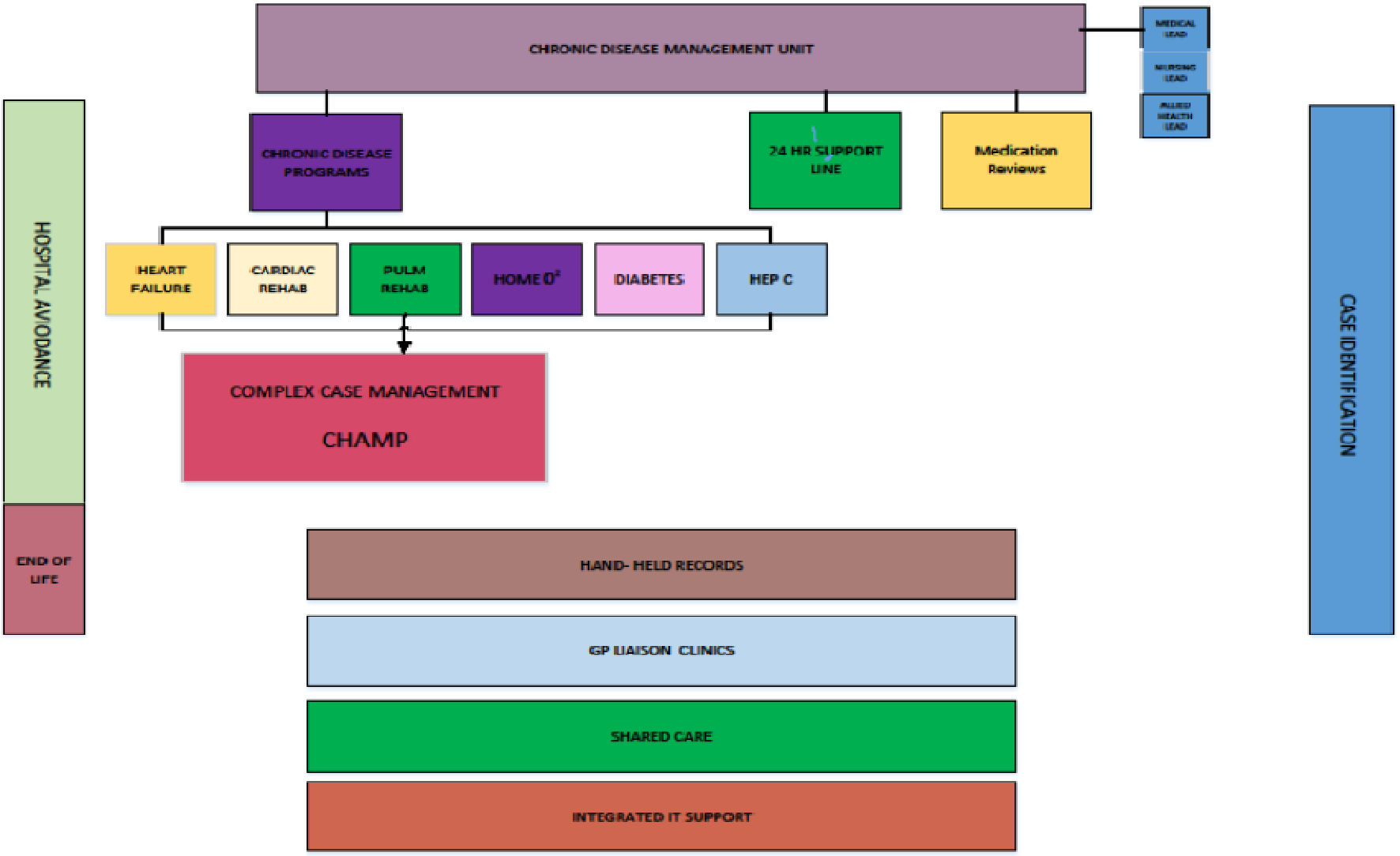
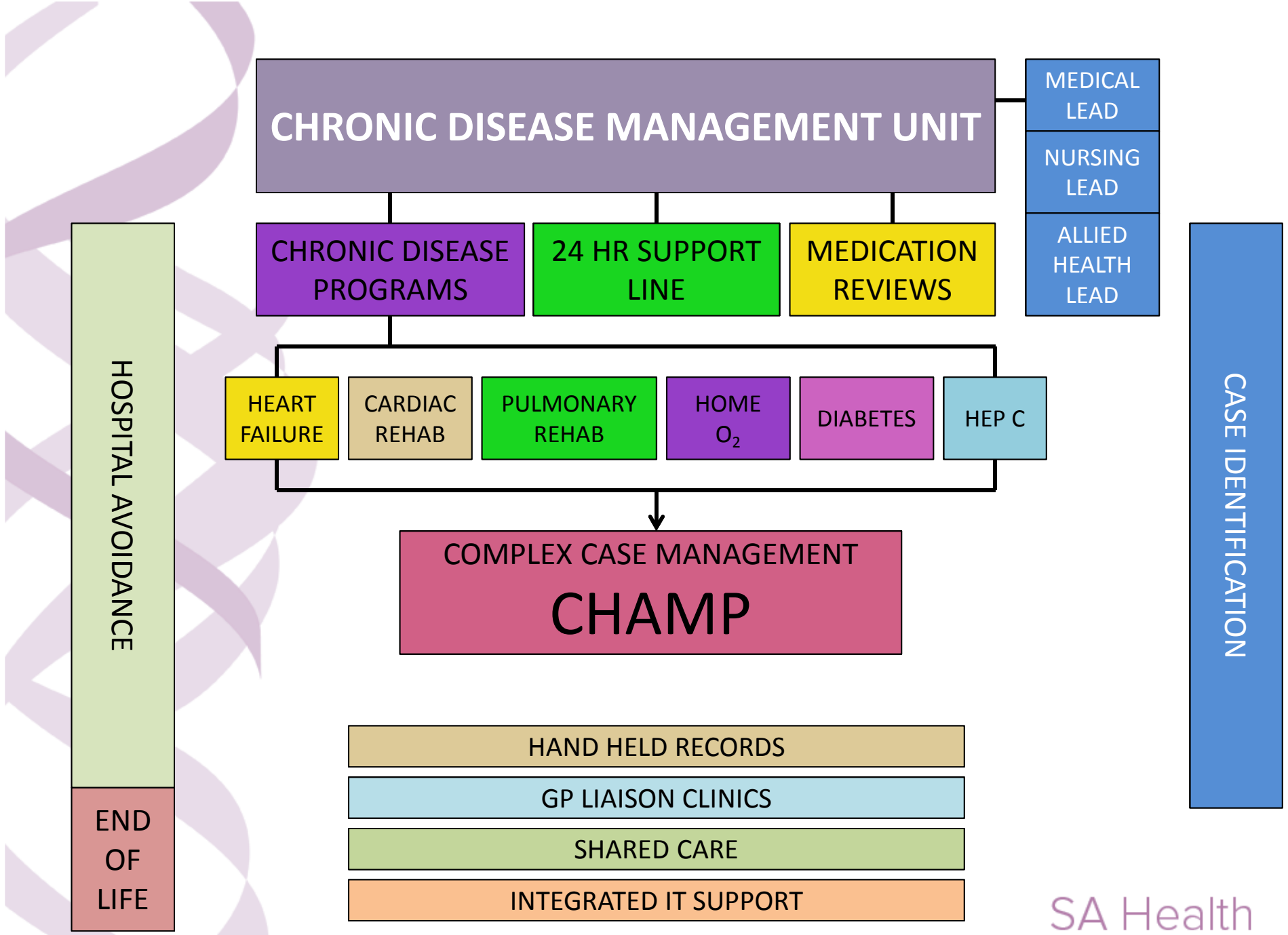
CHRONIC DISEASE MANAGEMENT UNIT

