

NSW Chronic Care Program Phase Three: 2006–2009

NSW Chronic Disease Strategy Executive Summary



NSW DEPARTMENT OF HEALTH

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Introduction

The prevalence of chronic disease is increasing. Chronic disease currently accounts for 70 per cent of the total disease burden in Australia and this is expected to rise to 80 per cent by 2020.¹ This presents a major challenge for our health system.

Chronic diseases include diabetes, cardiovascular disease (including stroke and heart failure), cancer, asthma, chronic obstructive pulmonary disease, arthritis and musculoskeletal disease, dementia and mental health problems and disorders. These diseases share the following characteristics as outlined in the National Chronic Disease Strategy.²

Chronic diseases:

- have complex and multiple causes
- usually have a gradual onset, but can have sudden onset/acute stages
- occur across the life cycle, becoming more prevalent with older age
- compromise quality of life through physical limitations and disability
- are long-term and persistent, leading to a gradual deterioration of health
- while not immediately life-threatening, are the most common and leading cause of premature mortality.

The NSW Chronic Care Program is a landmark NSW Health initiative aimed at reducing avoidable hospital admissions and improving quality of life for people with chronic disease and their carers.

Phase one of the NSW Chronic Care Program (2000–2003) focused on the priority areas of cardiovascular and chronic respiratory disease, and cancer, and the establishment and support of sixty priority health care programs across NSW focusing on these health priority areas. Other key initiatives of phase one included development of clinical service frameworks for the three priority areas, and development and dissemination of a patient held health record (*My Health Record*).

Phase two (2003–2006) built on the lessons and achievements of phase one. The three clinical service frameworks were released in July 2003. Their implementation was supported by the NSW Chronic Care Collaborative during 2004. The Collaborative drew on recognised collaborative methodology to spread evidence based knowledge, skills and proven good practice across multiple sites throughout NSW over a defined period of time.

The NSW Aboriginal Chronic Care Program (ACCP) and the Aboriginal Vascular Health Program (AVHP) are key related initiatives through which significant successes have been achieved in developing culturally and community specific models of health care for Aboriginal people and communities with chronic disease. These lessons are currently being transferred to a broader chronic disease model for Aboriginal communities of NSW.

Work is being undertaken with key partners and agencies to develop prototypes for clinical protocols and health assessment tools for the early detection and management of chronic conditions in Aboriginal people, appropriate training to support the implementation of the protocols, self-management models for Aboriginal people, and ongoing training plans and support for Aboriginal Health Workers working in chronic conditions management.

The NSW Aboriginal Chronic Conditions Area Health Service Standards were released in 2005. They are based on the available evidence of effectiveness or principles of best practice for chronic conditions interventions for Aboriginal populations. They are designed to assist health service providers enhance their current services through incorporating evidence based approaches.

The NSW Chronic Disease Strategy outlined in this document represents a key initiative for implementation during phase three of the NSW Chronic Care Program (2006–2009). The Strategy has been informed by the activities and outcomes of the first two phases of the NSW Chronic Care Program, relevant developments

in chronic care that have been occurring at both a national and international level, and ongoing consultation with chronic care clinicians across NSW. It complements and links with other key initiatives of the NSW Department of Health such as the NSW Chronic Disease Prevention Strategy, Aboriginal Chronic Conditions Area Health Service Standards and the Clinical Services Redesign Program.

This document

The NSW Chronic Care Program Phase Three, 2006–2009: NSW Chronic Disease Strategy comprises three documents:

- 1** Summary Document outlines the aims and key features of the NSW Chronic Disease Strategy.
- 2** Executive Summary (this document) outlines the aims, principles and components of the NSW Chronic Disease Strategy, its implementation and key performance measures, in the areas of:
 - outcomes for chronic care
 - strategic supports
 - elements of service delivery
 - disease specific focus areas.
- 3** NSW Chronic Disease Strategy (2006–2009) provides a detailed rationale and overarching supportive strategic framework to inform and guide state and Area Health Service planning and resource allocation in providing consistent, systematic approaches to local models of chronic care. This document includes a set of standards and demonstrations of compliance for use by Area Health Services in ongoing self-monitoring of implementation of strategic supports (Appendix 1). Standards and demonstrations of compliance for NSW Health to facilitate and support implementation are also included (Appendix 2). Existing models of care that will facilitate the practical application of the Strategy to a range of settings, life situations and levels of complexity of care requirements are provided to assist Areas in implementation of best practice.

