# Managing chronic disease in the community

A new model of care for managing chronic disease is helping reduce the amount of time patients need to stay in hospital.

Pamela Steele, is a former nurse at Redcliffe Hospital, and one of more than 200 patients to sign up to the Integrated Chronic Disease Model of Care program, which is run by the hospital in collaboration with Brisbane North Primary Health Network (PHN) Team Care Coordination nurses.

She said the program has given her a confidence she never dreamed of a couple of years ago.

As the primary carer for her husband and coping with her own chronic obstructive pulmonary disease (COPD), Pamela was feeling the toll and felt she was doing it all alone.

"I was going to have to spend a lot more time in hospital than I felt I could afford, particularly when I needed to be taking care of my husband," Pamela said.

Now, the program is keeping her out of hospital for the most part and providing a network of health professionals Pamela can call on at any time if she is unsure where the disease is taking her.

"If I feel anxious about what is happening to me I can just pick up the phone. I can get the information I need from the phone, or one of the Chronic Disease Team will be on my doorstep if the situation is serious enough," Pamela said.

"Before the program was introduced I would probably have to call an ambulance and go through all the admission procedures at the hospital which takes up time and space which may be needed for acute patients."

Integrated Chronic Disease Model of Care program Project Manager, Tracey Duke, said the care model was achieving positive results in both patient care and patient flow at the hospital.

**Since its introduction, the Integrated Chronic Disease Model of Care program has achieved:**

- a reduction in the length of the average stay in hospital is now just under 17 hours, which gives more patients greater access to acute inpatient medical beds.
- a decreased readmission rate from three to an average of 2.4 patients requiring readmission per month.
- a 50 per cent reduction in the number of acute medical beds occupied by this group each month.
- an increase in the hours per day ED staff can manage other patients.

> "A self-management approach to managing chronic disease at home means patients are less stressed and more aware of their symptoms."

*Opposite: Patients like Pamela Steele, pictured here with Redcliffe Hospital Chronic Disease care Nurse Gordon Cox, are being helped to stay out of hospital through programs such as Redcliffe's Integrated Chronic Disease Model of Care.*