The Sutherland Chronic Care Student Led Clinic Discipline and Community Services Information Manual

Developed by Man Fu Michael Tang (Project Co-ordinator) and Lauren Stanwell (Project Supporting Officer)

NSW GOVERNMENT Health
South Eastern Sydney Local Health District

Contents

Section 1

General Information on Chronic Disease

(Information adapted from the Australian Institute of Health and Welfare - Authoritative information and statistics to promote better health and wellbeing, 2013)

1.1 Diabetes

Diabetes is a chronic condition in which the body loses its ability to control the level of glucose (sugar) in the blood. Insulin is a hormone produced by special cells in the pancreas that helps the body to convert glucose from food into energy. People with diabetes either don't have enough insulin or their body cannot use insulin effectively, so glucose stays in the blood instead of being turned into energy, causing blood sugar levels to become high. Different insulin abnormalities cause different types of diabetes. Four main types of diabetes exist: type I diabetes, type II diabetes, gestational diabetes and other diabetes.

Type I Diabetes

Type I diabetes mainly occurs in children or young adults. In type II diabetes the body stops making insulin. Without insulin, the body cannot turn glucose into energy so it burns its own fats as a substitute and accumulate dangerous chemicals (ketoacidosis) in the blood which is potentially life-threatening if not treated.

Most cases of type I diabetes are caused by the destruction of the insulin-producing cells in the pancreas by the body's immune system. According to self-reported data from the 2007-2008 National Health Survey, around 10% of people with diabetes have this form of the disease.

Type II Diabetes

Type II diabetes is the most common form of diabetes. It occurs mostly in people aged 50 years and over and is becoming increasingly diagnosed in younger people. People with type II diabetes produce insulin, but cannot use it effectively or may not produce enough. Type II diabetes may initially be managed with changes to diet and exercise, and/or oral glucose-lowering drugs. People with type II diabetes may progress to needing insulin or a combination of these therapies if their condition cannot be managed through lifestyle changes and/or oral drugs. According to self-reported data from the 2007–2008 National Health Survey, Type II diabetes accounts for 87% of all people with diabetes.

Gestational Diabetes Mellitus

Gestational diabetes mellitus is a form of diabetes that can develop during pregnancy. It involves high blood sugar levels appearing for the first time during pregnancy in women not previously diagnosed with other forms of diabetes. This type of diabetes is short term and usually disappears after the baby is born. Gestational diabetes is also a marker of increased risk of developing type II diabetes later in life. Some cases of gestational diabetes are managed with changes to diet and exercise, and some require insulin treatment. About 5% of pregnant women are affected.

Other Types of Diabetes

Other types of diabetes can occur as a result of other conditions or syndromes, such as:

- Genetic defects of beta-cell function in the pancreas and insulin action
- Other diseases of the pancreas (including cystic fibrosis and cancer of the pancreas)
- Endocrine disorders (for example, acromegaly and Cushing's Syndrome)
- Drug- or chemical-induced diabetes (for example, steroid-induced diabetes)
- Infections (for example, congenital rubella)
- Uncommon but specific forms of immune-mediated diabetes mellitus
- Other genetic syndromes sometimes associated with diabetes.

Around 3% of people are affected by other types of diabetes.

Impaired Glucose Intolerance (IGT)

IGT is a state of higher than normal blood (or plasma) glucose concentration 2 hours after 75 gram oral glucose load but less than the diagnostic cut-off for diabetes. Patients usually have no symptoms and are diagnosed because a test is done upon patient request or because he/she falls into a high risk category. (World Health Organisation - WHO)

Prevalence in Australia (Australian Diabetes Council)

- Diabetes is Australia's fastest growing chronic disease
- An estimated 2.45 million Australians have pre-diabetes
- One person is diagnosed in every 5 minutes
- About 1,150,000 Australians are officially diagnosed with diabetes.
- Diabetes prevalence has increased approximately 8% per annum since the year 2000 Based on this, by 2017, the Australian Diabetes Council expects the number of people with diagnosable diabetes to total approximately 3.6 million
- The total number of people with diabetes and pre-diabetes at present is 3.6 million

Complications (Australian Diabetes Council)

- Increased risk of heart disease and stroke (80% of people with diabetes will die from a heart attack or stroke)
- Increased risk of blindness (rentinopathy affects about ¼ of people with diabetes and its development is strongly related to the length of time diabetes has been present and the control of blood glucose)
- Increased risk of kidney failure
- May result in limb amputation (neuropathy or peripheral nerve disease and blood vessel damage may lead to leg ulcers and serious foot problems)
- May cause erectile dysfunction in men

Management of Diabetes (Information from Australian Diabetes Council)

- Healthy eating (please refer to Dietetic discipline information)
- Increase physical activity (please refer to exercise physiology and physiotherapy disciplinary information)
- Medication/insulin management
- Blood glucose monitoring
- Weight management

1.2 Hypertension

Blood pressure is the force exerted by the blood on the walls of the arteries and is written as systolic/diastolic (e.g. 120/80 mmHg). High blood pressure is defined as:

- systolic blood pressure (SBP) greater than or equal to 140 mmHg, or
- diastolic blood pressure (DBP) greater than or equal to 90 mmHg, or
- Receiving medication for high blood pressure.

High blood pressure is a major risk factor for coronary heart disease, stroke, heart failure, peripheral vascular disease and renal failure. The risk of disease increases as the level of blood pressure increases.

Major causes of high blood pressure

Major causes include overweight, alcohol consumption, physical inactivity, dietary salt intake and nutrition patterns which involve a low intake of fruit and vegetables and a high intake of saturated fat.