The NSW Chronic Disease Strategy – aims and principles

2.1 Aims

The NSW Chronic Disease Strategy, Phase Three 2006–2009 aims to:

- prevent or delay the onset of chronic disease for individuals and population groups
- reduce progression and complications of chronic disease
- improve quality of life of individuals, their families and carers
- reduce avoidable hospital admissions and presentations for chronic disease
- achieve best practice in prevention, detection and ongoing management of chronic disease
- improve the capacity of the NSW health system to meet population demand for chronic disease prevention and care.³

2.2 Principles

The following principles underpin all aspects of the NSW strategic approach to chronic disease management and local service delivery:

- promoting person centred care
- promoting an active self management support approach
- encompassing prevention across the continuum of care
- providing equitable and timely access to appropriate services
- promoting integrated multidisciplinary care
- promoting care coordination and care planning
- providing evidence based care
- promoting effective organisational and service delivery systems that include assessment, diagnosis and chronic disease complexity stratification processes
- demonstrating effective leadership and governance
- working in partnership and collaboration
- demonstrating commitment to monitoring, outcomes and evaluation.

The NSW Chronic Disease Strategic Framework

Figure 1. NSW Chronic Disease Strategic Framework

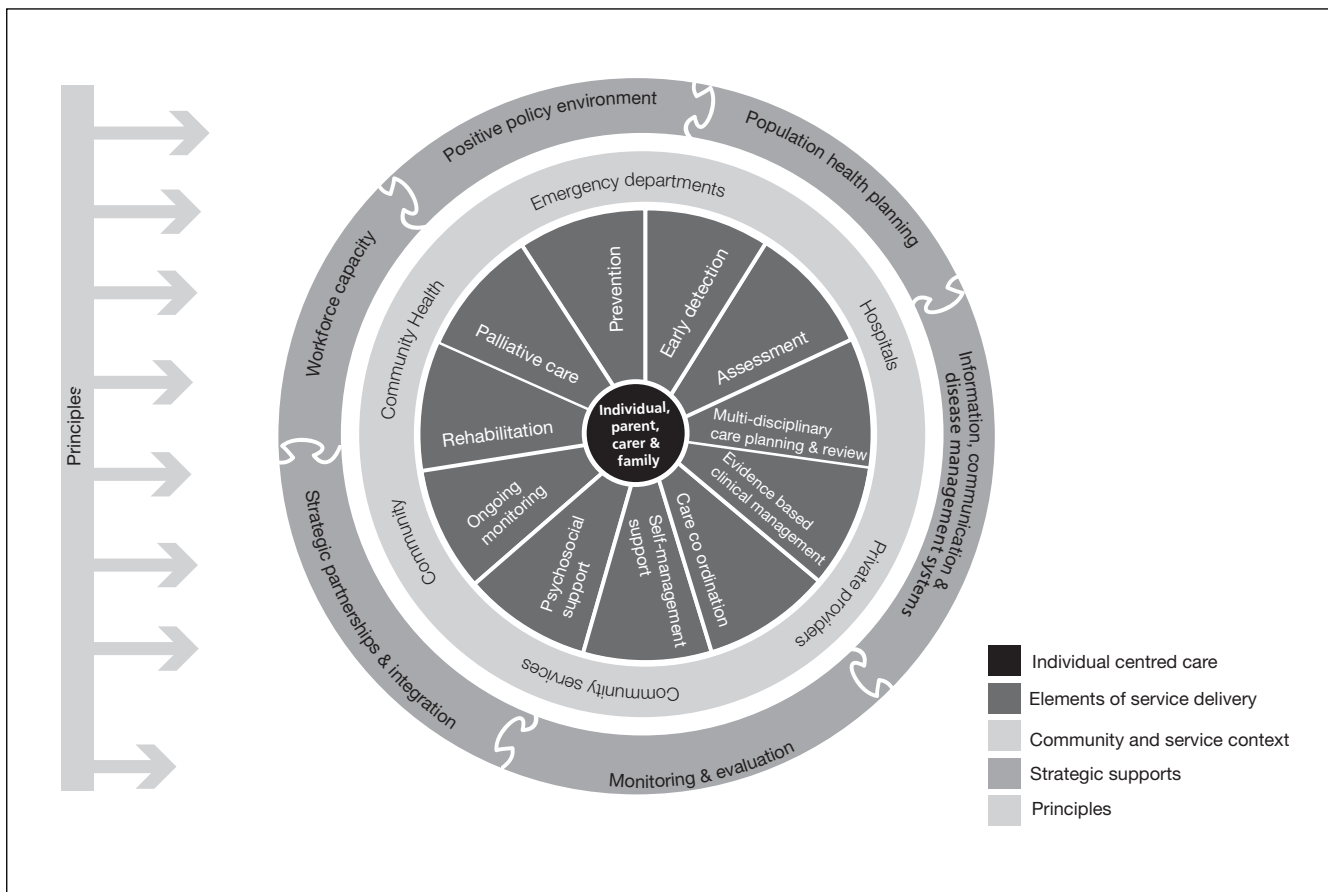


Figure 1 outlines the strategic framework that has been developed to translate the underlying aims and principles into key components at a strategic support and service delivery level. Further information on the strategic framework is provided in the companion document, NSW Chronic Disease Strategy (2006–2009).

3.1 Individual, carer and family focused care

