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Message from the Editor:

As this second issue comes off the press and lands on your desk the ambulatory care website will be up and running. You can visit the site at www.health.wa.gov.au/HealthyatHome

At this early stage the website serves to introduce the community-based programs run by the Department of Health in the Perth metropolitan area. As the site evolves, more information about services will be added along with links to each of the various programs.

With the current focus in the media on hospital waiting lists and bed shortages, ambulatory care services have a pivotal role in reducing avoidable hospital presentations. In searching for articles for this second newsletter, there was no shortage of high quality non-inpatient healthcare services to be promoted and good news stories to be shared with the broader health community.
Five-year-old Georgia Dimitrovich has received the necessary medical treatment for Osteomyelitis in the comfort of her own home, thanks to Princess Margaret Hospital’s (PMH) new Hospital in the Home (HITH) program launched earlier this year.

Georgia’s mother Vanessa said they were referred to see a specialist at PMH, and initially Georgia was admitted as an inpatient to the hospital.

“Georgia spent a week tucked up in a hospital bed before doctors suggested that she was ready to take advantage of the HITH program,” Vanessa said.

“The doctor explained the program and I felt comfortable about taking Georgia home.

“The doctor said that Georgia would have a port put into her arm so that the intravenous antibiotics could be given to her at home.

“We now have the nurse visit us every day to check on her, make sure her antibiotics are working and to assess her general well being.

“It has been fantastic that we didn’t have to stay another two weeks in the hospital. Also, having a two year old at home, running back and forwards to the hospital was really difficult.

“It’s been great for Georgia, she is more comfortable in her own home and she is a lot happier and more settled.”

A trial of the HITH program that has been running since October last year has already seen more than 100 PMH patients treated at home, freeing up more than 500 hospital bed days for other patients.

Anyone interested in applying for Hospital in the Home should discuss the program with PMH doctors and nurses.

For more information about Hospital in the Home call 9340 8201.
COPD: ‘O is for Optimism’

Chronic Obstructive Pulmonary Disease (COPD) is an important disease in our community. It is important because it is common. It is estimated to affect up to one in six people aged over 45, and this number will rise exponentially with the ageing of our population. It is the fifth leading cause of death in Australia.

COPD is important because it is expensive. The Australian Lung Foundation estimates that it costs the health system between $800-$900 million each year. Every day, 1000 COPD patients occupy Australian public hospital beds with an average cost of $3700 per admission and an average length of stay of 7.5 days.

Most significantly however, COPD is important because it greatly impacts on sufferers - our patients - in terms of the symptoms experienced, a reduced quality of life, admissions to hospital and premature mortality. It is the third biggest contributor to disease burden, behind stroke and heart disease, in the Australian community.

The good news is that there is cause for optimism. People with COPD have often been given a raw deal from health professionals, the health system and society in general. It was often considered to be a largely self-inflicted, incurable disease for which there were no effective treatments. This is not the case any longer.

The Australian Lung Foundation and the Thoracic Society of Australia and New Zealand have developed a set of management guidelines, the COPD-X Plan, as part of a national COPD program (www.copdx.org.au). One of the aims of these evidence-based guidelines is to shift the emphasis from pharmacological treatment of COPD to a range of interventions including patient education, self-management of exacerbations and pulmonary rehabilitation.

Even a quick glance at the summary of the guidelines gives cause for optimism. There is level ‘A’ evidence (considered to be the highest level of evidence gathered from multiple well-designed randomised control trials) for a significant proportion of the key recommendations involving strategies that improve lung function and prevent deterioration. One of the most important developments in the management of COPD in the past 10 years has been the establishment of Pulmonary Rehabilitation as the cornerstone of modern COPD management. Pulmonary Rehabilitation has been shown to reduce shortness of breath, anxiety and depression, improve exercise capacity and quality of life. It may also reduce hospitalisation.