Stress raises blood pressure transiently but in the long term may have indirect effects by influencing eating, drinking smoking and physical activity patterns. Tobacco smoking increases the risk of heart attack and stroke threefold in hypertensive individuals.

Prevalence in Australia

- The 1999-2000 The Australian Diabetes, Obesity and Lifestyle Study (which took blood pressure measurements) indicated that around 3.7 million Australians over the age of 25 had high blood pressure or were on medication for that condition.
- This equates to 32% of men and 27% of women.
- Based on self-reports from the Australian Bureau of Statistics' National Health Survey 2004-05, it is estimated that about 2.1 million Australians have high blood pressure. This corresponds to 10% of the population.
- 2004-05 study of general practice activity in Australia show that high blood pressure is the most common problem managed by general practitioners (6% of all problems managed).

Complications (Information from Heart Foundation)

Higher levels of blood pressure (BP) are strongly associated with increasing rates of cardiovascular disease, cardiovascular events and death. It is the major risk factor for stroke and coronary heart disease, and is a major contributor to chronic heart failure (CHF), Chronic Kidney Disease (CKD), and their progression.

Management of Hypertension (Information from Heart Foundation)

- Medication management
- Lifestyle changes (increase physical activity, healthy diet, smoking cessation and limited alcohol intake to ≤ two standard drinks per day for men or ≤ one standard drink per day for women)
- Weight control (recommended waist measurement < 94 cm for men and < 80 cm for women, body mass index (BMI) < 25 kg/m2. When recommending weight loss, advise patients on reducing kilojoule intake as well as increasing physical activity)

1.3 Coronary Artery Disease (CAD)

Refers to any condition attributed to obstruction of the coronary arteries and can range from angina through to myocardial infarct. (Heart foundation)

Angina is a chronic condition when a temporary loss of blood supply to the heart causes periodic chest pain. While generally not life-threatening, people with angina are more likely to have a heart attack or experience sudden cardiac death. New onset of angina can also be unstable and lead to admission to hospital, and in rare cases, to death. It is medically treated in a similar manner to heart attack.

Heart attacks and the most serious form of angina (unstable angina) are considered to be part of a continuum of acute coronary artery diseases, described as 'acute coronary syndrome'.

Prevalence in Australia

- In 2007–08, an estimated 3% of the Australian population had Coronary Heart Disease (CHD) (around 685,000 people).
- The age-adjusted proportion of males with CHD was twice that of females.
- CHD affected males at younger ages than females with a sharp increase in prevalence from the age of 45–54 years in men compared to 65–74 years for women.
- In 2009–10, there were 153,833 hospitalisations with a principal diagnosis of CHD (2% of all hospitalisations and 32% of hospitalisations for Cardiovascular Disease - CVD).
- The CHD hospitalisation rate was nearly twice as high for males as it was for females in each age group.
- Around 60% of hospitalisations with CHD were among people aged 65 years and over.

1.4 Congestive Heart Failure

Congestive heart failure refers to a specific type of heart failure characterised by ‘congestion’ or build-up of fluid in the lungs, liver or legs that frequently occurs in people with untreated heart failure.

Prevalence of heart failure in Australia

- Heart failure is a major burden on the community due to the high costs of care, the lower quality of life and premature death of those affected, claiming 2,729 lives in 2002 (2.0% of all deaths).
- It is estimated that at least 300,000 or about 4% of the population aged 45 or more Australians have chronic heart failure, with 30,000 new cases diagnosed each year. As the diagnosis is commonly missed in mild cases, the actual numbers could be as high as twice these estimates.

- Heart failure death rates fell by 43.3% among males and 41.5% among females over the period 1991–02.
- In 2000–02, death rates from heart failure among Indigenous Australians were almost three times as high as for other Australian
- In 2001–02, there were 41,874 hospitalisations in Australia where heart failure was the principal diagnosis (0.7% of all hospitalisations).

Management of CAD & Congestive Heart Failure (Information from Heart Foundation)

- Medication management
- Surgical procedure such as Coronary Artery Bypass Surgery
- Lifestyle changes (increase physical activity, healthy diet and smoking cessation)
- Decrease other risk factors such as hypertension, high cholesterol level, diabetes, depression and being overweight/obese)

1.5 Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) limits airflow in the lungs and can lead to mild or severe shortness of breath that is not fully reversible even with treatment. People with COPD often have emphysema (damaged lung tissue) and/or chronic bronchitis (indicated by a frequent cough caused by excessive mucus production). The terms COPD, emphysema and chronic bronchitis are sometimes used interchangeably but COPD is the current preferred medical term that includes both emphysema and chronic bronchitis.

The cause of COPD includes tobacco smoking, smoke from burning fuels of plant or animal origin, outdoor air pollution, fumes and dusts in the workplace, childhood respiratory infections and chronic asthma.

Severity of COPD (Lung Foundation)

Mild COPD: symptom may be the need to cough up mucus each morning. Some symptoms such as shortness of breath, coughing or coughing up mucus may only occur during winter or after a cold. Patients may also feel a little more puffed and out of breath on exertion.

Moderate COPD: Patients are likely to notice symptoms almost every day. Patients may also cough up more mucus, often feel very out of breath if they exert themselves or walk quickly, have trouble working because they get out of breath and need to take several weeks to recover from a cold or chest infection.

