Nangganawili Aboriginal Health Service

NAHS Chronic Disease Management Model - Implementation: 2013

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This document provides the background, implementation details, staffing and Medicare implications for the Chronic Disease Management Model to be implemented during 2013 at Nangganawili Aboriginal Health Service, Wiluna WA.

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Systemic practice change in NAHS

Implementing the Chronic Disease Management model

Introduction

Chronic diseases are amongst the most pressing health problems of the 21st century. In Australia health issues such as Diabetes, heart disease, airway (lung) disease, renal disease and obesity are highlighted daily in health literature and the press. The burden of chronic disease is felt by the sufferers, their family and society, also manifesting through lost productivity and a strained health care budget. Whilst the burden of chronic disease is increasingly prevalent in Australian society as a whole, it represents a greater threat to the life expectancy, social engagement, education and cultural continuity of Aboriginal people. Therefore efforts to reduce its prevalence and incidence are of paramount importance to improving the overall physical, social and mental health of Australia's indigenous people.

The effort to reduce the burden of chronic illness must proceed in a step-wise fashion. The first step is implementation of Medical, Nursing and Allied Health interventions designed to bring the various disease processes under control. Once the progression of chronic disease is slowed or halted then focus can shift to prevention rather than just intervention. In other words, by improving or stabilising the health of those with chronic disease, health services are able to focus more on prevention and early intervention thereby reducing the incidence of disease and consequently its prevalence. In turn a reduced chronic disease burden helps to increase community potential for growth in the socioeconomic spheres of education, employment and engagement. One of the greatest barriers to any socio-cultural group's progress is poor health. Anthropological studies indicate that improvement in the underlying health status of people leads to progress in all other fields of endeavour. Investment within a chronic disease management context is therefore likely to result in community progress and a closing of the gap between Aboriginal and non-Aboriginal health status.

Background

In much the same way as the eradication of Polio, Small Pox and Tuberculosis was of great importance during the 20th century, prevention and management of chronic disease may well be just as significant in the 21st century. State and Federally funded health services (e.g. Population Health, WA), Community Controlled Aboriginal Health services and Medicare Locals provide an ever increasing array of chronic disease management services for Australia's indigenous people. From the older 20th century predominance of acute service delivery to the more contemporary delivery of primary health and community-based programs, there has been a notable change in 21st century health service direction. Yet despite the direction change to delivery of health services a gap in health status between Aboriginal and non-Aboriginal people still exists and this gap represents a significant challenge to all health service providers.

According to the Australian Government Department of Health and Ageing "Closing the Gap – tackling indigenous chronic disease" (April 2010), Aboriginal people suffer a chronic disease (CD)