That leads on to the second reason for optimism for people with COPD in Western Australia. Through the Healthy@Home (Chronic Disease Management Teams) program, there are now eight new community-based Pulmonary Rehabilitation teams available to patients. This is a significant new initiative that complements existing hospital-based programs and maintenance community physiotherapy programs. Importantly, general practitioners can refer directly to the Healthy@Home program to access Pulmonary Rehabilitation for their patients.

One of the barriers to management of COPD in Australia is a lack of knowledge among patients and health professionals of proven, effective treatments for COPD. Everyone involved in the management of these patients is encouraged to visit the COPD-X website. It is easy to navigate, easy to understand and gives an up-to-date summary of modern evidence-based COPD management.

The take home message: ‘O is for Optimism’ and ‘P is for Pulmonary Rehabilitation’. Refer your patients today! (1300 855 841)

For more information contact Helen Bell:
Helen.Bell@health.wa.gov.au
Success of the COPD Community Linkage Service

Chronic Obstructive Pulmonary Disease (COPD) is one of the commonest disabling conditions in the community. In the early 2000s, hospital doctors and general practitioners were grappling with how to improve the care of patients with COPD. It was felt the emphasis should be on prevention (smoking cessation, diagnosis and early management) and keeping people out of hospital; services best provided in the community.

Director General Dr Neale Fong launched the COPD Community Linkage Service in February 2006. The Service is a collaborative venture between the South Metropolitan Area Health Service (Royal Perth Hospital), and the Canning and Perth and Hills Divisions of General Practice. Importantly, the Service is multidisciplinary, involving respiratory nurses, physiotherapists, a respiratory physician, and support staff.

The components to the COPD Community Linkage Service are:

1. **COPD Linkage nurse service**
   - Patient surveillance and case management in the home
     - General Practitioner-specialist-hospital linkage
     - Early hospital discharge support
     - Patient education such as inhaler techniques and oxygen therapy
     - Encouragement of self-management strategies
     - Practice nurse education.

2. **Community-based multidisciplinary COPD clinics at the Divisions of General Practice providing:**
   - Respiratory physician review
   - Physiotherapist review Pulmonary Rehabilitation programs, education on sputum clearance techniques, breathing control techniques and home exercise programs
   - Respiratory nurse review
   - Ventilatory assessment.

3. **Community pulmonary physiotherapy rehabilitation Services**

4. **Patient support groups**

5. **Chronic disease self-management courses and links to smoking cessation courses**

6. **Education of General Practitioners and practice nurses.**

After 15 months of service, 431 patients are registered with an average of 29 new referrals each month. There is evidence of reduced hospital admission rates for those patients in the Service. Two patient support groups have been established, five 6-week Chronic Disease Self-Management Courses have been run and multiple education events have been provided at the Divisions of General Practice involving GPs and practice nurses.

Patient feedback has been very positive, “After years of wheezing and shortness of breath, I feel like a new person.”

For more information contact Sean Mulligan on 9458 0570 at the Canning Division of General Practice.

Live Life Clubs - Canning Division of General Practice

If you have patients who are older than 50 years and are interested in meeting new people while also learning about their health, then attending a Live Life Club may be just the thing for them!

The Canning Division of General Practice supports and coordinates the Live Life Clubs that are currently located in Belmont and Gosnells. The Clubs provide social and educational support for people aged over 50 living with chronic conditions such as diabetes, heart conditions and arthritis.

Since establishment five years ago, members have assumed responsibility for selecting topics to be presented at the monthly meetings and have set up a committee to organise meeting activities.

Professional guest speakers are invited to talk on a wide range of health and lifestyle issues including diabetes, natural therapies, safety for seniors, Tai Chi and healthy eating.

Doreen Owens has been attending the group for more than four years and encourages all seniors to come along.

“The Live Life Club provides a great opportunity to meet new people and learn more about managing your health and wellbeing,” Doreen said.

For further information contact the Program Officer for Chronic Disease Sheryl Huizenga at the Canning Division of General Practice (Ph 9458 0530).