Severe COPD: Patients may be short of breath during normal daily activities such as taking a shower or getting the mail from the letterbox and can have a big impact on life. Patients may get tired easily, not able to continue to do any work or housework, constant need to clear mucus from their chest, get chest infections frequently and need to take several weeks to recover from a cold or chest infection.

Prevalence in Australia

- Almost 13% or one in seven Australians 40 or over are affected by COPD (at least half of those with moderate to severe COPD - 50% of reduction in lung capacity) (Lung Foundation)
- The death rate from COPD for males in 2009 was one third of that in 1970.
- In 1970, the male death rate from COPD was 8 times the female rate. In 2009, the male death rate was only twice the female death rate.
- In 2009–10, COPD accounted for about 54,244 or 0.6% of all hospitalisations
- 560 million or about 1% of all expenditure on diseases was spent on COPD in the 2004 – 2005 financial year

Management of COPD (Lung Foundation)

- Medication and oxygen management
- Lifestyle changes (increase physical activity, healthy diet, smoking cessation and limited alcohol intake to ≤ two standard drinks per day for men or ≤ one standard drink per day for women)
  Protection against exacerbation

Australian Institute of Health and Welfare (AIHW) - Authoritative information and statistics to promote better (http://www.aihw.gov.au/)
Health and wellbeing, Australian Government (http://www.aihw.gov.au/)
World Health Organisation (WHO) (http://www.who.int/en/)
Australian Diabetes Council (http://www.australiandiabetescouncil.com/)
Heart Foundation (http://www.heartfoundation.org.au/)
Heart Foundation, Guide to management of Hypertension 2008 – Updated December 2010 (http://www.heartfoundation.org.au/SiteCollectionDocuments/HypertensionGuidelines2008to2010Update.pdf)
Lung Foundation (http://www.lungfoundation.com.au/)
Caughey, G.E., Vitry, A.I., Gilbert, A.L. and Roughead, E.E. (2008) Prevalence of comorbidity of chronic diseases in Australia, Biomedcentral Public Health, 8:221 (http://ura.unisa.edu.au/view/action/singleViewer.do?dvs=1367992396748~698&locale=en_AU&VIEWER_URL=/view/action/singleViewer.do?&DELIVERY_RULE_ID=10&adjacency=N&application=DIGITOOL-3&frameId=1&usePid1=true&usePid2=true)

Section 2

Discipline Specific Information on Chronic Disease Management

(Information provided by discipline clinical supervisors)

2.1 Dietetics

- Diet and heart disease- hyperlipidaemia and hypertension (Appendix 1)
- Healthy eating with diabetes (Appendix 2)
- Dietary guidelines for Australian Adults and pamphlet (Appendix 3 and resource folder))
- Waist circumference guide (Appendix 4)
- Ethnic specific waist circumference guide (Appendix 5)
- Body Mass Index (BMI) reference chart (Appendix 6)

2.2 Exercise Physiology

Accredited Exercise Physiologists (AEP's) specialise in clinical exercise interventions for persons at high-risk of developing, or with existing chronic and complex medical conditions and injuries. These interventions are provided through exercise delivery; health and physical activity education, advice and support; and lifestyle modification with a strong focus on achieving behavioural change.

AEP's services include individual and group based exercise interventions, lifestyle counselling, self-management support and monitoring of behaviour changes. The aims of AEP interventions are to prevent or manage chronic conditions or injury, and assist in restoring one's optimal physical function, health or wellness with a view to promoting independent lifestyle management.

AEPs work with a range of populations and chronic conditions, including but not limited to:

- Chronic heart failure and Cardiovascular disease
- Hypertension
- Diabetes and Impaired glucose tolerance
- COPD and Asthma
- Osteoporosis
- Depression
- Cancer
- Arthritis and Chronic pain

Other physical activities information:

- National physical Activities guidelines for adults (Appendix 7)
- Choose Health: Be Active - A physical activities guide for older Australians (See resource folder)

2.3 Nursing

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles. (International Council of Nurses)

Nursing interventions for clients with chronic disease includes:

- Assessment and observation of vital signs
- Education on the disease, symptoms and self-management
- Medication education and monitoring
- Development of patient centred management plans
- Carer education and support
- Co-ordinating care

Other information about co-ordinating care for clients with chronic conditions:

- Better Living with COPD – A Patient Guide (see Resource folder)
- Living well with Chronic Heart Failure (see Resource folder)

2.4 Occupational Therapy

Until recently, Occupational Therapists have rarely worked in primary health care (Muir, 2012). Traditionally we have worked with people after they have sustained an injury, illness or have had a long term chronic condition and we have helped these people as they seek to adapt to the impact of these changes into their daily lives and roles.
In the Student Led Clinic students will be experiencing an emerging role for Occupational Therapists in primary healthcare; focussing on prevention, health and wellness.

Diabetes and Impaired Glucose Tolerance (IGT)
A recent study investigating Diabetes and Occupational Therapy (O.T.) interventions (Pyatak, 2011) suggests that O.T.s are involved in Diabetes Self-Management (DSM) programs to prevent acute and long term complications of diabetes with their patients. Since Occupational Therapy's scope of practice involves understanding people living in their environments doing the everyday tasks which make up their lifestyle, it seems very appropriate for O.T.s to help patients in this way.

Hypertension
As well as promoting a healthy lifestyle, Occupational Therapists may offer their clients stress management and relaxation sessions, either individually or in groups. The group at the Sutherland Hospital (TSH) runs when there are sufficient numbers of people wanting to attend. It runs once/week for four weeks. There is a folder in the Occupational Therapy department which has the program in it. Handouts and power point presentations are used in each session. It is important to read this material. Students in the Student Led Clinics may refer patients to this group or may wish to use the information for one to one sessions with clients. The O.T. Supervisor will advise you as you think about the best way to assist a particular patient.

