



**Government of South Australia**  
Southern Adelaide Health Service

# southern health

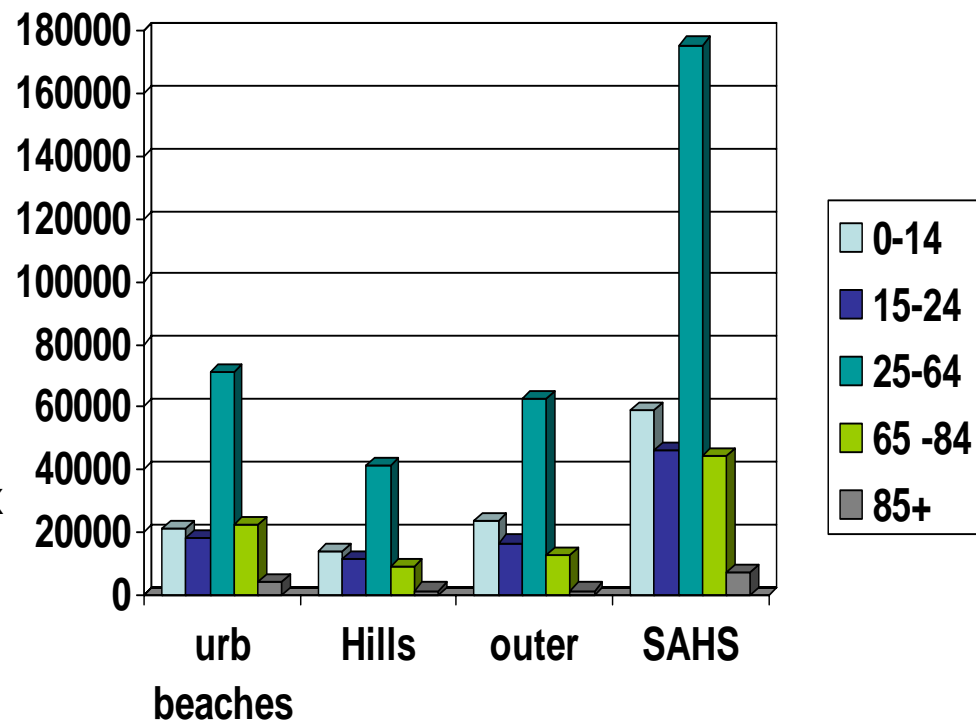
**Southern Adelaide Health Service**  
**Jeanette Walters**  
**Program Manager, Demand Management**