The Australian Lung Foundation

The Australian Lung Foundation (ALF) focuses on improving the understanding, management and relief of lung disease. Established in 1990 by a group of thoracic physicians, the organisation relies on sponsorship, fund-raising and donations.

Activities include:
- educating patients and the general public about lung disease
- supporting health professionals working with respiratory illnesses
- bringing together key opinion leaders in lung disease through committees, and communicating the latest findings
- government lobbying for changes to health policy and greater recognition of lung disease
- fund-raising for research into lung disease.

Australian Lung Foundation Areas of Interest include:

1. **Chronic Obstructive Pulmonary Disease**
   - www.copdx.org.au
   - www.pulmonaryrehabilitation.com.au

2. **Lung Cancer**

3. ‘Orphan’ Lung Diseases (parenchymal lung disease)

4. **Respiratory Infectious Diseases**

LungNet, a community-based project providing national support to patients, health professionals and the general public, supports all ALF projects and areas of interest. LungNet services include:
- toll-free information and support line
- free quarterly newsletter
- network of self-help patient support groups
- links to pulmonary rehabilitation programs Australia-wide
- disease-specific patient information brochures
- website - www.lungnet.com.au
- annual patient education seminars throughout Australia.

Contact LungNet on 1800 654 301 or via email enquiries@lungnet.com.au
Autumn Edition 2007

Metropolitan heart failure workshop

A metropolitan heart failure workshop was held at SCGH in February to review the recently updated Chronic Heart Failure (CHF) guidelines.

The ambulatory care Chronic Disease Management Teams (CDMTs) worked in collaboration with the National Heart Foundation and the West Australian Health and Cardiac Rehabilitation Association (WAHCRA) to showcase the guidelines to those working in cardiac health in WA.

Doctors believe that CHF is under diagnosed. Statistics show that more than 300 000 Australians are affected by heart failure. Approximately one-third of these people are hospitalised each year. Two-thirds of these hospitalisations are preventable. The figures demonstrate the clear need for community-based care and self-management programs such as the CDMTs.

The CHF guidelines were updated in November 2006 to provide current and evidence-based practice recommendations for the prevention, early diagnosis and optimal management of CHF.

Speaking at the meeting, SCGH cardiology fellow Arieh Keren said that CHF is sometimes reversible and could be partly managed by lifestyle factors such as diet and exercise.

“The guidelines emphasise non-pharmacological management and multidisciplinary care as being just as important as pharmacological methods of care,” he said.

Effective medical management together with multidisciplinary care, physical activity programs, patient and carer education in self-management, and improved access to advice and support will slow progression, minimise exacerbations, prevent complications, relieve symptoms, improve quality of life and prolong survival. In addition, there are improved clinical outcomes and reduced cost burdens to the health system.

CHF affects more than 300 000 Australians at any one time

- Approximately one-third are hospitalised each year
- Two-thirds of the hospitalisations are preventable
- 30 000 new cases are diagnosed each year
- 10 per cent people aged 65 years and older have CHF
- More than 50 per cent of people aged 85 years and older have CHF
- CHF is one of the most common reasons for hospital admission and GP consultation in people aged 70 years and older
- CHF is under-diagnosed in primary care
WA Health has introduced high quality, multidisciplinary care in the community to help people with chronic conditions better manage their health. There are eight CDMTs in the metropolitan area and they are working to improve quality of life for participants whilst reducing avoidable ED presentations and inpatient admissions.

Royal Perth Hospital (RPH) cardiac patient Peter Welling is a great example of someone who has benefited from the guidelines. Peter suffered a heart attack 18 months ago and was admitted to RPH. He was involved in the workshop as a live case study.

“I was a smoker, I had a cigarette on the way to the hospital,” Peter said.

“I had high cholesterol, loved salty foods and was overweight. I was active in life but I didn’t exercise.

“If I had had regular checkups with my GP, the heart disease could have been identified earlier or I could have been able to do things to prevent the heart disease progressing to the point that it did.