Coronary Artery Disease and Congestive Heart Failure (CHF)

Coronary Artery Disease is the general category of diseases affecting the cardiovascular system including Myocardial Infarct, Congestive Heart Failure and Hypertension.

Myocardial Infarct is commonly called a heart attack. There are set protocols for Cardiac Rehabilitation of patients. Many of the patients admitted to TSH with an MI will spend time in the CCU (Coronary Care Unit) and may also be seen at the Cardiac Clinic whilst they are an inpatient to have stenting or some other form of intervention which may assist to improve the blood flow to the heart muscle from the coronary arteries. The SHALT (**S**utherland **H**eart **a**nd **L**ung **T**eam) run a comprehensive Cardiac programme including education sessions, monitoring of heart and lung function and exercise classes in the rehab gym in Killara Rehab. The O.T. department has a copy of the current booklet which is given to patients when they attend the 6 week education program as part of their morning sessions. It is a summary of information given to them by the various presenters over the 6 week program. There is an O.T. session in the program. There is also an accompanying Power Point and handout for the session. It covers topics such as grading activity, energy conservation and work simplification. Patients are encouraged to know their bodies and be aware of their body's responses to activity. Students should be familiar with this information and refer appropriate patients to this team.

Much of the information in the O.T. session in the SHALT programme is relevant to people with Congestive Heart Failure as well. One of the causes of CHF can be a MI. Emphasis in O.T. intervention with CHF is reducing and controlling the stress placed on the heart. A gradual Cardiac Rehabilitation programme with the SHALT team may assist people in the early stages of this disease. People with severe CHF may be very limited in activity due to shortness of breath, fatigue, nausea, oedema, confusion and impaired thinking.

Chronic Obstructive Pulmonary Disease

The primary problem in COPD is a loss of lung function which leads to gradual reduction of airflow. During activity our need for more oxygen increases but a person with COPD has to work harder than most to keep up with this demand and becomes short of breath. This results in a gradual reduction in performance of ADLs. A chronic cycle of muscle weakness, inactivity, feelings of inadequacy, poor self concept and depression can develop.

As students working with people who have been newly diagnosed with this disease it is very important to understand the risk of this cycle developing. Again the SHALT team will be able to help you to provide gentle exercise classes and education. Treatment focuses on graded activities to improve strength and endurance, training in ADLS and IADLS and education on the disease, work simplification, energy conservation, relaxation and self-management.

Atchison, B. J., & Dirette, D. K. (Eds.). (2007). *Conditions in Occupational Therapy: Effect on Occupational Performance* (3rd ed.). Baltimore, United States of America: Lippincott Williams and Wilkins.

Clark, F., Azen, S. P., Carlson, M., Mandel, D., LaBree, L., & Hay, J. (2001). Embedding Health Promoting changes into the daily lives of independent-living older adults:Long term follow-up of occupational therapy intervention. *Journal of Gerontology , 56*, 60-63.

Clark, F., Azen, S. P., Zemke, R., Jackson, J., Carlson, M., & Mandel, D. (1997). Occupational Therapy for independent-living older adults:A randomized controlled trial. *Journal of the American Medical Association , 278*, 1321-1326.

Hwang, J. E., Truax, C., Claire, M., & Caytap, A. L. (2009). Occupational Therapy in Diabetic Care-Areas of Need Perceived by Older Adults with Diabetes. *Occupational Therapy in Health Care , 23 (3)*, 173-188.

Muir, S. (2012). Occupational Therapy in Primary Healthcare:We Should Be There. *The American Journal of Occupational Therapy , 66*, 506-510.

2.5 Physiotherapy

(Information from the Australian Physiotherapy Association)

Physiotherapists assist people with chronic disease to safely optimise their level of physical activity and effectively manage their own care. The role of physiotherapists includes; health promotion, enabling people to self-manage their condition and managing the impact of co-morbidities.

Physical exercise accompanied by lifestyle changes have been proven effective for clients with Impaired Glucose Intolerance in reducing their risk to developing type II diabetes. Physiotherapists also provide health consultations for clients with chronic disease such as relieving positions for clients with chronic obstructive pulmonary disease and prescription of exercise programs in cardiac and pulmonary rehabilitation. Physiotherapists also provide treatment/consultation for co-morbidities that accompany chronic disease such as musculoskeletal conditions, decreased mobility and balance.

2.6 Podiatry

Podiatry deals with the prevention, diagnosis and management of medical and surgical conditions of the feet and lower limbs. Podiatry plays an important role in chronic care management, including, however not limited to, patients with diabetes, wound care and patients with neurological and vascular conditions. Podiatrists also treat a wide range of chronic conditions that include bone and joint disorders, such as arthritis, soft-tissue and muscular pathologies. Regular podiatric interventions, including annual foot screenings, regular podiatry reviews, wound management and foot orthoses can help to significantly reduce rates of foot ulceration and amputation in people with diabetes. As providers of comprehensive foot care, podiatrists play an important role in maintaining mobility and lower limb function in all members of the community.

