Gold Coast Chronic Disease Steering Group  
Chronic Disease Strategy

Background

The CD Steering Group comprises representatives from general practice, Gold Health Service District, non government agencies, consumers and private practitioners.

The purpose of the steering group is to provide strategic leadership on the improvement, integration and coordination of chronic disease services on the Gold Coast.

Its objectives are:

- **Clinical Leadership** – Utilise the knowledge and expertise of clinical leaders, health service providers, consumers and other partners to improve coordinate and integrate chronic disease services on the Gold Coast.
- **Strategic Planning** - Develop a chronic disease strategic plan for the Gold Coast that identifies opportunities for improved service delivery.
- **Planning** – Plan, design, implement and evaluate models of care that improve the prevention and management of chronic disease.
- **Integration and coordination of services** – Establish and implement clinical pathways and models of shared care that support the delivery of evidence based multidisciplinary care across primary, community and acute health service settings.
- **Performance** – Improve patient health outcomes by monitoring, evaluating and improving the delivery of multi-disciplinary clinical care to patients.
- **Evidence Based Reporting** – Report against health and systems outcomes and make recommendations for further evidence based models of care to inform future development and investment based on health outcomes.

The steering group has adopted the Queensland Strategy for Chronic Disease 2005-2015 as an overarching framework, and the Chronic Care Model Matrix (1) as a useful guide to program reform and realignment to improve chronic disease prevention and management (attached). A matrix based on this model and mapping existing chronic initiatives is also attached.
Gold Coast demographics and burden of chronic disease

The report Burden of Disease and Health Adjusted Life Expectancy in Health Service Districts of Qld Health, 2003, provides state level estimates of Disability Adjusted Life Years (DALYs) for a range of causes of illnesses for Queensland. The key findings of the report were:

- Cancers and cardiovascular disease were the leading broad cause groups, together causing more than one third of the total burden of disease and injury in Qld.
- The importance of mental disorders is highlighted as the leading cause of disability and the third leading cause of overall burden.
- Lifestyle related disease is among the leading causes of burden. Leading risk factors are tobacco, high body mass, high blood pressure, physical inactivity, and high cholesterol.
- The rate of burden increases with old age with peaks also in infancy and young adulthood.

This state level burden data was disaggregated to produce estimates for each Statistical Local Area (SLA). Modelling techniques were used so that the level of burden in each SLA reflected the age and sex distribution of its population, its Accessibility/ Remoteness Index of Australia (ARIA+) category, its SEIFA quintile (index of relative disadvantage) and the proportion of its population that was Aboriginal or Torres Strait Islander. The results for the Gold Coast HSD were:

- DALY rate was similar to the Qld Rate
- Life expectancy and Health adjusted life expectancy (HALE) were marginally higher than the Qld average
- While the HALE in the district was similar to that in Qld, gains can be achieved though addressing unintentional injury and cardiovascular disease burden
- Within the district, key areas for reducing health inequity overall are cardiovascular disease, cancer and mental health(1)

Hospital Separations

While the number of separations for ischemic heart disease, heart failure, COPD and Asthma increased only marginally over the period 99/00 to 05/06, separations for renal failure doubled and for diabetes mellitus tripled. Renal failure accounted for 56% of all Chronic Disease hospital separations (2).

National and State Chronic Disease Initiatives

Both the Commonwealth and Queensland governments have chronic disease strategies in place to improve chronic disease prevention and management.

Funding to support these initiatives have been made available by Council of Australian Governments (COAG) through the Australian Better health Initiative, and by the Queensland Government through the Queensland Chronic Disease Strategy and Connecting Health Care in Communities (CHIC). Wherever possible the steering group will attempt to influence the allocation and implementation of these funds and monitor the outcomes and health improvements of these in accordance with its purpose and Terms of Reference.
Goals of the Chronic Disease Strategic Plan

The Goals of the Strategic Plan are:

- Improve the quality of life for people with chronic disease on the Gold Coast
- Reduce the prevalence of chronic disease
- Improve timely access to appropriate services

The steering group has determined three priorities for action to achieve these goals as follows:

1. Making better use of existing resources

The healthcare system is characterised by fragmentation and lack of coordination among health and community providers. This priority recognises that efficiencies can be achieved by services within the existing system working more collaboratively. Initiatives such as the Australian Better health initiative (ABHI) and CHIC are intended to enable a more collaborative approach to service delivery and a more efficient and seamless patient journey through the system. Projects under these initiatives seek to improve service coordination and integrated chronic disease prevention and management.

Our Aims are to:
- Improve patient centred care by enabling better coordination of care
- Improve knowledge of services and access to them

Opportunities
- Define and improve clinical and service pathways for chronic disease, with an emphasis on cardiovascular disease, renal and mental health.
- Develop systems to coordinate the care of patients with chronic disease
- Increase access to primary health care and community services by Gold Coast residents, and providers
- Improve transition of care between primary and secondary/ acute care services
- Improve access to acute services
- Standardised referral and assessment forms between health and community providers

How will we know if we are successful?