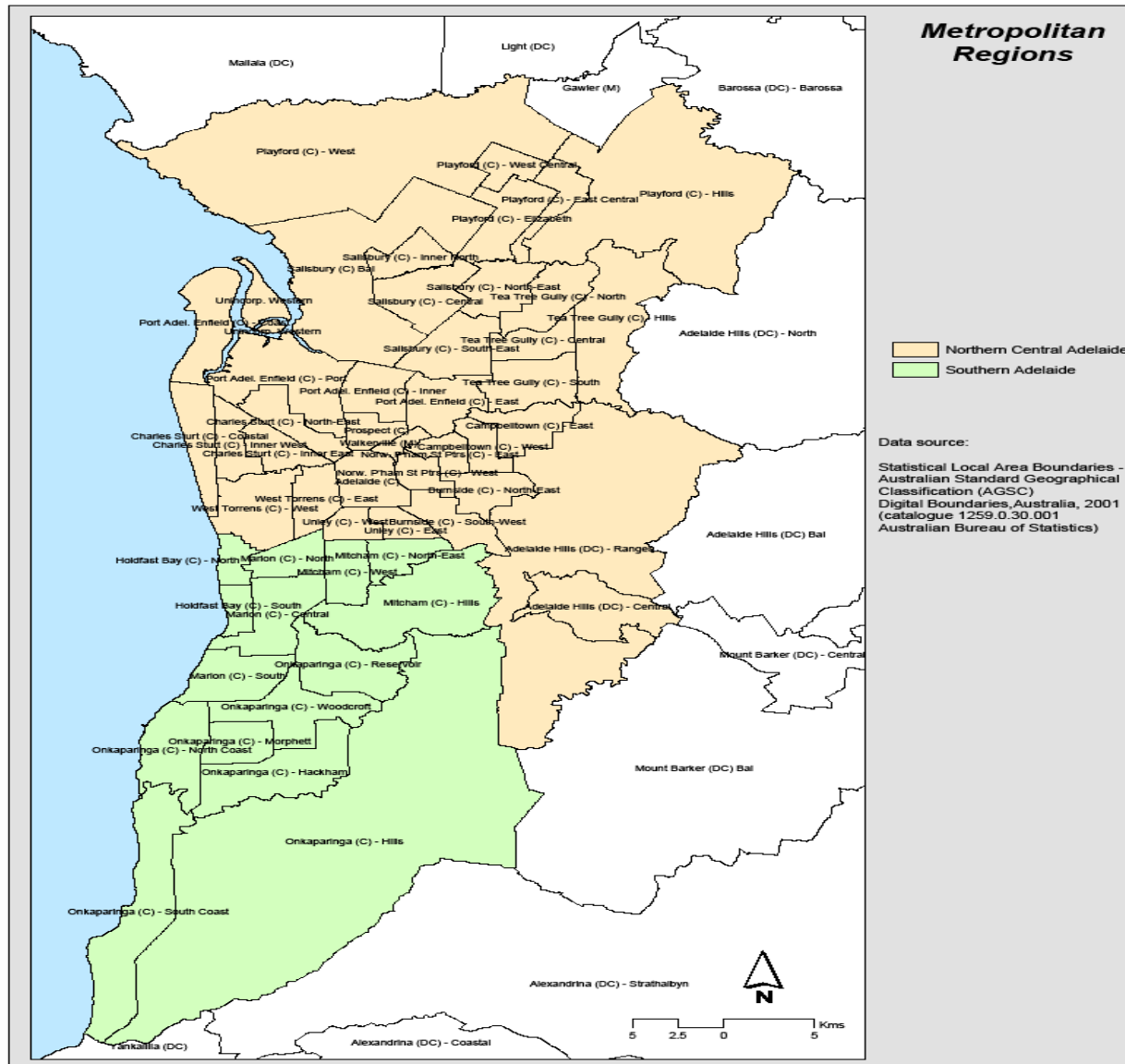
# ***Outline***

- Background
- Response & Results
- Service Reform
  - **Accredited Provider Panels**
    - the process
    - the benefits
    - the future

# Southern Adelaide region

- Southern metropolitan Adelaide
- 1/5<sup>th</sup> of population of South Australia, 300,000
- Urban beaches, hills & semi rural areas
- 3 public hospitals, Private hospitals
- Primary health services
- 4 main DTC and numerous private providers
- 100 GP practices with approx 400 GPs
- 50% Practice nurses





# ***Background***

- 103,000 People (>20 yrs) in South have at least one chronic disease that is preventable
- one third of Hospital casemix expenditure in 2002-03 attributable to cardiovascular disease, diabetes, arthritis / musculoskeletal conditions, asthma & chronic obstructive pulmonary disease
- 7/10 GP visits
- like the State as a whole, the Region's population is projected by the ABS to age in future- reached 2020 prediction of 18%

## ***Changing the approach***

- management of chronic disease is often reactive in nature
- responding to an acute exacerbation of the illness rather than being directed at the cause
- dealing with the rising prevalence of chronic disease
- health system must be strengthened and geared towards prevention, early intervention and integrated management
- consistent use of best evidence

## ***What were the issues at the local level?***

- communication between acute & community services - bring sectors together to coordinate care
- focus on self management
- Allied Health was fragmented in the services offered, variable in ease of access to clients & disparate in application, use of clinical guidelines & standards
- easier access to Allied Health, - *right time, right place, right service*
- building GP team & local services capacity
- consistent & coordinated system of care that was easily accessible & evidence based standard



## ***The response***

- content – (what)
- target group – (who)
- service reform – (how)

# **Chronic Disease Community Program**

southern  
health

SA Govt funded hospital avoidance strategy:

- reduce rate & number of unplanned hospital admissions
  - improve population & individual health outcomes
- by
- actively supporting people to engage in self management of their chronic disease
    - **local services**
    - **clear communication between all providers incl GPs**
    - **patient/client involvement at all stages of care pathway**



