organisations working with and representing people with chronic illness and their carers.

Background

Chronic disease is defined for the purposes of the NSW Chronic Care Program, consistent with definitions used in national and other initiatives, as being:

“characterised by complex causality, multiple risk factors, a long latency period, a prolonged course of illness, functional impairment or disability, and in most cases, the unlikelihood of cure.”¹

The incidence of chronic illness is increasing worldwide, with chronic disease accounting for nearly 80 per cent of the disease burden worldwide by 2020. Chronic disease has a significant impact on hospital admissions and readmissions. The ageing of the population will also impact on the increasing burden experienced due to chronic disease.

The NSW Chronic Care Program was established in 2000 for a three-year period under the Government Action Plan to enhance the care provided for people with chronic illness. The focus was on the priority diseases of cardiovascular and respiratory disease and cancer.

This activity reflected initiatives being undertaken at a national level through the National Health Priorities Action Council (NHPAC). NHPAC was established as a sub-committee of the Australian Health Ministers' Advisory Council (AHMAC) in June 2000 and charged with the responsibility of driving improvements in health services to achieve better health outcomes in the national health priority areas. The national health priority

areas include cardiovascular disease, diabetes, cancer, asthma, mental health, arthritis and musculoskeletal conditions and injury prevention.²

There were many significant achievements during phase one of the NSW Chronic Care Program. These included:

- Key policy frameworks developed and disseminated including:
 - Blueprint document outlining policy directions for chronic care in NSW
 - Clinical Service Frameworks for heart failure, respiratory disease and cancer
 - *My Health Record*, the patient held health record.
- Sixty priority health care programs established across NSW focusing on the priority health areas. Through these programs:
 - Over 200 staff were employed to work with people with chronic illness across NSW
 - Over 42,000 patients were enrolled
 - Over 56,000 bed days were avoided, equating to a saving of 89 hospital beds throughout NSW during the approximate 2 years of operation of these programs.

In view of the successes of phase one of the NSW Chronic Care Program, \$15 million recurrent was allocated to support its continuation to phase two (2003–2006). This funding has been allocated to:

- Area Health Services (AHSs) for local implementation of the Clinical Service Frameworks and successful elements of the priority health care programs from phase one, many of which are continuing into phase two
- NSW Chronic Care Collaborative, including \$26,000 for each participating Area Health Service for project support and GP involvement
- Review, revision and ongoing distribution of *My Health Record*.

NSW Chronic Care Program: Phase Two

NSW faces significant challenges in dealing effectively with the increasing burden of chronic illness. To meet these challenges successfully, policies and strategies need to be effected:

- across chronic disease groups
- across the health service system
- across the spectrum of care
- across age and population groups.

Development and implementation of these initiatives must actively involve patients and their carers, community and hospital based clinicians, general practitioners and other health care providers. There is recognition that improved health outcomes for people with chronic disease will only be achieved if there is integration and coordination between a patient centred approach, a positive policy environment, initiatives for enhanced health system organisation and community resources and services.

The **aims** for phase two of the NSW Chronic Care Program are to:

- improve the quality of care provided for people with chronic and complex conditions
- improve the quality and quantity of life of people with chronic and complex conditions
- improve the quality of life of their carers and families
- reduce crisis situations and unplanned and avoidable admissions to hospitals.

The **principles** for phase two incorporate:

- patient-centred care
- empowerment of patients to participate in their own health care
- equitable, easy and timely access to appropriate and optimal care
- coordinated and integrated care
- supportive organisational, governance and leadership structures
- enhancement of workforce capacity to improve the general and specialised care provided for people with chronic illness
- promotion of a quality and safety framework
- monitoring and evaluation.

The **nine strategic directions** during phase two are to:

- provide governance and leadership
- develop and integrate chronic care policy
- strengthen the focus on patients and carers
- establish a comprehensive self-management approach
- strengthen workforce capacity for chronic care
- develop and refine chronic care information systems
- develop the chronic care funding model
- communicate the successes and lessons learned from the NSW Chronic Care Program
- evaluate and monitor the NSW Chronic Care Program phase two.



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The following table provides a summary of the key proposed activities to be undertaken for each of the strategic directions for phase two.