We’ll see:
- Improved continuity of care between all health and community service providers
- Primary health care providers using integrated shared care pathways to support chronic disease prevention and management
- Health care providers, community service providers and consumers using tools/ systems that enhance access to services
2. Invest in preventative strategies

Commonwealth and state governments have recognised the contribution of preventable risk factors to the increasing burden of chronic disease and have committed to reducing risk factors among the population. This priority recognises the current imbalance between funding for treatment as opposed to prevention, and commits to directing greater resources into prevention. The Queensland Strategy for Chronic Disease is designed to reduce the risk factors through a comprehensive whole of population approach as follows:

Primary Prevention
- Reduce smoking
- Reduce high risk alcohol use
- Improve nutrition
- Increase physical activity
- Improve identification and management of lifestyle and behaviour risk factors

Secondary Prevention
- Increase early detection and management of high blood pressure, high cholesterol, glucose intolerance, protein in the urine, increased body mass and impaired lung function

Management and Tertiary Prevention
- Provision of quality multidisciplinary care
- Reduce the risk of complications
- Access to quality palliative care services

Our Aims are to:
- Improve the capacity of health services to undertake prevention
- Improve general practice capacity to manage chronic disease
- Improve continuity of care among health and community services
- Improve access to palliative care services

Opportunities
- Increase general practices utilisation of existing preventative health measures
- Support the introduction of new preventative and lifestyle modifications programs
- Build capacity across government, non government and general practice to support children and their families to achieve positive education and health outcomes
- Increase knowledge and capacity of primary care providers to prevent and manage renal disease
- Increase the number of general practices measuring and benchmarking performance against clinical indicators on an increasing range of chronic diseases
- Development of shared care protocols between health services, commencing with renal disease
- Development of secure messaging between all health service providers
- Development of shared electronic health records between providers

How will we know if we are successful? We’ll see:
- Increased use of Lifescripts and MBS health checks and health assessments
- Increased number of patients achieving agreed goals through lifestyle modification programs
- Increased patients on chronic disease registers, with an emphasis on cardiovascular disease, renal and mental health.
- Increased health care services that measure and benchmark performance against clinical indicators
Primary health care providers using integrated shared care pathways to support chronic disease prevention and management

3. Recognising the importance of social support, connection and self management

Evidence suggests that a person’s level of social connectiveness and involvement in a community are strong contributors to resilience, early help seeking and the ability to self manage health and well being. Social connectedness is influenced by transport, feelings of safety, public spaces, community networks and social activities in the community and access to services. Self management educates patients about managing the symptoms and signs of chronic disease and engages individuals in activities that protect and promote well being and reduce health system dependency.

Our Aims are to:

- Support initiatives to build social capacity, social connection and reduce isolation
- Develop sustainable models of self management to meet the needs of the Gold Coast population

Opportunities

- Development of social inclusion projects as a part of new and emerging infrastructure planning and development.
- Development of activities within communities to increase social inclusion for those with chronic disease
- Coordinate the delivery of self management courses to assist in the sustainability of providers and to increase attendances

How will we know if we are successful?
We’ll see:

- Health and well being are considered in community planning documents
- Patients with chronic disease report greater involvement in their community is improving their quality of life
- Increased number of patients achieving agreed goals through self management referral

Evaluation and monitoring

The steering group has a responsibility to report against health and systems outcomes and make recommendations for further evidence based models of care to inform future investment.

References:
3. Queensland Hospital Admitted Patient Data Collection (QHAPDC), Queensland Health
The following table has been constructed by GPGC from Swerissen, H., & Taylor M. (2008). *System reform and development for chronic disease management*. A report prepared by the Australian Institute for Primary Care, La Trobe University, Melbourne. The full document can be provided if required. The Document discusses options for program reform and re-alignment to improve chronic disease prevention and management in the Australian primary care sector. It provides a useful description of an ideal model of Chronic Care Management (CCM), an analysis of existing chronic disease programs, and proposes solutions to perceived gaps and deficiencies in current systems. The model proposes three levels of care:

- **Level 1** – medical management only; for example patients with chronic disease and some risk factors, who present an uncomplicated clinical picture from a medical and psychological standpoint.

- **Level 2** – medical management plus multidisciplinary care; patients with multiple chronic diseases with numerous risk factors, who present a more complex clinical picture which requires the involvement of other health professionals to provide multidisciplinary care.

- **Level 3** – medical management, multidisciplinary care; case management and social services. Patients have in addition to level 2 needs, social care needs requiring more intensive support and case management beyond that which GPs and allied health professionals can provide.

It is intended that this will assist the Chronic Disease Steering Group in its decision in agreeing on chronic disease initiatives to be funded under the QH CD funding in 08/09.