“However, the guidelines have made me get up and do something about my situation. Now I exercise at the gym, I have bought myself a treadmill for home and I watch my diet, especially my salt intake.”

Peter has learnt to self manage his medication. He knows what purpose each medicine has and the effect that they have on his condition. Peter monitors his cardiac health daily and works with his cardiologist to alter his medication according to his condition at the time.

The workshop was very successful in raising awareness of the guidelines and using live case studies and an expert panel to demonstrate best practice for the prevention, diagnosis and management of CHF. Another benefit of the day was the formation of ‘healthy partnerships’ between cardiac health providers within and across the hospital and community sector, working towards achieving a more integrated health care system.

For more information contact Jemma Watson on 0420 305 124 or by email: jemma.watson@health.wa.gov.au

Jayne Williams (CNS for the Rockingham/Kwinana Chronic Disease Management Team) was a member of the expert panel at the heart failure workshop.

Jayne qualified as a Registered Nurse in 1991 in Wales, UK. After two years as a Coronary Care Unit (CCU) nurse she commenced a working holiday in Australia, Asia and India in the areas of cardiology, aged care, and AIDS/HIV. In 1998 Jayne completed a Diploma of Higher Education in Specialised Nursing at John Moores University, Liverpool.

As Ward Manager she was involved in NHS Clinical Practice Benchmarking (CCU) for the North West of England and developed a Preceptorship Program for CCU staff at Manchester Royal Infirmary. In 2003 she began work at Fremantle Hospital as a Clinical Nurse and Staff Development Nurse for the CCU, the Cardiac Catheter Laboratory and Teacher Practitioner for the Post Graduate Critical Care Course Students. Jayne has a passion for caring for heart failure patients that has led her to her current position with the CDMT.
Eighty-five per cent of the population visit a GP at least once a year\(^1\). In the latest Bettering the Evaluation And Care of Health (BEACH) study into general practice activity across Australia, GPs on average managed 1.5 problems per 15-minute encounter. At more than 10 per cent of consultations three or more problems were managed. The every day reality for most GPs is managing a high level of complexity which requires consideration of the physical, emotional and social dimensions of the person, the preventive and curative aspects of care and the individual, family and community levels of practice, all within very limited time and resource constraints\(^2\).

As the current and future impact of chronic disease is increasingly recognised across the health system, the rate of management of chronic disease in Australian general practice has also continued to increase\(^3\). General practice remains the major point of continuity of care in the community with most people in Australia identifying their own regular GP\(^4\).

GPs must be prepared to deal with the broad range of material, that is whatever the patient brings through the door. McWhinney states that GPs, unlike any other group in medicine, are committed to the person rather than to a particular body of knowledge, group of diseases or special technique\(^5\). The starting point of everything is patients, who they are, their problems in the context of their life circumstances, and how they cope and view their illness. GPs therefore tend not to think of a group of patients with a specific disease, but of a person who has a collection of problems and circumstances.

With an increasing prevalence of chronic disease in general practice, an ageing population, increasing complexity in care, greater awareness of health issues among the general public, changing workforce and information management trends, general practice systems have evolved over the years. GP organisations such as Divisions of General Practice have been involved in the establishment of programs that aim to help GPs in the management of diabetes, respiratory and other chronic diseases.

So what does this mean in terms of communicating with GPs to improve care?

- GPs need timely information about their patients who have had contact with other parts of the health system to ensure that good follow up care occurs.
- GPs are time poor. Use succinct methods of communication.
- Use and be prepared to receive information that is generated electronically. Nine out of 10 GPs in the 2005-06 BEACH study used a computer, the majority using it for prescribing, ordering tests and keeping patient data in an electronic medical record. Two out of three use email and internet at the major practice address\(^6\).
- Make use of the network of GP liaison officers in the various health areas and local Divisions of General Practice to provide advice on effective communication with GPs.