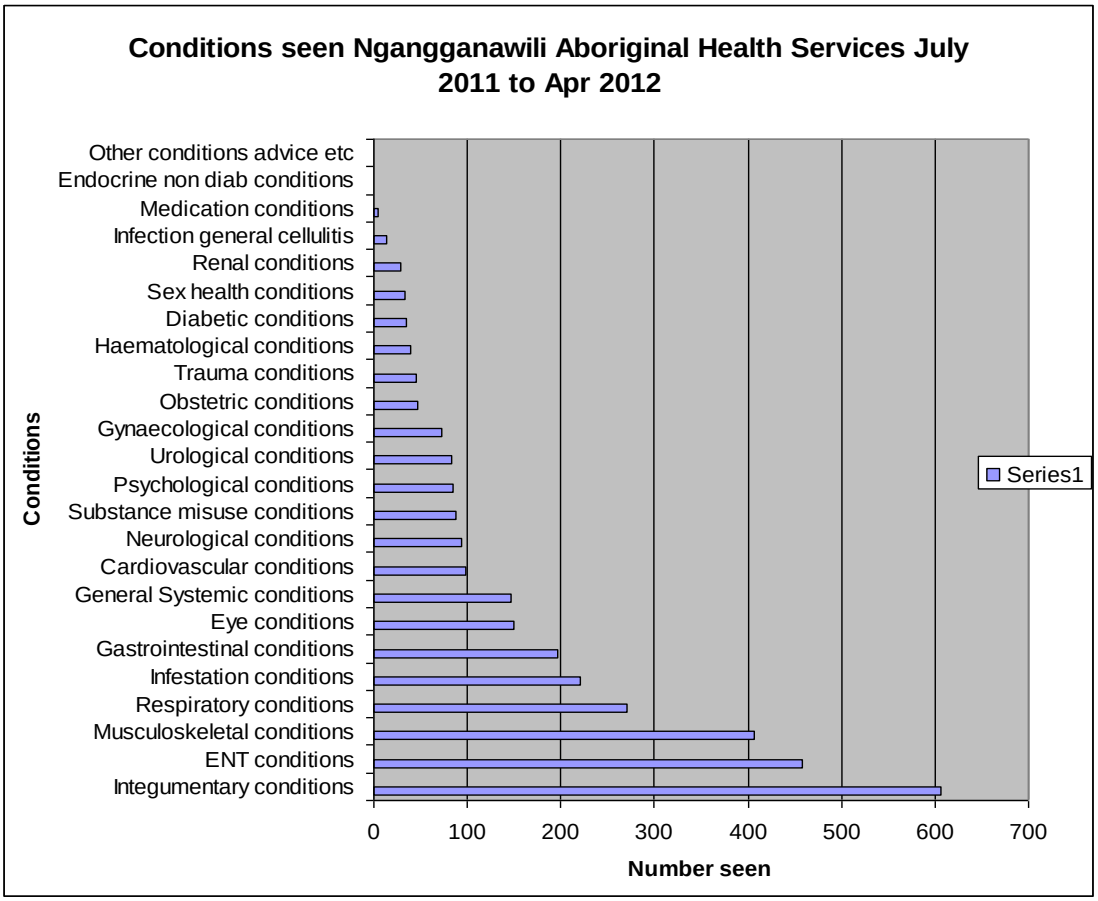
burden 2.5 times greater than that suffered by non-Aboriginal people. Aboriginal people are also disproportionately represented in relation to hospital admissions and separations across the country (Goldfields Regional Aboriginal Health Planning Forum [GRAHPF] 2010). Over the last decade, Federal Chronic Disease Management (CDM) health initiatives, including Aboriginal health priorities such as "Closing the gap", have provided health services with incentives to broaden their reach and effectiveness. Accordingly, the Ngangganawili Aboriginal Health Service (NAHS) has focused physical and financial resources toward improving health care outcomes for people suffering chronic disease. In order to further narrow the gap between Aboriginal and non-Aboriginal health status in Wiluna shire, the NAHS needs to formulate and implement a community wide approach to preventing, treating and facilitating self-management of chronic diseases.

According to the 2010 Goldfields Aboriginal Health Plan (GAHP), Aboriginal people in the Goldfields suffered from a higher chronic disease associated mortality rate than non-Aboriginal people of the same region (ABS Mortality data and WA cancer data 1997 - 2008) highlighting the need for chronic disease associated health programs. Whilst the NAHS was unable to participate in the 2010 GAHP review, the size of NAHS service area and the breadth and scope of health issues within it require increased engagement with all regional providers. Drawing on additional data from the 2010 GAHP review, the top four chronic diseases within the Goldfields Aboriginal Population were: Diabetes, Ischaemic Heart Disease, Cancer and Chronic Lower Respiratory disease. Of particular note is the mortality ratios related to these diseases – e.g. the death rate associated with Diabetes is up to 18.8 times the rate of death for non-Aboriginal people. Therefore services such as NAHS need to be able to grow prevention, treatment, disease management programs and care networks in order to close the gap.

In line with Federal initiatives such as the Practice Incentive Program - Indigenous Health Incentive (2010), the NAHS has already increased service activity aimed at reducing the impact of chronic disease as demonstrated by the greater use of relevant CDM MBS items by medical staff (Communicare data 2012). The NAHS also wishes to engage the community in early intervention and chronic disease self-management which will of necessity increase the total NAHS activity. In respect to this predicted increase in activity and broader community engagement, the NAHS is mindful of the need for increased financial and human resources particularly in the area of chronic disease care and self-management programs.

The CDM initiatives and MBS related activity under the "Closing the Gap" program have already impacted the NAHS clinic throughput. In the period July 2011 to April 2012, 17,288 (NAHS Daily Service Analysis all providers/places/services - Communicare) episodes of care took place across the 187,000 sq km service area. In the Wiluna NAHS clinic during this same period there were 7150 episodes of direct patient contact. It is anticipated that with greater community based engagement the total service episodes in and outside of the clinic will grow by 30 – 50% over the next 3 – 5 years, requiring significant changes to work flow and function as well as financial and staffing resources. In order to maximise the effect of all services being offered and delivered, a greater level of service co-ordination will be necessary.

Table 1: Conditions and individual patient numbers seen at NAHS



Whilst the conditions seen within the NAHS (Table 1) are many and varied, the unseen statistic is how many presentations are associated with each condition. Most of the high presentation conditions are short episodes of care. The management of chronic conditions however is more labour intensive and whilst the actual number of CD presentations is smaller they represent a significant proportion of clinic time. Through a largely self-funded process of infrastructure improvement (new clinic 2012), a total review of service provision and structure (NAHS Service review April – July, 2012) and integration of CDM as a principal model of care, the NAHS is endeavouring to position itself as a centre of excellence in the management of Chronic Disease within remote communities. In line with regional/local population disease manifestation, the NAHS will focus on Heart Disease (ischaemic and congestive failure), Diabetes 1 and 2, Renal dysfunction, Respiratory disease and Ear/Nose/throat disorders amongst younger people recognising that improved health in these key areas would lead to a healthier community on many levels.

