

Addressing Chronic Disease in the Townsville District Community

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Introduction

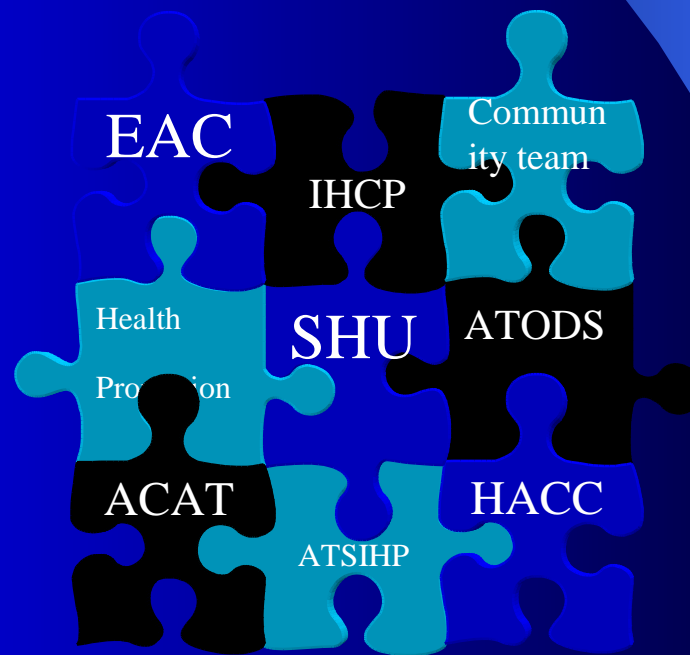
- Overview of the current Services in the Institute of Primary Health and Ambulatory Care
- Current initiatives and projects
- Future developments

Current service provision

- Health Promotion – universal to specific screening
- Community Health Chronic Disease Overview – Stanford Model (Chronic Disease Self Management, Osteoarthritis Self Management); Osteoporosis Self Management; Anxiety and Depression Self Management; Facilitation of support groups eg. Stroke, MS etc; Cardiac Rehab Stage 2 and 3, Case management of people with home oxygen; Diabetes education etc

Current service provision cont.

- IHCP – Integrated Health Care Partnerships – Specific Chronic Disease focus



Current services continued:

- EAC – Post acute care services include wound management, Home IV, Discharge Co-ordinators, Community Hospital Interface Program, Domiciliary Service
- ACAT and HACC
- Aboriginal and Torres Strait Islander Health Program
- Sexual Health
- ATODS
- Breast Screening, Mobile Women's, Chlamydia Screening,
- Oral Health
- Palm Island, Ingham, Magnetic Island

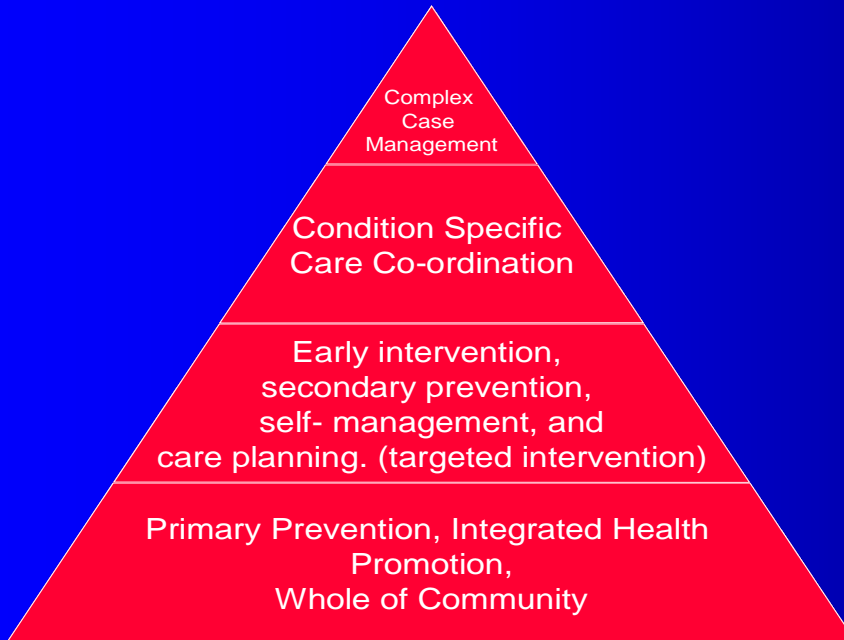
Current initiatives and projects

- CHIC funding – TGPN (Nurse Practice Co-ordinator and GP Medical Advisor) will work with IHCP to extend this program
- Flinders Training – as we speak
- Community Teams Integration
- Community Nursing Services Review
- ATSIHP – Cultural Consultant
- Veterans Liaison Officer
- Nurse Practitioners – Sexual Health and Magnetic Island
- Palm Island projects

Longer term conditions framework

Proposed Integrated Long Term Condition Model

Team members may move up and down the continuum based on client needs and interventions required. Thus working collaboratively across disciplines and community care settings.



Client moves up and down the continuum based on clinical and social needs following review and reassessment.

Single Point of Access and Assessment for the patient and the referrer whether GP or Hospital.

Complex Case Management.
 Care co-ordinated by a case manager for people with Chronic disease and complex needs who frequently use the hospital.
 Case management via identified care plan in collaboration with GP/District teams/NGO's/Social Work/health practitioners.
 Supported by Condition specific specialists.
 Transitional case management between all levels of care.
 24 hour telephone advice and support.