2.7 Social Work

Social Work practice acknowledges that chronic health problems are more than the disease itself and looks at other contributing factors that impact on people's health and wellbeing. These factors can include: adjustment to the disease, socio-economic circumstances, family and social supports, mood and coping strategies. At all times Social Work looks to find ways to empower people and focus on their strengths so that they can go on to find ways to care for their own needs. Social Workers then focus their interventions on how the person is coping in their home environment, identifying barriers to good health care, looking at the kind of family and social supports they have, identifying community services that may be beneficial and supporting families and carers to care for and support the person. Social Work also provides support for people whose mood may be impacted on as a result of living with chronic health care needs. This support might come in the form of counselling or referral to a counsellor, providing coping strategies to help manage their daily life and looking at ways to focus on the person's strengths and how to strengthen their support network.

Fact sheet information:

- Anxiety (Appendix 8)
- Depression (Appendix 9)
- Checklist when sadness won't go away (Appendix 10)

2.8 Speech Pathology

Speech Pathologists assess, diagnose, treat and provide management services to people with communication impairments. Communication difficulties include:

- Difficulty expressing what one wants to say, or getting stuck on words
- Difficulty understanding what other people say
- Slurred speech
- Difficulty planning speech sounds and words
- Changes to voice quality

Speech Pathologists also work with people who have difficulties swallowing food and drink. Swallowing problems may occur as a result of stroke, other neurological conditions, respiratory problems, cancer, and the ageing process. People with swallowing difficulties may require softer types of food and/or thickened drinks.

Other speech pathology related information:

- Communication and swallowing difficulties after stroke (Appendix 11)
- Information of Dysphagia and Respiratory Illness (Appendix 12)

Section 3

Other Information on Chronic Disease Management

- NSW Health policy directory and guidelines for chronic condition related rehabilitation: http://www0.health.nsw.gov.au/cdm/policies_and_guidelines.asp
- NSW Chronic Care Program – Part one (Rehabilitation model and services in NSW) http://www0.health.nsw.gov.au/pubs/2006/pdf/chroniccare_vol1.pdf)
- NSW Chronic Care Program – Part two (Implementation and assessment tools for psychological, physical and quality of Life) http://www0.health.nsw.gov.au/pubs/2006/pdf/chroniccare_vol2.pdf)
- NSW Department of Health policy directory for falls prevention http://www0.health.nsw.gov.au/policies/pd/2011/pdf/pd2011_029.pdf)
- Preventing Falls and Harm from falls in Older People – Best Practice Guidelines for Australian Community Care 2009 by Australian Commission on Safety and Quality in Health Care (2009) http://www.activeandhealthy.nsw.gov.au/assets/pdf/Community_Care_Guidebook.pdf)
- 'Don't Fall For It' booklet – A guide to preventing falls for older people by the Department of Health and Ageing http://www.health.gov.au/internet/main/publishing.nsf/Content/8DE953DBDE1B850CCA256FF100275AA1/$File/Don't%20fall%20for%20it.pdf)
- NSW Department of Health policy directory for Aboriginal Chronic Condition Area Health Service Standards (2005) http://www0.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_588.pdf
- Chronic disease management – Quick reference guide for Allied Health Professionals for individual Allied Health service under Medicare Australia (Appendix 13)
- Fact Sheet for Chronic disease Individual Allied Health Services under Medicare (Appendix 14) http://www.health.gov.au/internet/main/publishing.nsf/Content/79299CE412BC11F4CA256F19003CB46A/$File/Fact%20sheet-%20individual%20AH%20services%20for%20people%20with%20chronic%20conditions%20and%20complex%20care%20needs,%20final%20August%202012.pdf
- Australian Dietary Guidelines for Adults (2013) – (see resource folder) http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/n29.pdf
- Better Living with COPD - a Patient Guide - (see resource folder) http://www.lungfoundation.com.au/wp-content/uploads/2012/06/COPD-Patient-Guide-2012-PROOF_all_FINAL.pdf
- Living well with Chronic Heart Failure (See resource folder) http://www.heartfoundation.org.au/SiteCollectionDocuments/Living%20well%20with%20chronic%20heart%20failure.pdf

Students are to develop the information for the education classes and individual consultations from the above guidelines on chronic disease management.

Section 4

Allied Health and Nursing Department Contact Information and Clinical Supervisors Information

4.1 The Sutherland Hospital Department Contact Information

(Clinical supervisors and students can seek discipline specific advice from the department when discipline clinical supervisors are not available in the clinic)

Diabetic Education Centre	Phone: (02) 9540 7841
	Fax: (02) 9540 8106
Dietetic department	Phone: (02) 9540 8300
	Fax: (02) 9540 7717
Exercise Physiology (Sutherland Heart and Lung Team)	Phone: (02) 9540 7046
	Fax: (02) 9540 7855
Nursing Education department	Phone: (02) 95407929
	Fax: (02) 9540 7505
Occupational Therapy department	Phone: (02) 9540 8300
	Fax: (02) 9540 7717
Physiotherapy department	Phone: (02) 9540 8300
	Fax: (02) 9540 7717
Podiatry department (Foot Clinic)	Phone: (02) 9540 7841/ 9540 7841
	Fax: (02) 9540 7855/ 9540 8106
Social Work department	Phone: (02) 9540 8300
	Fax: (02) 9540 7717
Speech Pathology department	Phone: (02) 9540 8300
	Fax: (02) 9540 7717
SouthCare Intake officer	Phone: (02) 9540 7956
	Fax: (02) 9540 7869
Connecting care – Both St. George and Sutherland hospital (Contact person: Daniel Shaw)	Phone: (02) 91133999
	Fax: (02) 91133388

4.2 Clinical Supervisors Contact Information

Dietetics
Name of Clinical Educator: **Erin Caruana**
Phone: (02) 954 0830
Email: Erin.Caruana@sesiahs.health.nsw.gov.au