The person with chronic illness, their carer and family are at the hub of chronic care service delivery. A patient centred approach to chronic care typically relegates carers and family to a secondary role whereas an approach that is patient, carer and family focused acknowledges the significant role that carers, family and social and community context generally play in the well-being of the person with chronic illness.

3.2 Elements of service delivery

A set of key inter-related service delivery elements have been identified through the growing chronic care literature. These include:

- prevention
- early detection
- assessment
- multi-disciplinary care planning and review
- evidence based clinical management
- care coordination
- self-management support
- psychosocial support
- ongoing monitoring
- rehabilitation
- palliative care.

Implementation of these elements using an integrated approach to planning and service delivery is crucial to achieving positive chronic care outcomes, both at an individual and population-based level. At an individual level, these elements need to be tailored and coordinated to meet changing individual needs along the disease continuum.

3.3 Community and service context

Most chronic care occurs in a community context. This includes:

- assessment, referral and short-term treatment
- prevention, early detection and intervention for health problems and risks
- ongoing care of people with chronic and complex conditions in collaboration with more specialist services
- acute care in the community.

The broad range of services for people with chronic diseases needs to be configured and organised such that the differing care and support requirements of various specific sub-populations can be met, from those with mild stable disease to those with severe disease or factors increasing the complexity of care required. Effective and timely care and smooth transitions between types of care depend on appropriate linkages and good communication between the different providers and settings of care.