SA Health

Bob kept missing the point and was forced to wait around for the next one.

Chronic Disease Management Unit




CHRONIC DISEASE MANAGEMENT UNIT
MEDICAL LEAD
NURSING LEAD
ALLIED HEALTH LEAD
CHRONIC DISEASE PROGRAMS
24 HR SUPPORT LINE
MEDICATION REVIEWS
HEART FAILURE
CARDIAC REHAB
PULMONARY REHAB
HOME O_2
DIABETES
HEP C
COMPLEX CASE MANAGEMENT
CHAMP
HOSPITAL AVOIDANCE
END OF LIFE
CASE IDENTIFICATION
HAND HELD RECORDS
GP LIAISON CLINICS
SHARED CARE
INTEGRATED IT SUPPORT

SA Health

"It's fine to discover cures, but, remember, chronic conditions are our bread and butter."

Respiratory Services

-Medical
-Nursing
-Pulmonary Rehab Physiotherapy
-Allied Health discipline 1:1 and group intervention

Direct interface with tertiary services
eg. Resp Nursing, Home O2, PFT.

Diabetes Services

-Nursing
-Allied Health discipline 1:1 and group intervention
Direct interface with tertiary services
eg. Hospital Diabetes Centre, Endocrinology, Multi-disciplinary High Risk Foot Clinic

CHAMP

Case coordination and self management support for 'high admission risk' disease service patients (plus 'vulnerable' with other Chronic Disease)

Heart Failure Services

-Medical
-Nurse Practitioner
-Exercise Physiology
-Allied Health discipline 1:1 and group intervention
Direct interface with tertiary services
eg. Cardiology

Hep C Services

-Nursing
-Allied Health discipline 1:1 and group intervention
Direct interface with tertiary services
eg. Gastroenterology, Infectious Diseases.