Dr Moira Sim
Liaison GP, NMAHS Chronic Disease Team and Osborne Park Hospital

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2. Medalie, J.H. (1978 ). Family medicine: Principles and applications (pp. 18, Figure 1.2). Baltimore: Williams and Wilkins.
Getting better faster

Adapting to Culture

The Vietnamese Diabetes Self-management Program Experience
(Healthy@Home - Chronic Disease Management Teams)

In 2006, the Chronic Disease Management Team (CDMT) ventured into new territory in response to receiving referrals for Vietnamese speaking clients. Nga Tran, Vietnamese Diabetes Support Officer, conducted the diabetes self-management program with support from the team clinical nurse specialist (CNS), social worker and dietician.

Some observations from the health worker perspective:

All participants mentioned that the number of people involved with their care overwhelmed them. Since diagnosis with diabetes, they had visited their GP for medication and blood tests. Now they had met the multidisciplinary team, which included a CNS, dietician, physiotherapist, podiatrist and social worker.

The program developed by the team was adapted to the Vietnamese culture mainly in the area of nutrition. A trip to the Vietnamese supermarket to purchase Asian groceries proved worthwhile as participants could understand the fat, sodium and fibre content contained in the food they eat everyday by reading labels on the nutrition information panels.

All clients enjoyed the different types of exercises emphasising flexibility, strength, balance, and cardiovascular fitness. One lady who had never been in a pool before found the exercise in the water very scary at first, but just a few laps later she joined the group unaided, without fear.

On completion of the program, telephone follow-up was used to assist participants to reach their target levels for key risk factors for their health. The diabetes management book the clients received during the program allowed the clients to obtain their results from their GP, which they hadn’t previously asked for or received. Most of the clients had raised HbA1c when they commenced the program. After following the recommended dietary guidelines and adjusting their lifestyle activity (i.e. stop smoking) they have achieved the recommended <7% HbA1c goal.

Nga Tran, Vietnamese diabetes Support Officer

For further information contact the CDMT:
1300 855 841
Jenny Duff (Clinical Nurse Specialist (CNS) for the Perth and Hills Chronic Disease Team) facilitated the Vietnamese group.

Jenny completed her nursing degree at the Royal Melbourne Hospital in 1976 and practiced in rural hospitals throughout Victoria, moving to WA in 1988. Jenny worked as a practice nurse in Midland before becoming involved in a two-year trial run by Dr Woollard, RPH and UWA. The aim of the trial was to see if practice nurses who were up-skilled with clinical knowledge and trained in motivational interviewing could have a better effect at obtaining behavioural change in clients who had diabetes or heart disease. Jenny later worked in the diabetes education unit at Fremantle Hospital and completed a post graduate certificate in diabetes education from Curtin University. Jenny also worked for Diabetes Australia (WA) running the DIAL diabetes advice line and as diabetes educator at Swan Districts Hospital and Lockridge community centre. In 2006 Jenny was appointed as CNS for the CDMT. She has been involved in establishing the diabetes self-management program.

In March Jenny presented at the ADEA conference in Busselton, showcasing the adaptation of the chronic disease self-management program for Vietnamese clients. She has also won the Sanofi-aventis International Conference Award and will be attending the International Diabetes Conference in Amsterdam in September.

Jenny Pearce (senior dietician at the Perth and Hills and Joondalup CDMT) was responsible for the Curtin University student placements.