Strategic directions and key proposed activities for Phase Two
1. Provide governance and leadership
<ul style="list-style-type: none">■ Establish the Chronic, Aged and Community Health Care Health Priority Taskforce.■ Establish the revised NSW Chronic Care Implementation Group.■ Establish Clinical Expert Reference Groups for cardiovascular disease, respiratory disease, cancer and diabetes.■ Establish the Aboriginal Chronic Disease Advisory Group.■ Continue the Chronic Care Program Managers Forum.■ Facilitate annual Forums in the priority disease areas of cardiovascular disease, respiratory disease and cancer.■ Facilitate the Aboriginal Chronic Disease State Conference (2005) and regular Aboriginal Vascular Health Workers' Forums through the Aboriginal Vascular Health Program.■ Establish mechanisms to support chronic care champions in NSW.
2. Develop and integrate chronic care policy
<p>At a broader level</p> <ul style="list-style-type: none">■ Develop the NSW Chronic Care Model that defines the key players, elements and interrelationships for optimal chronic care.■ Participate in the development of key national initiatives influencing chronic care in NSW, including the National Chronic Disease Strategy and National Service Improvement Frameworks. <p>Across chronic disease groups</p> <ul style="list-style-type: none">■ Continue implementation of the Clinical Service Frameworks for the initial priority health areas of respiratory disease, heart failure and cancer across NSW.■ Monitor progress against the agreed standards and demonstrations of compliance from July 2003, incorporating effective elements of the local priority health care programs.■ Implement the NSW Chronic Care Collaborative in conjunction with the Clinical Excellence Commission to enhance implementation of the Clinical Service Frameworks for chronic obstructive pulmonary disease (COPD) and heart failure across NSW.■ Develop the NSW Clinical Service Framework for Chronic Disease.



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Across the health service system

- Develop the model of care for people with chronic illness with an emphasis on community-based care, involving general practitioners and private health providers and working with aged care services. The model should also address the needs of carers and health workers.
- Strengthen links with general practitioners through the NSW General Practice Council, NSW Alliance of Divisions of General Practice, Divisions of General Practice and other general practitioner organisations and bodies.
- Establish strong links with NSW Health Department initiatives such as the new NSW General Practice Council and the after hours general practice initiative.
- Identify and disseminate successful strategies for engaging GPs from Phase one.
- Strengthen links across the health system to support care provided for people with chronic illness including primary health care and acute post-acute care in the community.
- Identify effective elements of psychosocial care and incorporate these as part of chronic care service delivery.
- Strengthen links with mental health services.
- Participate in the development of key national initiatives influencing chronic care in NSW, including the National Chronic Disease Strategy and National Service Improvement Framework.

Across the spectrum of care

- Support implementation of the NSW Chronic Disease Prevention Strategy 2003–2007 in collaboration with NSW Centre for Chronic Disease Prevention and Health Advancement.
- Explore initiatives for intervening at earlier stages of the chronic disease trajectory.
- Strengthen the role of care coordinators, care planning and review, multidisciplinary care and rehabilitation in providing enhanced care for people with chronic illness.
- Strengthen links with palliative care services to support care provided to people with chronic illness.



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Across age and population groups

- Strengthen systems of care for children and young people with chronic illness.
- Support the implementation of primary prevention initiatives aimed at children and young people in particular to prevent the later onset of chronic disease.
- Support the implementation of initiatives for children and young people with parents with chronic illness.
- Continue to strengthen care provided to adults with chronic illness.
- Strengthen systems of care for older people with chronic illness to ensure effective, coordinated and integrated care.
- Finalise, launch, implement and monitor the *NSW Aboriginal Chronic Disease Service Standards for Area Health Services* across NSW.
- Strengthen links with the NSW Aboriginal Vascular Health Program.
- Strengthen links with Aboriginal community controlled health services.
- Encourage provision of information on chronic illness and care in community languages.
- Ensure that chronic care initiatives are responsive to the special needs of culturally and linguistically diverse population groups.
- Strengthen initiatives to enhance health care provided to rural and remote populations with chronic illness.
- Establish initiatives to enhance chronic care among prison populations.

3. Strengthen the focus on patients and carers

- Ensure that patients and their carers are placed at the centre of care.
- Review and disseminate the next edition of *My Health Record*, the patient held record, specifically for people with chronic illness to better manage their illness.
- Ensure that people with chronic illness and their carers have access to quality information about the illness and its diagnosis and management.
- Explore options for promoting the health and quality of life of carers of people with chronic illness, including young carers.