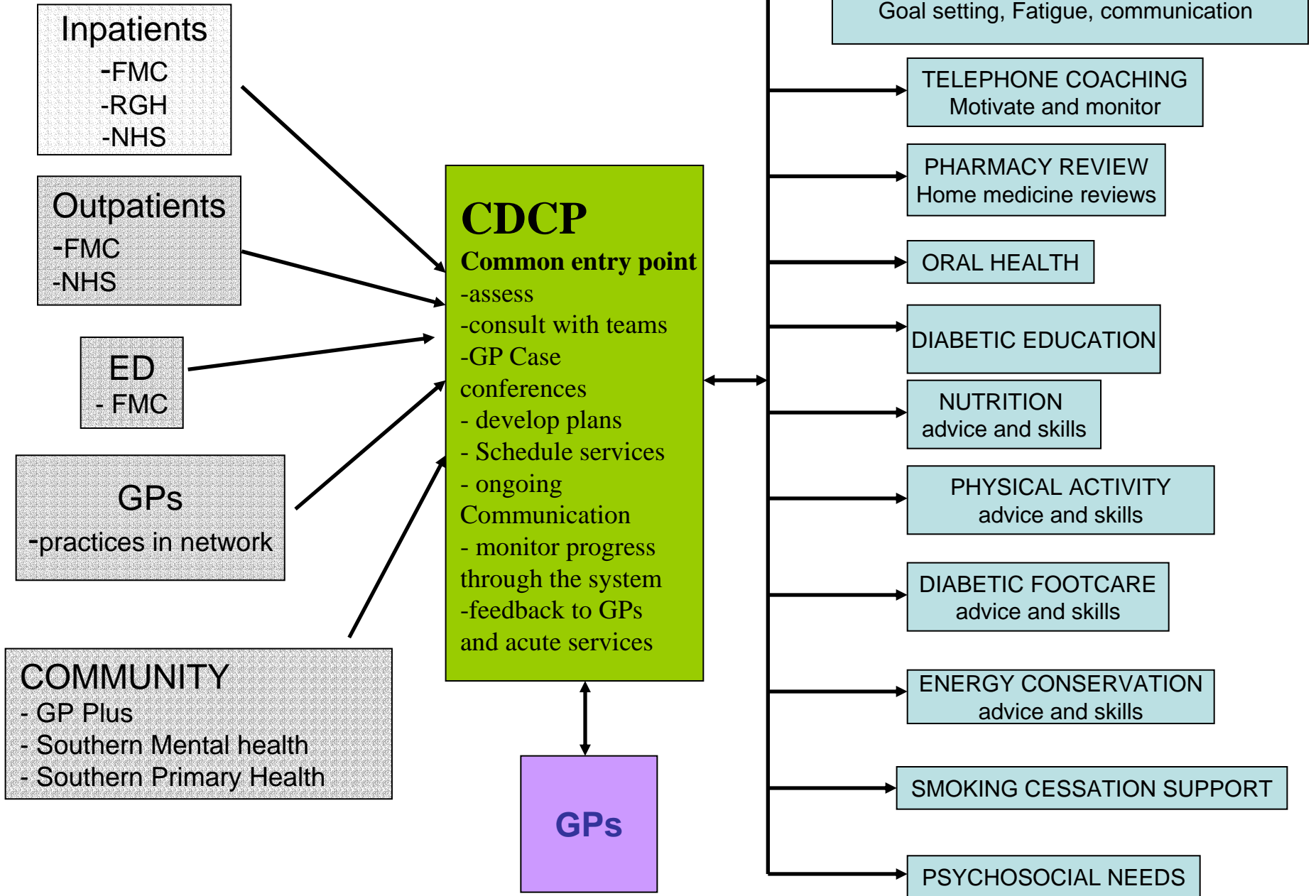
## ***Eligibility***

- diagnosis of COPD, Heart failure/Unstable Angina or Diabetes
- have 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)
- willingness to participate in self-management