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<tr>
<th>Principles of Chronic Care Management</th>
<th>Existing Medicare CD program</th>
<th>Gaps/ Opportunities</th>
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<tbody>
<tr>
<td><strong>Health care organisation</strong></td>
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<td><em>Ensures governance and management of health care providers are designed the role of patients around the needs of consumers</em></td>
<td>Limited to the quality of care processes rather than quality of care outcomes. GPs have little direct role in accessing or coordinating HACC, CACPS and EACH programs. State based programs have different assessment, care planning, service coordination and care planning models from Medicare</td>
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<td><strong>Self management support</strong></td>
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<td><em>The role of patients needs to shift from passive to active involvement in their own chronic care. Optimal health outcomes require support for self management by patients. Partnerships are needed between consumers and providers to ensure that consumers are able to effectively self manage risks and chronic disease</em></td>
<td>Current MBS items for GPMP include “agreeing management goals with patient” and identifying any actions to be taken by the patient. Diabetes/ Asthma SIP include provision of self care education. GP MHC Plan includes “agreeing goals with patient” and “any actions the patient will take”</td>
<td>• Increase capacity and coordination of self management courses (Self management collaborative occurring with GCDGP and Spiritus) • Service coordination of community resources including self management and chronic disease education and support by CD NGOs</td>
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<tr>
<td>Principles of Chronic Care Management</td>
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<td><strong>Decision support</strong>&lt;br&gt;  <em>Evidence based guidelines integrated into everyday clinical practice to support the delivery of optimal chronic care</em></td>
<td>Diabetes SIP item incorporates evidence based best practice guidelines into the MBS item descriptor</td>
<td>• Development of CD clinical pathways for Diabetes T2, COPD, Renal, heart disease and MHC (occurring through ABHI project)  &lt;br&gt;• Care coordinators ensure appropriate levels of service in accordance with service specific guidelines</td>
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<td><strong>Delivery system design</strong>&lt;br&gt;  <em>Requires a planned approach to chronic disease care, including multidisciplinary approach to care, clinical case management, services ranging from risk prevention to chronic care. Care pathways for the prevention and management of chronic disease where consumers access services on the basis of assessment and care planning</em></td>
<td>Planned approach to care is implicit in various care plan preparation items; however, proliferation of programs has resulted in disjointed systems of care planning for patients with chronic disease and mental disorders. Several care plans potential exist constructed by several partitioners and services, Follow up implicit in review items under each program, but varying in the degree to which they are required  &lt;br&gt;TCAs allow for the coordination of a team to provide multidisciplinary care with access to Medicare rebates for allied health services (5 for CD, but 12 for mental health)</td>
<td>• Standardised assessment process (interchangeable between GPs, hospitals, discharge planners, aged and disability services) and a consistent simple pathway to access service for chronic disease prevention and management  &lt;br&gt;• Develop models of service coordination across practitioners, service types and provider agencies in line with assessment of need  &lt;br&gt;• Service coordination by case managers (practice nurses or existing state health services) should incorporate patients who require more than multidisciplinary care and straightforward pathway into community services. Services should include a range of domestic, respite, transport and social support services.</td>
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<td><strong>Clinical information systems</strong></td>
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| Support registers of patients, dissemination and use of decision support elements, and the ability to provide feedback on the quality of care provided (performance against clinical indicators) | PIP has promoted improvement through IM/IT incentives. Diabetes payment includes an incentive payment for the maintenance of a register of diabetic patients. Little integration of IM/IT across the primary and community care system, or between this systems and the acute system. | • Broad electronic health record system  
• Population based reporting and feedback  
• Measuring and benchmarking performance against clinical indicators (occurring though GCDGP QI activities such as diabetes and CHD collaboratives)  
• Expand disease states for clinical indicators  
• Messaging among clinicians and community organisations (commencing through iHealth Care project)  
• Incentives for patient monitoring and continuity of care/ clinical outcomes |
| **Community resources and policies**  |
| Health care providers are linked with community organisations that provide patients with other support services, such as: home and community support, exercise programs, social connectiveness and supports. | While the CDM and GP MHC programs have provided the means for extended linkages with other health professionals, linkages with community services are comparatively underdeveloped. The lack of linkages and incentives does not encourage the seamless delivery of services across Medicare funded services, state funded services and community care programs. | • For level 2 and 3 patients, where greater social support and service coordination is required, **patient related accountability and reporting** should be nursing or service coordinators to ensure GP time is maximised in managing the medical elements of care  
• Coordination and collaboration exists among community health and community organisations to ensure streamlined pathways to appropriate services and reduced duplication.  
• Information systems provide health professionals and care coordinators with access to community services, resources and pathways (occurring)  
• Social connectedness and social support services are supported, linked and recognised as part of Patients quality of life |