Exercise Physiology
Name of Clinical Educator: **Brendon McDougall**
Phone: (02) 9540 7046
Email: Brendon.Mcdougall@sesiahs.health.nsw.gov.au

Nursing
Name of Clinical Educator: **Clare Loveday**
Phone: (02) 9540 7929/ 0408 823295
Email: Clare.Loveday@sesiahs.health.nsw.gov.au

Occupational Therapy
Name of Clinical Educator: **Meredith Pleffer**
Phone: (02) 9540 8300 page 420
Email: Meredith.Pleffer@sesiahs.health.nsw.gov.au

Physiotherapy
Name of Clinical Educators: **Anna O'Brien**
Phone: (02) 9540 8300
Email: Anna.Obrien@sesiahs.health.nsw.gov.au

Podiatry
Name of Clinical Educators: **Jessica Anderson/ Julia Capper**
Phone: (02) 9540 7175/ 95407841
Email: Jessica.Anderson@sesiahs.health.nsw.gov.au/ Julia.Capper@sesiahs.health.nsw.gov.au

Social Work
Name of Clinical Educators: **Dallas Nolan/ Sandra Foley**
Phone: (02) 9113 2494 page 1047/ 95408729
Email: Dallas.Nolan@sesiahs.health.nsw.gov.au/ Sandra.Foley@sesiahs.health.nsw.gov.au

Speech Pathology
Name of Clinical Educator: **Emma Ramirez**
Phone: (02) 9540 8300
Email: Emma.Ramirez@sesiahs.health.nsw.gov.au

Section 5

Community Services Information for the Management of Chronic Conditions

(The following information may be subject to change and regular update of service information is required)

5.1 Government/Hospital Services

Community Service	Description of Service	Eligibility	Cost	Contact Information
Connecting Care (NSW Health Severe Chronic Disease Management Program)	➢ Care co-ordination and case management support planned around patient's health needs and unplanned admissions to hospital ➢ Shared health information and health action plans that include all partners ➢ Support to access range of services to support client self-management, such as health coaching.	Any community members aged 16 or above with one of the five chronic conditions (Diabetes, CHF, CAD, COPD or HTN)	free	Ph: (02) 99479885 Fax: (02) 99479886
Meals on Wheels (Sutherland Food Services)	Provides meals to people in need	➢ Older, frail persons ➢ Younger persons with a disability ➢ Carers of those persons above	Subject to fees	Ph: (02) 95407365 Email: Info@mealsonwheelssutherland.com.au
Quitline	Provides confidential and individually-tailored service to assist in the quitting process	➢ Smokers	free	Ph: 137848 Website: http://www.icanquit.com.au/ Email: prevention@cancerinstitute.org.au
Mental Health 24 hours hotline	Provides a telephone triage assessment and referral service	➢ Any clients with mental health related issues	Free	Ph: 1800011511

Drug and Alcohol service for South Eastern Sydney	Provides support with drug and alcohol issues	➢ Any clients with drug and alcohol related issues	Free	Ph: (02)9332877 or 91132944
Drug and Alcohol information service (ADIS)	Provides support, information, advice, crisis counselling and referral to services in NSW	➢ Any clients who need drug and alcohol information	Free	Ph: (02)9361 8000
Sutherland Hospital Cardiac Rehabilitation program	Provides an exercise and education program	Clients post cardiac surgery, coronary artery disease, congestive heart failure	Voluntary Donations	Ph: (02)9540 7309 or page 629 Or fax: (02) 9540 8954
Sutherland Pulmonary Rehabilitation program	Provides an exercise and education program	Clients with Chronic Obstructive Pulmonary Disease (COPD)	Free	Ph: (02) 95407540 or Fax a Southcare referral form to 95407869
Respiratory Coordinated Care Program (RCCP)		Clients with Chronic Obstructive Pulmonary Disease (COPD), over 60 years of age, limited lung function (FEV1<50% of the predicted), known to a Respiratory Physician and psychosocially stable	Free	Ph: (02) 95407018 Or fax: (02) 95407051
Diabetic education centre		Clients with diabetes and require education of medication and insulin injection	Free	Ph: (02) 954037841 Fax: (02) 954038106
Get Healthy Information and Coaching service	Provides a telephone service with information and support for adults in relation to healthy eating, physical activity, and achieving and/or maintaining a healthy weight.	All adults	Free	Ph: 1300 806 258 Website: https://www.gethealthynsw.com.au/

5.2 SouthCare Community Services

(For more Information, please refer to South Eastern Sydney Local Health District Website: http://seslhnweb/SGSHHS/TSH/Services_and_Departments/Southcare/default.asp#ACAT)

