Government of South Australia
Southern Adelaide Health Service

southern health

Southern Adelaide Health Service
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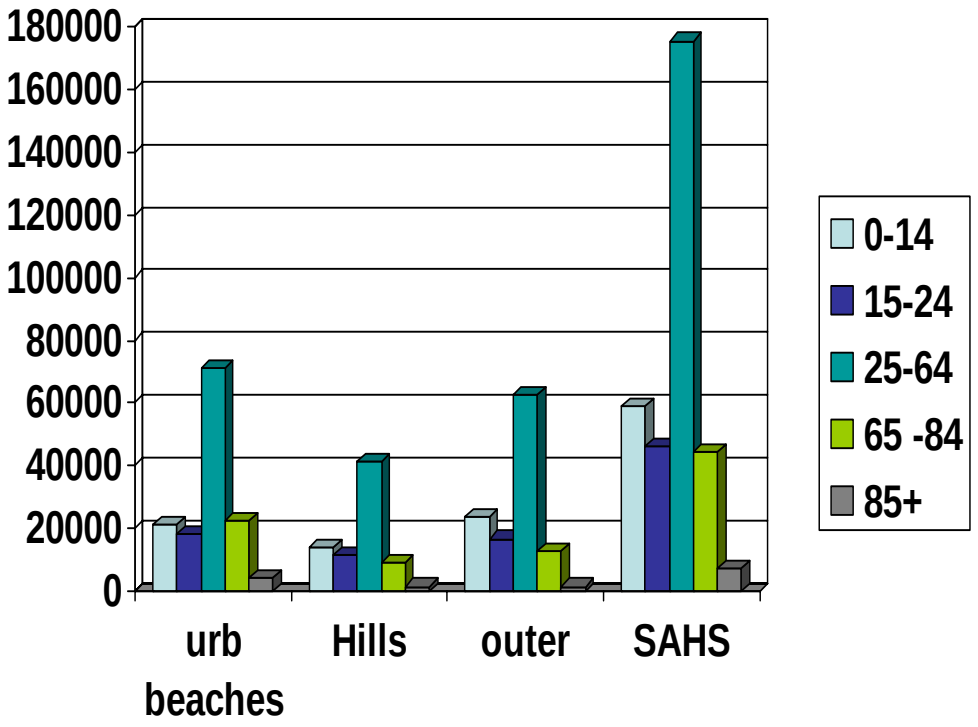
Program Manager, Demand Management