4. Establish a comprehensive approach to self-management support

- Develop the NSW approach for self-management support for people with chronic illness.



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5. Strengthen workforce capacity for chronic care
<ul style="list-style-type: none">■ Enhance the workforce capacity in providing care for people with chronic illness through education and training and enhancing organisational capacity.
6. Develop and refine chronic care information systems
<ul style="list-style-type: none">■ Develop a chronic care information template for inclusion in community-based information systems such as the Community Health Information Management Enterprise, that also captures hospital based patient information.■ Participate in the development of the Electronic Health Record as relevant for people with chronic illness.
7. Develop the chronic care funding model
<ul style="list-style-type: none">■ Develop the chronic care funding model that is relevant for the NSW context and comprising NSW health service system components and appropriate links with Commonwealth, local and community based organisations.
8. Communicate the successes and lessons of the NSW Chronic Care Program
<ul style="list-style-type: none">■ Disseminate the NSW Chronic Care Program Report <i>Strengthening capacity for chronic care in the NSW health system: Report on Phase One</i> and associated resources list.■ Communicate the lessons of the <i>Evaluation of the Aboriginal Vascular Health Program 2000–2003</i>.■ Continue to develop and disseminate the <i>NSW Aboriginal Vascular Health Matters</i> newsletter.■ Continue forums in priority disease areas.
9. Evaluate and monitor the NSW Chronic Care Program Phase Two
<ul style="list-style-type: none">■ Continue regular reporting on progress in meeting the standards outlined in the Clinical Service Frameworks for heart failure, respiratory disease, cancer and Aboriginal chronic disease.■ Review the impact of the NSW Chronic Care Collaborative.■ Establish a process for evaluation of phase two.

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Implementation of the Clinical Service Frameworks and priority health care programs highlighted several key areas in which further focused efforts are required to achieve best practice in chronic care. The following table outlines the key areas identified and the activities undertaken or started by July 2004 to address them.

Key areas for activity	Activity undertaken/started by July 2004
Improving access to spirometry for the diagnosis of COPD and asthma	<ul style="list-style-type: none"> ■ \$285,000 allocated to AHSs to purchase and maintain spirometers. ■ Spirometry training conducted.
Improving access to echocardiography for the diagnosis of heart failure	<ul style="list-style-type: none"> ■ NSW Chronic Care Collaborative. ■ Survey of Area Health Services in July 2004.
Improving uptake of angiotensin converting enzyme (ACE) inhibitors and beta blockers for people with heart failure	<ul style="list-style-type: none"> ■ NSW Chronic Care Collaborative.
Increasing access to and participation in rehabilitation for people with chronic illness	<ul style="list-style-type: none"> ■ Collation of rehabilitation manuals and associated resources from phase one.
Increasing the focus on self-management	<ul style="list-style-type: none"> ■ Consultancy to develop NSW approach to self-management. ■ Three statewide workshops using the Flinders self-management model.
Establishing cancer service management structures	<ul style="list-style-type: none"> ■ Work underway through NSW Cancer Institute.
Enhancing the appointment of care coordinators for people with chronic conditions	<ul style="list-style-type: none"> ■ NSW Chronic Care Collaborative. ■ NSW Cancer Institute.
Ensuring a multi-disciplinary approach in providing care for people with chronic illness	<ul style="list-style-type: none"> ■ NSW Chronic Care Collaborative. ■ NSW Cancer Institute.
Ensuring continuity of care across health services	<ul style="list-style-type: none"> ■ NSW Chronic Care Collaborative. ■ NSW Chronic Care Model consultancy.
Engaging general practitioners (GPs)	<ul style="list-style-type: none"> ■ Consultancy to identify successful GP engagement initiatives, phase one. ■ \$81,000 allocated to participating Area Health Services for GP involvement in the NSW Chronic Care Collaborative.
<i>My Health Record</i>	<ul style="list-style-type: none"> ■ Review of <i>My Health Record</i> commissioned July 2004.
Promoting advance care planning and use of advance care directives	<ul style="list-style-type: none"> ■ NSW Chronic Care Collaborative – workshop undertaken to promote advance care planning.



References

¹ National Public Health Partnership. 2001. *Preventing Chronic Disease: A Strategic Framework Background Paper*. Pg 9. National Public Health Partnership, Melbourne.

² National Health Priority Action Council. <http://www.health.gov.au/pq/nhpa/nhpac.htm> as accessed March 2003.