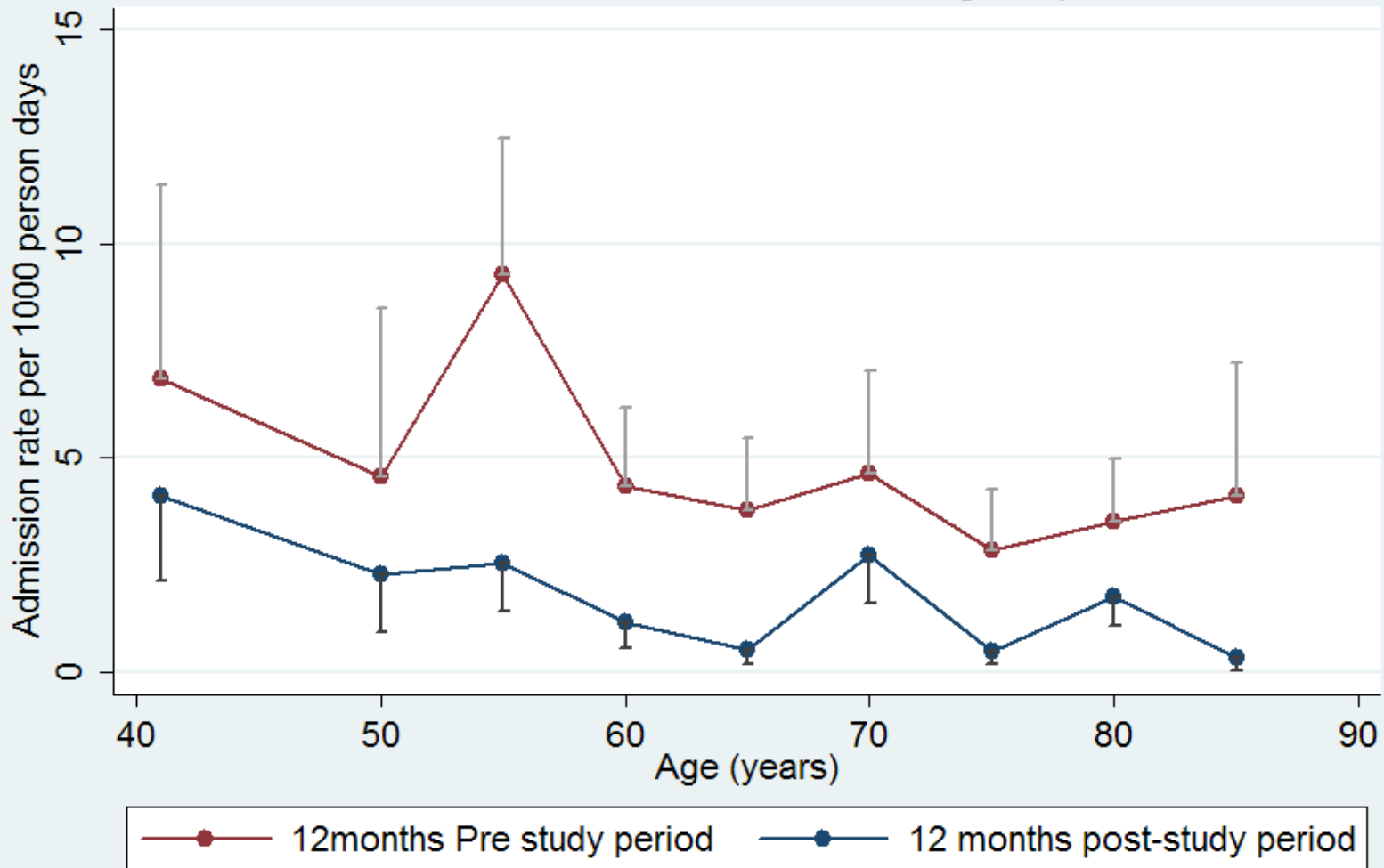
## **Exclusion criteria**

- living in residential care
- palliative/end stage of their disease process

# CDCP PATHWAY



Rate of admissions Pre and Post Program periods



## ***Service reforms***

- local services that can link people in to other services on d/c
- quality services in line with evidence
- consistency of service & information
- consistent data for evaluation
- partnership with private, public & NGO funded providers of Allied Health services.
  
- **a virtual team**

# ***Accredited Provider Panels***

- built on clinical guidelines – what skills & knowledge required to better manage their chronic disease and prevent complications
- worked with professional associations to engage private therapists
- standards developed with private, DTC providers and acute sector staff
  - **Type of service**
  - **Dosage**
  - **Benchmark timeframes**

## ***Accredited Provider Panels contd***

- tender process & contracts
  - agree to work to common standards of quality and clinical guidelines, use agreed communication processes, data and to be accessed through a common entry point

# ***Accredited Provider Panels -benefits***

- providers are located across a wide geographical area allowing access to services close to people's home & links to additional services
- offering a wide variety of services – **value added features**
- ongoing program of education re evidence based practice in chronic disease management
  - **learn more about each other's roles,**
  - **enhance their own practice and**
  - **encouraged consistency of information and practice**
  - **development of new services**



- Increasing capacity & linking sectors
  - **promoted to GPs & other referrers**
  - **clear information flow between the acute & community sectors**

- **18 providers**
- **23 sites across the region + home visits**
- **PT**
- **OT**
- **Speech**
- **D+N**
- **Pod**
- **SW**

## ***Next steps***

- continue to increase the choice of providers for services; build on the public/NGO/private partnerships, extend enrolment sites to more of SPH supported by workforce development
- panels to include:
  - **physical activity programs**
  - **falls prevention services and assessment**
  - **disease specific CDSM**
  - **other aged related allied health services**

# ***Questions***

## **Contact details**

**Jeanette Walters**

**PH: (08) 8201 7814**

**[jeanette.walters@sahs.sa.gov.au](mailto:jeanette.walters@sahs.sa.gov.au)**