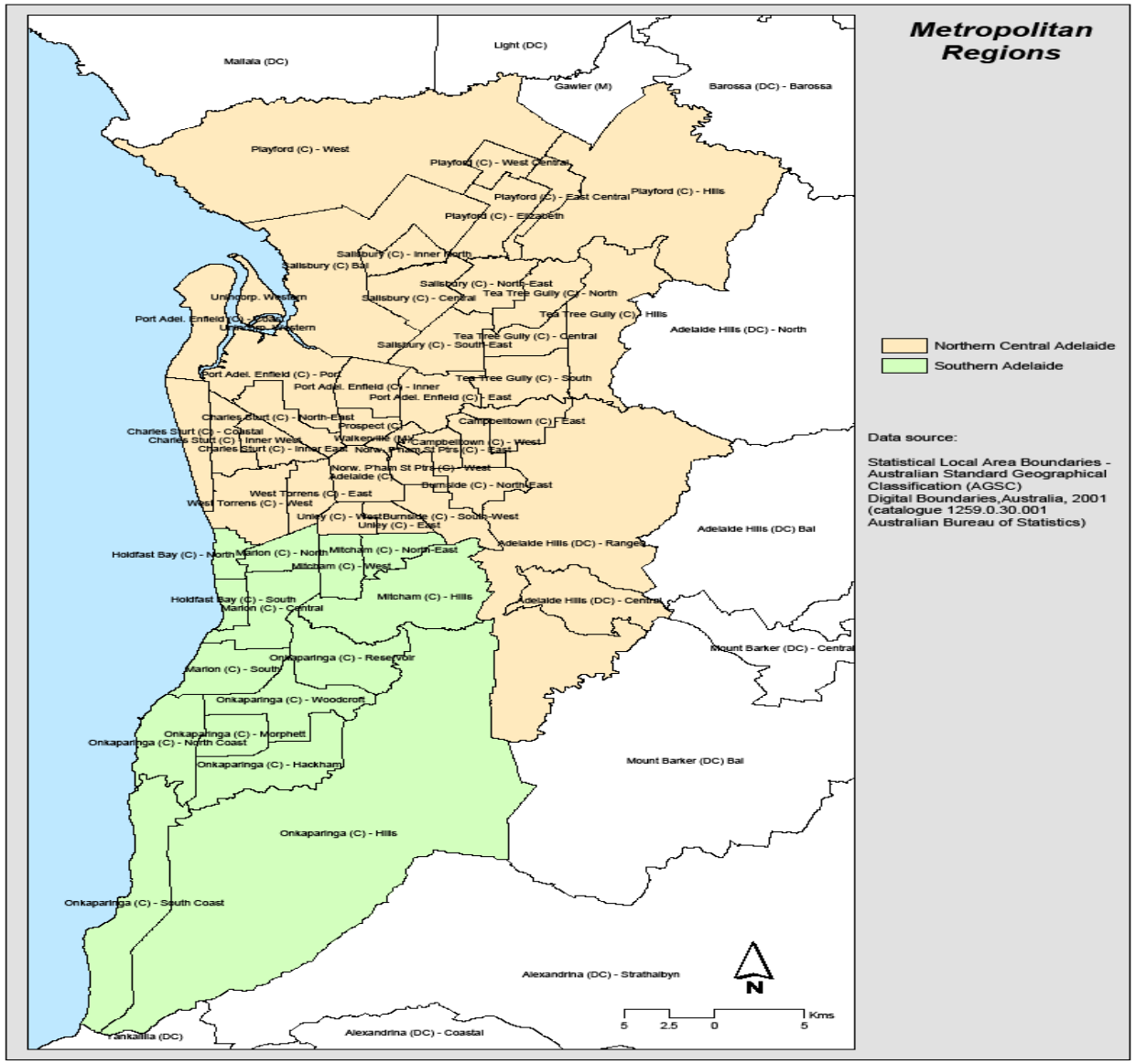
Outline

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

Southern Adelaide region

- Southern metropolitan Adelaide
- 1/5th 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




Metropolitan Regions
Mallala (DC)
Light (DC)
Gawler (M)
Barossa (DC) - Barossa
Playford (C) - West
Playford (C) - West Central
Playford (C) - East Central
Playford (C) - Hills
Playford (C) - Elizabeth
Salisbury (C) - Inner North
Salisbury (C) Bal
Salisbury (C) - North-East
Salisbury (C) - Central
Tea Tree Gully (C) - North
Tea Tree Gully (C) - Hills
Adelaide Hills (DC) - North
Tea Tree Gully (C) - Central
Salisbury (C) - South-East
Tea Tree Gully (C) - South
Port Adel. Enfield (C) - Port
Port Adel. Enfield (C) - Inner
Port Adel. Enfield (C) - East
Campbelltown (C) - East
Campbelltown (C) - West
Norw. P'ham St Ptrs (C) - East
Norw. P'ham St Ptrs (C) - West
Burnside (C) - North-East
Burnside (C) - South-West
Adelaide Hills (DC) - Ranges
Adelaide Hills (DC) Bal
Adelaide Hills (DC) - Central
Mitcham (C) - North-East
Mitcham (C) - West
Mitcham (C) - Hills
Mount Barker (DC) - Central
Onkaparinga (C) - Reservoir
Onkaparinga (C) - Woodcroft
Onkaparinga (C) - Morphett
Onkaparinga (C) - North Coast
Onkaparinga (C) - Hackham
Mount Barker (DC) Bal
Onkaparinga (C) - Hills
Onkaparinga (C) - South Coast
Alexandrina (DC) - Strathalbyn
Alexandrina (DC) - Coastal
Yankalilla (DC)
Northern Central Adelaide
Southern Adelaide
Data source:
Statistical Local Area Boundaries - Australian Standard Geographical Classification (AGSC) Digital Boundaries,Australia, 2001 (catalogue 1259.0.30.001 Australian Bureau of Statistics)
N
5 2.5 0 5
Kms

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

SA Govt funded hospital avoidance strategy:

- reduce rate & number of unplanned hospital admissions
- improve population & individual health outcomes

by

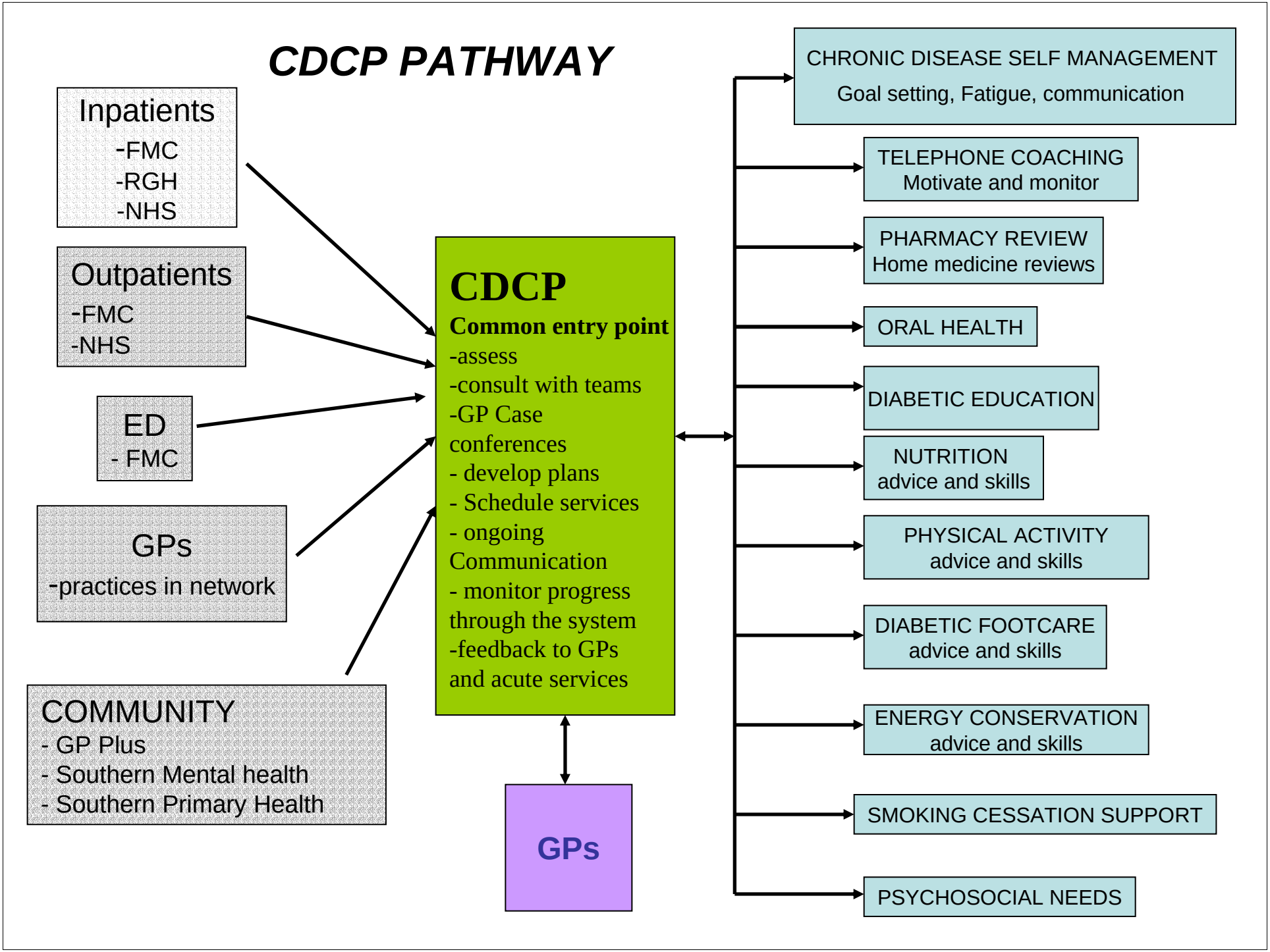
- actively supporting people to engage in self management of their chronic disease
  - **local services**
  - **clear communication between all providers incl GPs**
  - **patient/client involvement at all stages of care pathway**