3.4 Strategic supports

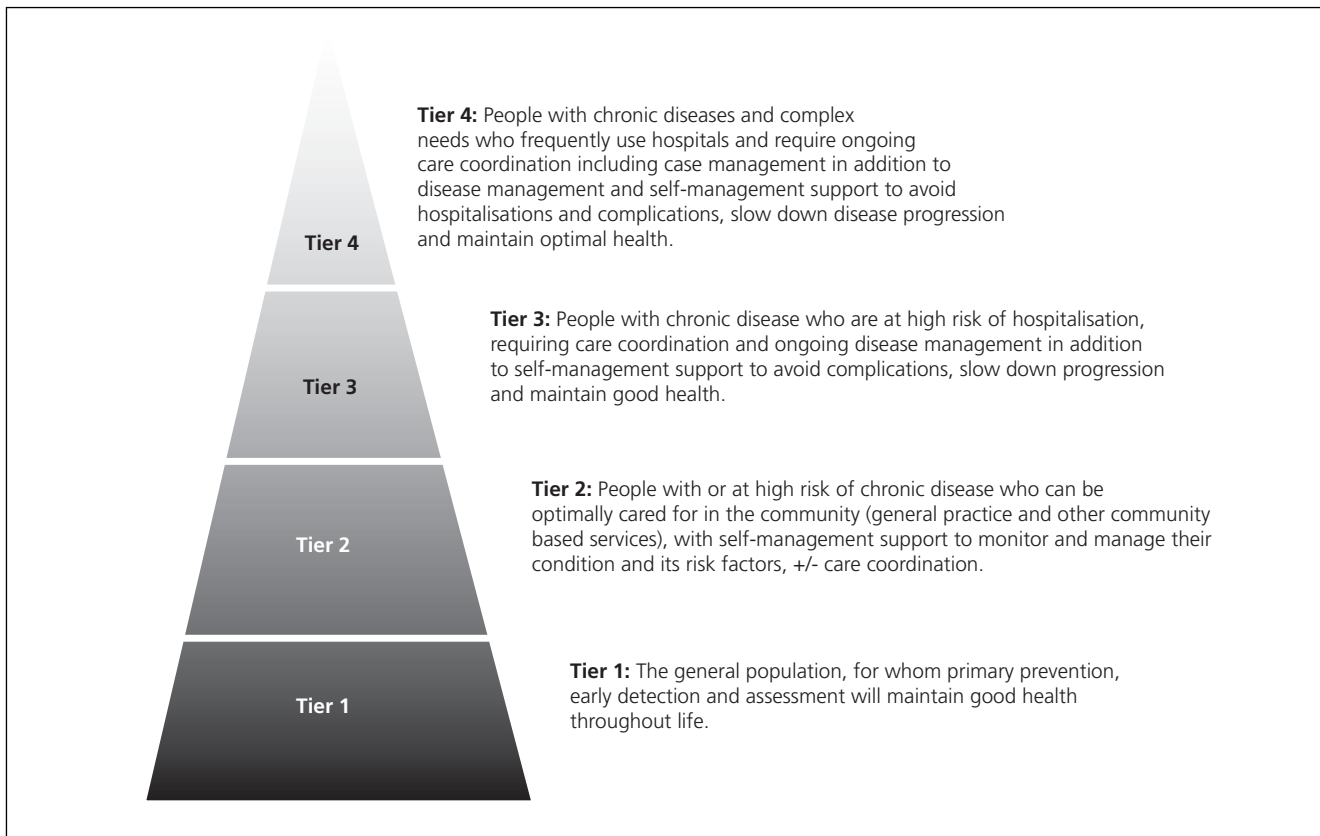
The strategic supports for chronic care are the strategic enablers and facilitators that support implementation of the NSW Chronic Disease Strategy at a state and Area level. A set of standards has been developed to guide implementation of effective strategic supports. At the state level, the strategic support standards provide an overarching matrix to lead, guide and support statewide and Area Health Service chronic care service development and ensure synergy with national strategic approaches. At the Area Health Service level, the strategic support standards comprise a set of strategic approaches that underpin local evidence based chronic care service delivery.

3.5 Planning services for levels of need for chronic care

Central to the operation of the NSW Chronic Disease Strategy at an individual level is assessment of the nature and complexity of each person's care requirements and care coordination needs in a biopsychosocial context. At an Area level, this categorisation can also assist planning for provision of appropriate service types and mixes to suit local populations. Building on the Kaiser Permanente and UK National Health Service⁴ approach of stratification of the population requiring chronic disease management, Figure 2 describes how the chronic disease population can be broadly divided into four tiers based on complexity of care and support requirements.