Condition Specific Care Co-ordination.
 Assessment and care planning for people with chronic disease who use the hospital or are at risk of hospitalisation.
 Care co-ordinated through a key worker/specialist.
 Multidisciplinary interventions to support care plan across all levels of care.
 Transitional management between levels.
 Access to self-management programmes.
 Access to Specific telephone advice.

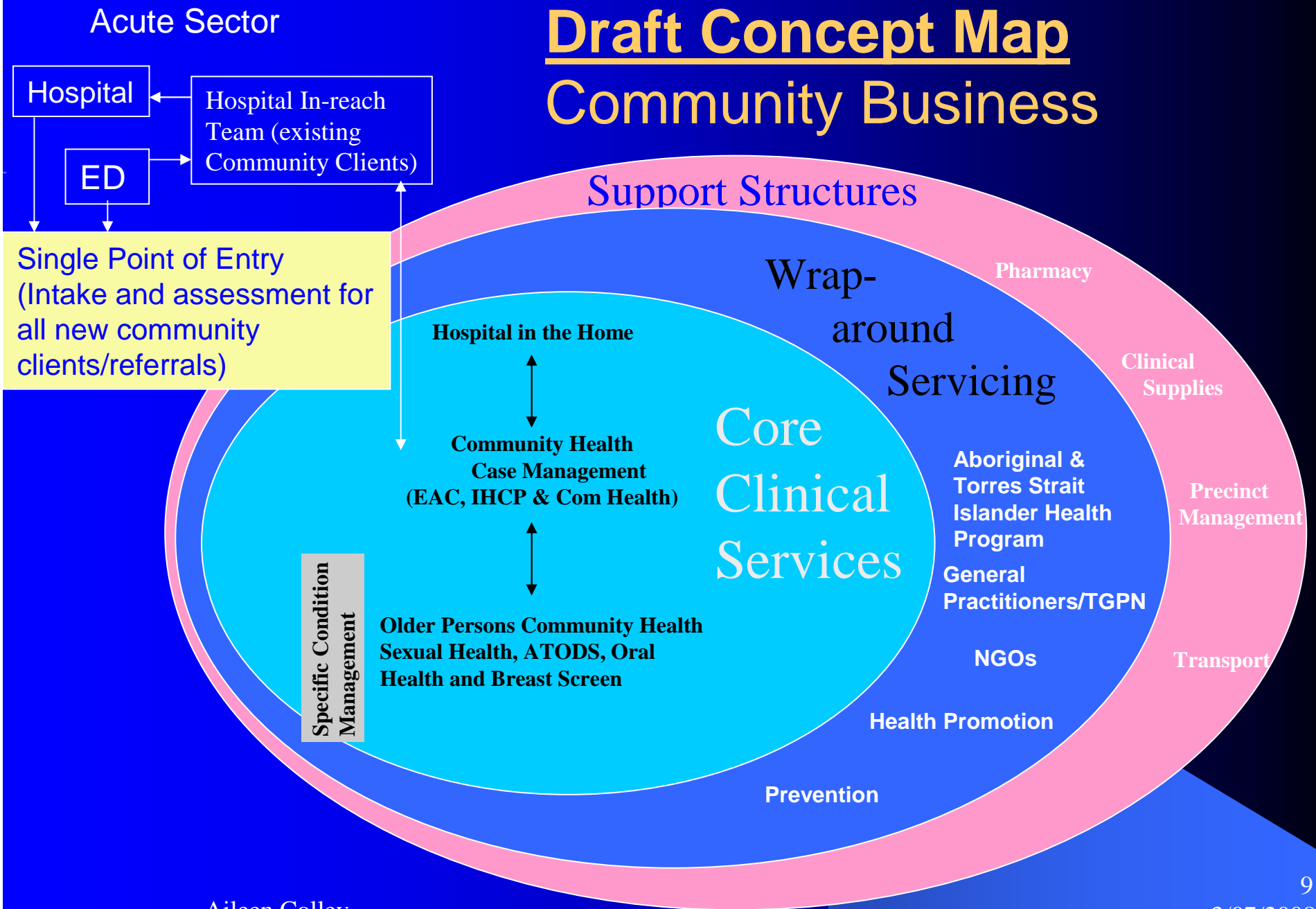
Early Intervention, self – management programmes.
 Identified entry point for people with chronic disease assessed as likely to become unstable leading to hospitalisation.
 Individual and group based interventions coordinated by a key worker along with GP care.
 Condition specific and generic activities such as self-management programs.
 Input from specialist clinicians as required.
 Access to Generic telephone advice.

Integrated Health Promotion.
 Community Health Integrated Health Promotion Plan and activity.

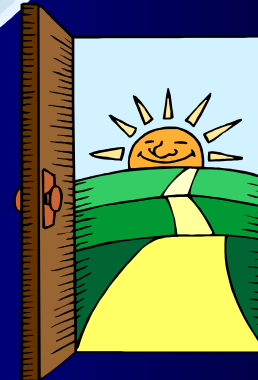
Future developments

- Single point of entry – Clinical Intake system
- Extended hours
- Data Manager
- Exploring Electronic Record and other technologies to assist
- Exploring Hospital in the Home concepts
- Working with ED, TGPN – other options for clients – GP super clinic, precinct health centres, etc

Draft Concept Map Community Business



Summary



The way services should
be designed