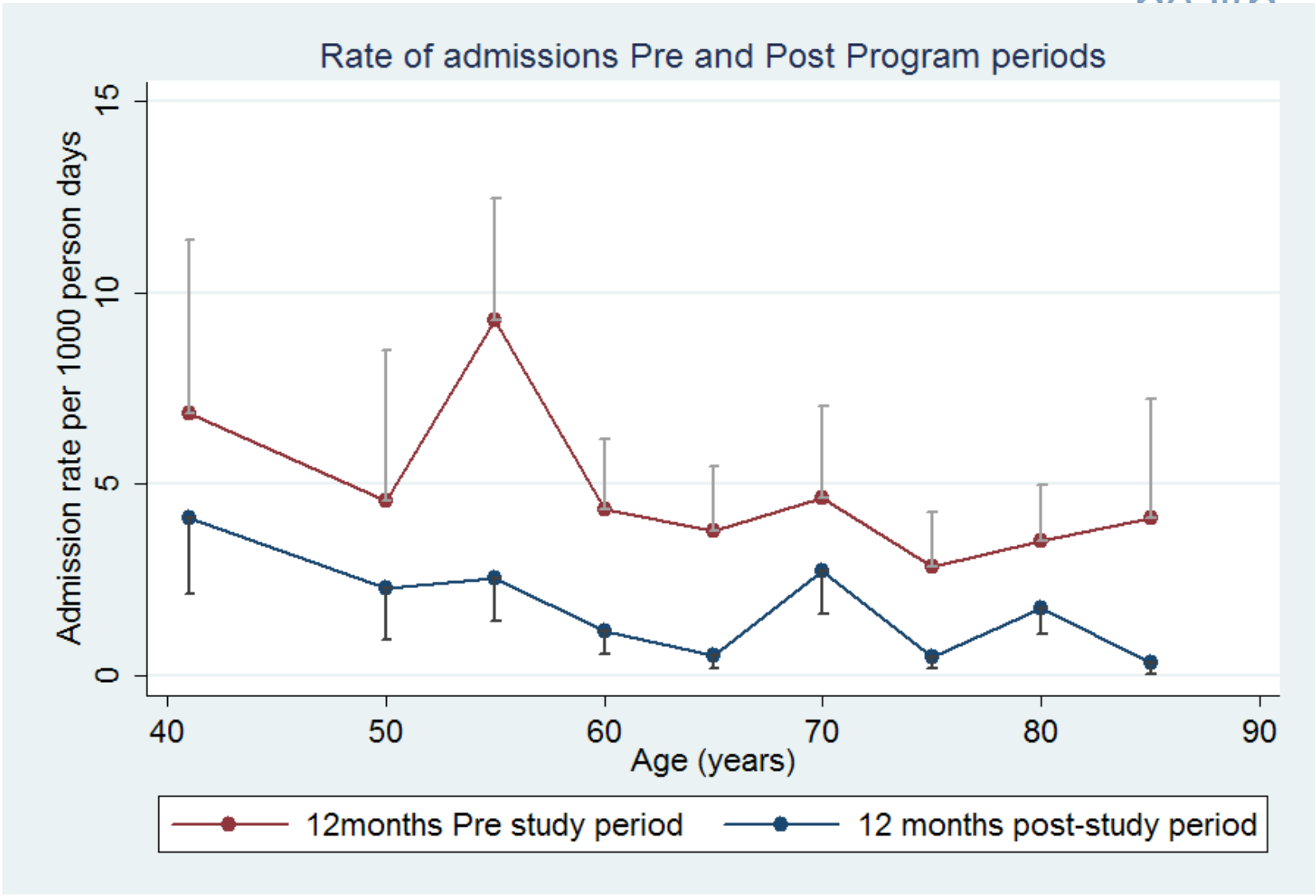
Eligibility

- 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
Inpatients
-FMC
-RGH
-NHS
Outpatients
-FMC
-NHS
ED
- FMC
GPs
-practices in network
COMMUNITY
- GP Plus
- Southern Mental health
- Southern Primary Health
CDCP
Common entry point
-assess
-consult with teams
-GP Case conferences
- develop plans
- Schedule services
- ongoing Communication
- monitor progress through the system
-feedback to GPs and acute services
GPs
CHRONIC DISEASE SELF MANAGEMENT
Goal setting, Fatigue, communication
TELEPHONE COACHING
Motivate and monitor
PHARMACY REVIEW
Home medicine reviews
ORAL HEALTH
DIABETIC EDUCATION
NUTRITION
advice and skills
PHYSICAL ACTIVITY
advice and skills
DIABETIC FOOTCARE
advice and skills
ENERGY CONSERVATION
advice and skills
SMOKING CESSATION SUPPORT
PSYCHOSOCIAL NEEDS


Rate of admissions Pre and Post Program periods
Admission rate per 1000 person days
0
5
10
15
40
50
60
70
80
90
Age (years)
12months Pre study period
12 months post-study period

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

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