These are as follows:

Figure 2. Stratifying the chronic disease population



Stratification of the chronic disease population is widely recognised as a useful way of tailoring chronic care.^{5, 6} It should be noted that individuals may move between tiers in either direction throughout the course of their disease. The goal of successful chronic disease management is to prevent progression to higher tiers and, for those in tiers 3 and 4, to promote movement to a lower tier of complexity.

Approaches to implementation that can be taken at an Area Health Service level based on the four tiers of complexity are further detailed in the companion document NSW Chronic Disease Strategy (2006–2009). Examples of service delivery models that operate at each of these levels are also included.

Implementation of the NSW Chronic Disease Strategy will be monitored by NSW Health through a range of performance measures relating to chronic care outcomes, strategic supports, elements of service delivery and specific disease focus areas. The companion document, NSW Chronic Disease Strategy (2006–2009) describes these performance measures in more detail. A subset of these measures will be identified and further developed as key performance indicators to manage performance.

Implementation and monitoring

Implementation of the NSW Chronic Disease Strategy from 2006 until 2009 will be monitored through a range of indicators currently in development.

Monitoring of these indicators will occur via several methods, including:

- Area Health Service Performance Agreements
- self-assessment by Area Health Services (tool provided)
- Community Health Information Management Enterprise (CHIME) data monitoring of key performance indicators (in development)
- quality improvement methodology including audits.

The focus of the NSW Chronic Care Program in phase three is on broadening the spread of chronic care activities into the community. The use of CHIME as the chronic care reporting mechanism will highlight this focus. Therefore, the defined population for reporting of these service delivery indicators will be a referral to community health with a diagnosis of chronic disease. It is recognised that this will not capture the activity of similar services and programs that are primarily hospital based. However, it is proposed that other developments occurring in this area (eg with TASC [Towards a Safer Culture] projects) will assist in bridging this gap in the longer term.

Outcomes for chronic care will be monitored by NSW Health through the Area Health Service Performance Agreements. Area Health Services will be expected to report on these to the NSW Department of Health annually.

Strategic supports performance measures for chronic care demonstrate the implementation of a chronic care approach within an Area Health Service. A list of standards for strategic support is included in Appendix 1 of the companion document. It is expected that Area Health Services will use this list of standards and demonstrations of compliance to guide implementation of the strategic supports for chronic care.

Elements of service delivery are those considered to be critical for the provision of optimal chronic disease prevention and management across population groups and settings. It is planned to report on service delivery indicators through CHIME. Work is currently underway to ensure that this facility is available.

Disease specific focus areas build on the implementation of the Clinical Service Frameworks in phase two of the NSW Chronic Care Program, while acknowledging the increasing disease burden in other chronic disease areas. Key performance measures to assess progress regarding cardiovascular and chronic respiratory disease are being developed in consultation with the relevant Clinical Expert Reference Groups. These indicators will be monitored on an annual basis from June 2007. Performance measures are to be developed for diabetes, arthritis and musculoskeletal disorders and dementia during phase three.

References

- 1 Australian Institute of Health and Welfare 2002, *Chronic diseases and associated risk factors in Australia, 2001*, Canberra: AIHW.
- 2 National Health Priority ACtion Council (NHPAC) 2006. *National Chronic Disease Strategy*. Australian Government Department of Health and Aging, Canberra.
- 3 Modified from primary objectives stated in: National Health Priority ACtion Council (NHPAC) 2006. *National Chronic Disease Strategy*. Australian Government Department of Health and Aging, Canberra.
- 4 UK Department of Health 2005, *Supporting people with long term conditions. An NHS and Social Care Model to support local innovation and integration*, Department of Health, London.
- 5 Ibid.
- 6 *Victorian Chronic and Complex Care Program – targeting service response*, 2005.