Jenny is a Dietetic graduate of Curtin University. She has also qualified in Health Service Management and as a Sports Dietitian and Diabetes Educator. She has many years experience in rural practice as sole clinical/community dietitian, coordinator of diabetes programs, and Acting Area Senior Dietetics. She developed a passion for nutrition and chronic disease management, which resulted in recruitment to the CDMT in 2006. She has been involved in establishing the dietetics service. Jane has commenced her Masters of Dietetics, looking at client behaviour change as a result of completing the six-week COPD self-management program. Jane sits on the National Dietetics Association of Australia Dietetic Standards and Accreditation Advisory Committee and DAA(WA) Executive. Jane will be presenting ‘Incorporating Dietetics Into Chronic Disease Teams’ at the National Dietetics Association of Australia conference in Hobart in May.
In 2006, the Chronic Disease Management Team (CDMT) commenced student placements, with four students from the Curtin University of Technology, Postgraduate Diploma in Dietetics spending four weeks with CDMT for their community placement. Developing this relationship with the School of Public Health Nutrition and Dietetics Program allows Dietetics students to experience working in a community health setting and participate in all aspects of program delivery, as well as conducting their own project work. The project work has contributed to the development of the service. Feedback from all students was positive and the Dietetics team is in the process of formalising future community placements.

Comments from students at the service in 2006:

We were fortunate to complete our community placement at Healthy@Home. Our major project was to design, run and evaluate a supermarket tour handbook, for future clients to use as a self-paced supermarket tour to practise their food label reading skills and instigate healthy changes to their diet. The highlight of our time at Healthy@Home was working within a multidisciplinary team. We participated in group education sessions, nursing, physiotherapy and podiatry assessments, and physiotherapy exercise sessions. Working with the team at Healthy@Home significantly increased our awareness of the role of all areas of healthcare and the benefits of working as a team to provide patient care.

Gemma Quayle and Eloise Carey

Perhaps most important to my future dietetic practice was the opportunity to work within a self-management ethos with the Healthy@Home team. I had grappled with this way of working as a health professional, however the significance of this philosophy grew rapidly as I watched the team working to empower and support the clients of their service. Seeing this multidisciplinary team giving people the coping skills to self-manage their conditions, it soon became very clear to me: it really is those people that self-determine and self-manage their health strategies that have the strength to cope with their disease. I was grateful for this affirmation as I aspire to commit myself in applying this ethos in my own future dietetic practice.

Patricia Crawford
The ROAMS initiative has been developed as part of the ambulatory care strategies for 2006/2007, to assist in minimising preventable presentations to the emergency department (ED) and managing demand strategies.

ROAMS has been established as a six-month trial that commenced in January. It is an acute ambulatory care/hospital in the nursing home service, providing residents from Residential Aged Care Facilities (RACF) with access to an acute medical team. The team comprises a doctor and a specialised acute care nurse, visiting the resident in the RACF to provide a medical assessment and diagnosis and to commence treatment.

Medical staff involved in the trial are selected general practitioners (GPs) and advanced trainees from the Rehabilitation and Aged Care department from the North Metropolitan Area Health Service (NMAHS). Nursing staff come from the Home Link team at Sir Charles Gairdner Hospital. The team carries equipment and medications to assist in providing a comprehensive acute assessment.

Access to the ROAMS team is via the Residential Care Line (Department of Health call centre) where the call from the RACF is triaged. If the recommendation is that the resident is seen by a doctor within four hours and the usual GP or Locum service is unavailable, then the ROAMS service is contacted. These patients would usually present to the ED.

In the NMAHS, 41 RACFs have access to the ROAMS. It is available Monday to Friday between the hours of 4 - 9 pm. This is when RACF staffing numbers are reduced and GPs are less likely to be available.

Consultation and Partnerships

Over the past three years, through the RCL initiative and with the development of the ROAMS initiative, a strong relationship has been developed between the residential aged care sector, acute care sector, primary care sector and the community care sector achieving many positive outcomes.

Engaging in extensive communication with widespread stakeholder groups; aged care peak bodies; NMAHS Rehabilitation and Aged Care; Joondalup Health Campus; Osborne Park Hospital, Sir Charles Gairdner Hospital; Department of Health; Locum services and Silver Chain has helped in understanding each area’s issues. Working together to integrate and not duplicate services will provide better outcomes for residents in RACFs.

For more information on the RCL or ROAMS program contact the Program Coordinator, Carol Douglas on 0404891022 or by e-mail, carol.douglas@health.wa.gov.au