Outcomes – Medical Subspecialties

- Diabetes

  -234 emergency reviews preventing admission or ED presentation

  -1200 insulin stabilisation episodes facilitating early discharge and preventing readmission

- Chest pain

  -658 inpatient admissions prevented

Outcomes – CHAMP

(Early indicators)

- Cohort of 60 patients for whom full data has been analysed
- Comparison of equivalent period pre and post program (median 5 months)
- Admissions
  - Admissions dropped from 135 to 64 (53% reduction)
- OBD
  - 518 days pre to 345 post program (33% reduction)

"It was very beneficial, very useful, I learned how to deal with asthma and diabetes management better and am now I'm looking at building my life by addressing my relationships, depression, self esteem and life ahead in general"

Hospital Avoidance and readmission prevention

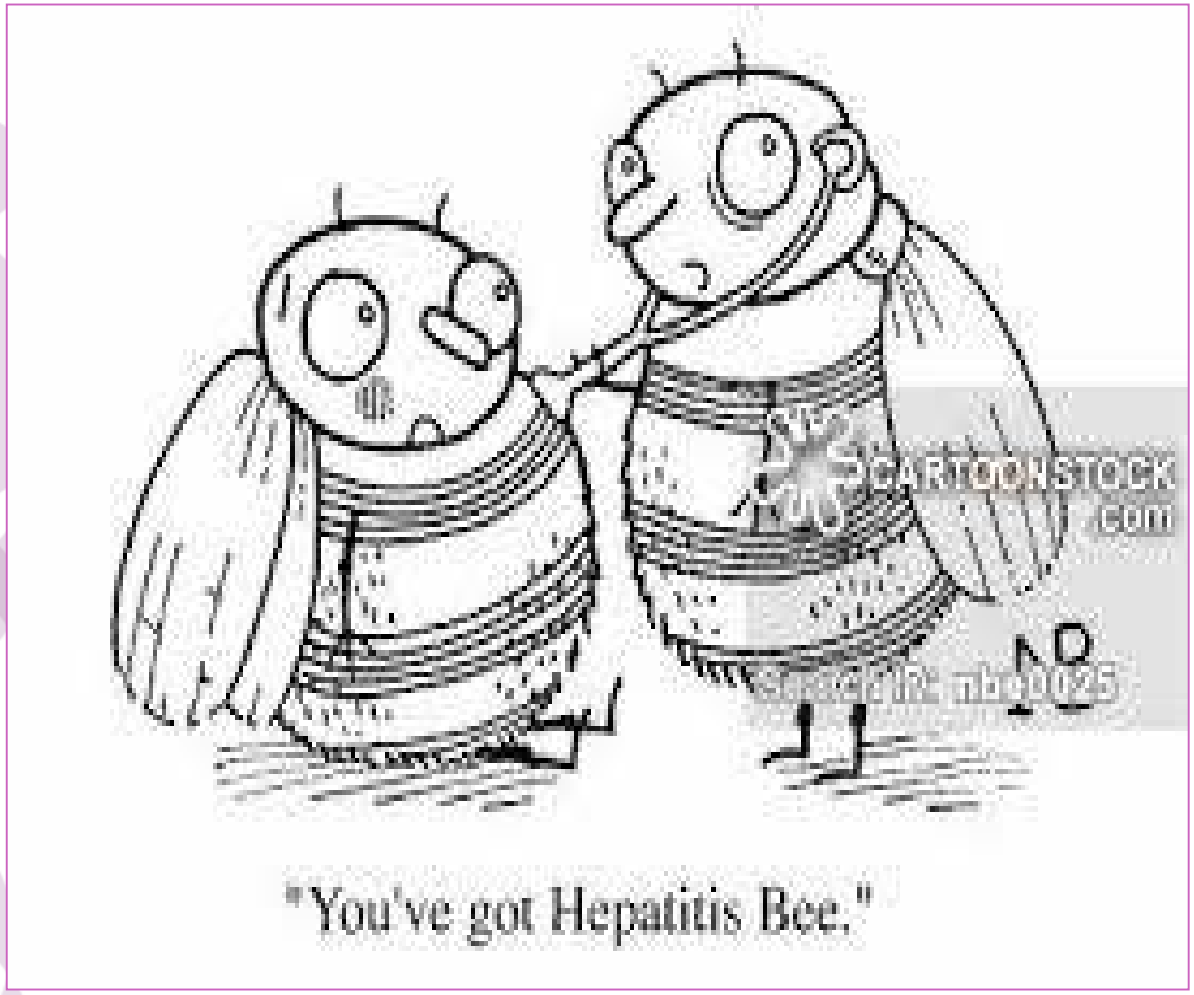
- QAC
- Hospital in the Nursing Home
- Post-Hospitalisation Support
  - 20% of vulnerable patients readmitted within 30 days
  - Phone call
- Discharge Readiness Assessment
- End of Life
- Care Pathways: Cellulitis

Patient Identification

- Aboriginal Pathways
- Models of identifying high risk patients
  - LACE screening toll
  - Mayo screening tool

Next Steps for CDMU

- Criteria for entry AND EXIT!
- Engage GPs
- Single referral pathway
- Develop tools
- End of Life


"You've got Hepatitis Bee."