Community Service	Description of Service	Referral Criteria	Contact Details
Combined Caring Centres of Sutherland Shire	20 Caring Centres run by volunteers, provides a social outlet at least one day a week, for people who because of frailty, age, isolation or disability are unable to participate in other programs provided by the community. Door to door transport is provided. Programs vary and can include outings, entertainment, indoor bowls, cards, snooker, gentle exercise, craft.	➢ Residents of the Sutherland Shire who are aged, frail, disabled or isolated and requires socialisation. ➢ Nursing Home Residents are excluded	Ph:(02) 95256400 Or fax a SouthCare referral form 95407869 Clients can self-refer
Community Options (Sutherland case management services)	Provides case management for complex cases.	➢ Residents with a disability and/or frailty of the Sutherland Shire, who need a variety of support services to remain living in their home and unable to obtain the service that is needed or has a complex care needs that requires case management ➢ Carer of a person with a disability	Ph:(02) 95256133 Or fax a Southcare referral form to 95407869 Client can self-refer
Generalist Community Nurses	Registered and Enrolled Nurses provide the following nursing care: ➢ General Home Assessments ➢ Administration of medication and injections ➢ Wound management ➢ Palliative care ➢ Personal care ➢ Education and support to clients and carers	Resident of the Sutherland Shire needing community nursing services.	Ph:(02) 95407175 or (02) 95407540 Or Fax:(02) 9540 7869 Client can self-refer
Mobility Clinic	The Mobility Clinic aims to encourage and provide the opportunity for clients, who have experienced a recent decline in their mobility and	➢ Is a resident of the Sutherland Shire (or residing with) ➢ Has a medical referral ➢ Has the potential to	Ph: (02) 95407956 Or Fax a SouthCare referral form

	have the potential to improve, by having their gait analysed and being taught skills to help them with their mobility e.g. exercises for strength, flexibility and balance; practice getting up from the floor and visits to shopping centres for retraining and confidence in mobility in the community i.e. stairs, lifts and escalators.	mobilise ➢ Has the ability to follow instructions ➢ Has the potential for muscular-skeletal improvement ➢ Is motivated to continue an exercise regime at home ➢ Has a goal of participating in outside activity e.g. Bowls <u>Exclusion criteria:</u> ➢ Profoundly deaf ➢ Blind ➢ Severe chronic illness e.g. COPD ➢ Severe or unmanaged incontinence	95407869 Need to be refer by a medical officer
Occupational therapy service	Provides services for the aged and younger disabled population in the Sutherland Shire with the aim of optimising function and maintaining the client in their home. This involves the assessment of the client in the home, prescription of equipment and home modifications	Residents of the Sutherland Shire who have a physical disability and have the potential to remain in their own home. <u>Exclusion Criteria:</u> People living in a Nursing Home or Third party insurance clients	Ph:(02)95407175 or (02)9540 7540 Or Fax: (02) 9540 7869 Client can self-refer
Pharmacist	➢ Assessment of client's or their carers ability to handle and administer medication ➢ Education for clients and their carers about medication and the importance of compliance ➢ Assistance for clients who are taking multiple medications or who have a difficult regime to follow ➢ Follow-up post discharge from hospital to ensure continuity of medication. This includes: medications, BSL, BP& INR checks. ➢ Liaison with relevant professionals to ensure continuity of medication ➢ Liaison with relevant	Residents in Sutherland shire with a disability, who are living at home and having difficulty managing their medication. Also, has hospital admissions due to medication-related episodes e.g. falls	Ph:(02)95407540 or Fax a Southcare referral form to 95407869 Client can self-refer

	professionals to ensure that the client complies and understands their medication regimen		
Physiotherapy	The Physiotherapy Service provides a home visiting service for housebound elderly and disabled residents of the Sutherland Shire. Physiotherapy treatment is provided for: ➢ Chest therapy ➢ Rehabilitation after a recent hip, knee or shoulder operation ➢ Recent injury/pain ➢ Mobility problems and assess for walking aids ➢ Assess for TENS ➢ Assess for exercise program ➢ Exacerbation of existing condition ➢ Hydrotherapy and Mobility groups	A person that is a resident of the Sutherland Shire (or residing with) who: ➢ Is a pension card holder (Aged / Disability) ➢ Is housebound to receive home visits ➢ Has a medical referral <u>Exclusion criteria:</u> ➢ People living in a nursing home ➢ Third party or insurance clients	Ph:(02)95407175 or Fax a Southcare referral form to 95407869
Podiatry	The Podiatry Service provides assessment and education. Treatment may be given while foot problems are active.	Residents of the Sutherland Shire who are: ➢ Receiving the aged pension, disability support or veteran Affairs pension without podiatry entitlement ➢ At high risk of foot complications that meet the following medical criteria: * Peripheral vascular disease (PVD) or peripheral neuropathy (PN) with active problems such as infection, ischaemia, fissures or interdigital maceration * Previous foot ulcers * Previous amputation * PVD without active foot problem * PN without active foot problem Clients who are diabetic, not	Ph:(02)95407175 or Fax a Southcare referral form to 95407869 Client can self-refer, GP letter

		housebound and have foot ulcers should be referred to the Diabetes Education Centre High Risk Foot Clinic. <u>Exclusion criteria:</u> People living in residential aged care facilities are not eligible for home visits	
Pulmonary Rehabilitation program	Provides an exercise and education program by physiotherapist	Clients with Chronic Obstructive Pulmonary Disease (COPD)	Ph: (02) 95407540 or Fax a Southcare referral form to 95407869
Social Worker	The Social Work Service provides assessment and intervention for aged clients and disabled clients, who are residents of the Sutherland Shire. The Social Workers provide experienced consultation and intervention in relation to the following issues: ➢ Complex issues in dementia care ➢ Suspected cases of abuse of older persons ➢ Guardianship and financial management issues ➢ Counselling and/or further referral about personal issues concerning older persons or younger people with chronic illness and their carers ➢ Complex care planning and advocacy ➢ Intervention as appropriate for complex residential placement and accommodation needs	Residents of the Sutherland Shire needing social work services	Ph:(02)95407175 or (02)9540 7956 or Fax a Southcare referral form to 95407869 Client can self-refer
Sutherland Heart and Lung Team (SHALT)	Provide home monitoring, specialised education and gym based exercise programs to people with congestive cardiac failure or chronic heart disease	Residents of the Sutherland Shire at risk of admission to hospital due to unstable congestive cardiac failure or chronic heart disease	Ph:(02)95407047 or Fax a Southcare referral form to 95407869 Hospital staff referral

The Retreat (Frail Aged day Care)	Day care centre for frail or disabled aged people requiring more assistance than can be provided by volunteer run Caring Centres. The centre provides social activities in a group environment and regular respite for the carer. Transport (bus has wheelchair hoist) to and from the centre is available.	Residents of the Sutherland Shire who are elderly and frail or disabled with high care needs, who would benefit from group socialisation.	Ph:(02)95407175 or (02) 95407540 Fax a Southcare referral form to 95407869 Client can self-refer

5.3 Non-Government Organisations

Organisation	Description of Service	Contact information
Australian Diabetes Council / Diabetes Australia	Information on diabetes including description of the disease, community support groups and programs.	Phone: (Diabetes Council) 1300342238 (Diabetes Australia): 1300136588
		Website: (Diabetes Council) http://www.australiandiabetescouncil.com/ (Diabetes Australia) http://www.diabetesaustralia.com.au/
Heart Foundation	Information on heart and cardiovascular diseases including description of the disease, community support groups and programs.	Phone: 1300362787
		Website: http://www.heartfoundation.org.au/
Lung Foundation Australia	Information on lung disease including description of the disease, community support groups and programs.	Phone: 1800654301
		Website: http://lungfoundation.com.au/
Lifeline	24 hour Emergency helpline Information and support for Anxiety, Depression , Loneliness, abuse & trauma, physical/mental wellbeing, suicidal thoughts or attempts, stresses from work, family or society	Phone: 131114
		Website: http://www.lifeline.org.au/Home
Sane Australia	24 hour helpline Helping all Australians affected by mental illness lead a better life – through campaigning, education and research	Phone: 1800187263
		Website: http://www.sane.org/
Mental Health Australia	➢ Raises awareness about and promotes mental well-being ➢ Promotes skills and activities, both online and in public spaces to maintain good mental health ➢ Provides support to individuals at risk of developing a mental illness or those who are experiencing the ➢ effects of mental illness ➢ Supports families and loved ones of individuals who are experiencing the effects of mental illness ➢ Supports individuals and communities on their journey of recovery	Phone: 1300729686
		Website: http://www.mentalhealth.org.au/
BeyondBlue	Information to different age group regards to depression and anxiety related mental health conditions and provide program for coping strategy and support group.	Phone: 1300 22 4636
		Website: http://www.beyondblue.org.au/

5.4 Community Exercise Programs

Community Program	Service Provided	Eligibility	Cost	Contact Information
Stepping On program	Provides information on how to reduce falls risk and maximise independence of clients (in various locations)	➢ 65 or over ➢ Living at home ➢ Able to walk independently or with a walking stick ➢ Fearful of falling or recent fall ➢ Requires GP referral	Subject to fees	Ph:0400771281 Email: Steppingon@sesiahs.health.nsw.gov.au
SHARE Programs	Provides a range of supervised exercise programs. Classes include Tai Chi, Aqua fitness, aerobics, resistance training, and stretching & relaxing exercise (in various locations)	Over 50	Subject to fees	Ph:(02)95334422 Fax: (02) 95466784 Email: info@share.org.au
Active & healthy internet web site	Internet search web site for finding listed and registered exercise programs in NSW	Anyone	Free	Website: http://www.activeandhealthy.nsw.gov.au/
GP exercise Referral Scheme (Sutherland Shire Council)	Accredited Exercise Physiologists will assess client's functional capabilities and design an individualised exercise program.	Suitable for everyone with or without diabetes, sedentary lifestyles, clinical obesity (BMI > 30), Hypertension, high cholesterol, osteoarthritis, stress, stable heart condition and COPD	Subject to fees	Ph: Sutherland Leisure Centre (02) 85369706 or Engadine Leisure Centre (02) 95484221
Heartmoves (Heart Foundation)	Provides a gentle physical activity program suitable for anyone	Anyone, however a GP consult is required before starting a Heartmoves program	Subject to fees	Ph:(02)92192479 Emaill: kamilla.haufort@heartfoundation.org.au
Over 60s strengthening Program	Group based strength training program	Clients over 60 WITHOUT recent heart attack, unstable angina, uncontrolled arrhythmia, third degree heart block, acute congestive cardiac failure	Free	Ph:(02)91131397 Or Email: Susan.smith3@sesiahs.health.health.nsw.gov.au

Section 6

Appendices

Appendix 1: Diet and heart disease- hyperlipidaemia and hypertension

Appendix 2: Healthy eating with diabetes

Appendix 3.1: Dietary Guidelines for Australian Adults booklet

Appendix 3.2: Dietary Guidelines for Australian Adults (general healthy eating) pamphlet

Appendix 4: Waist circumference guide

Appendix 5: Ethnic specific waist circumference guide

Appendix 6: Body Mass Index (BMI) reference chart

Appendix 7: National physical Activities guidelines for adults

Appendix 8: Fact Sheet for Anxiety

Appendix 9: Fact Sheet for Depression

Appendix 10: Checklist when sadness won't go away

Appendix 11: Communication and swallowing difficulties after stroke

Appendix 12: Information of Dysphagia and Respiratory Illness

Appendix 13: Chronic disease management – Quick reference guide for Allied Health Professionals for individual Allied Health service under Medicare Australia

Appendix 14: Fact Sheet for Chronic disease Individual Allied Health Services under Medicare