In its paper "Indigenous Chronic Disease Package – Care Coordination and Supplementary Services Program Guidelines" (April 2010) the Federal government articulates the need for chronic disease care coordination and relevant programs to improve health service access for Aboriginal people, especially for those with heart disease, diabetes, renal dysfunction, respiratory disease and cancer. Further, the Federal government suggests that this coordinated program be delivered by qualified

health care workers (ICDP CCSS 2010, p2). Whilst there has been increased CDM activity at the NAHS, when compared to other regional providers of health care for indigenous people, a service gap does exist. In order to bring the NAHS practice in to line with Federal government expectations and to further improve service delivery and reduce the burden of chronic disease, the NAHS is now re-aligning its fundamental service delivery model to incorporate Chronic Disease Management as core business.

Chronic Disease Care Management – Drivers

In 2009 the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes commenced. The $1.6 billion package was formed to support health initiatives designed to reduce the difference in life expectancy between Indigenous and non-Indigenous Australians within a generation (ICDP, Oct 2011). The essential thrust of the package was to reduce smoking, increase physical activity and encourage the adoption of healthy lifestyles amongst Aboriginal and Torres Strait Islander people with a view to reducing the development of chronic disease. As the health package was rolled out significant resources were directed toward the development of healthy lifestyle teams whose purpose was to implement quit-smoking and physical activity campaigns. In addition to this, the package also provided for the incorporation of Practice Managers and Chronic Care Coordinators whose primary purpose was to ensure that the health programs were correctly targeted and met COAG NPA goals.

Whilst the fundamental platform for the ICDP was of a primary care nature, acknowledgement was made of the need to improve treatment and monitoring of patients suffering chronic disease (ICDP, Oct 2011). In particular Diabetes, heart disease, renal disease, lower respiratory disease and cancer were identified as significant health issues that needed to be more effectively addressed in order to reduce the burden of chronic disease amongst indigenous Australians. Strategies such as increasing the use of relevant CDM related MBS items, workforce training, increasing relevant resources/equipment, improving access to specialist medical and allied health services, alongside increased use of relevant PBS medicines where appropriate have been offered as components that would help close the gap on life expectancy by reducing the chronic illness burden. In order for these strategies to be effective however, they must be targeted and implemented in a meaningful way requiring a high level of care coordination. In ACCHO's the most efficient way of ensuring program and ICDP success is through the use of a Practice Manager/Chronic Care Coordinator whose responsibility is to facilitate, monitor, measure and evaluate care programs.

Financial/Service provision/incentives

- PIP/SIP indigenous health: The Federal Govt. has increased revenue through Medicare to underwrite increases to the range of MBS items related to Indigenous CDM. Through its incentive programs the Federal Govt. is encouraging greater use of relevant MBS CDM items in order to improve prevention, assessment and treatment of chronic disease amongst indigenous Australians.

- PBS co-payment scheme: designed to reduce cost of medicines for Indigenous Australians with chronic diseases. Historically, cost has been a barrier to achieving desirable health outcomes as people prioritized other areas of expenditure over medication; available to people who have GPMP's and other CDM related care plans.

- Medical Specialist Outreach Assistance Program: One of the most problematic areas of all in relation to "Closing the Gap" is access to Medical specialists. This ICDP incentive allows those in remote areas to gain improved access to specialists – either through increased remote area visits by specialists or via tele-health.

- Multidisciplinary care team access: The Federal government has increased the number of visits to Allied health practitioners that an Indigenous Australian can make in any given year. In effect this means that those people with chronic diseases who require the services of any type of Allied Health service can now receive that care necessary to treatment or prevention of CD related health issues.

- Health Workforce training: the Federal government has provided significant funding to up-skill the nursing and Aboriginal Health Worker workforce to better enable them to implement CDM related programs. Up-skilling includes but is not limited to lifestyle program implementation, quit smoking campaigns, CD self-management programs and assessment techniques

Given the nearly 18,000 health service related contacts per year that the NAHS already provides/facilitates, it would be unrealistic to expect that the ICDP Federal initiatives and incentives could be operationalized without additional personnel, programs and support. For example, as part of the Flinders "Closing the Gap" CDM program it is expected that a minimum of 100 indigenous patients per year are admitted in to the assessment and treatment arm of any participating ACCHO. Given that the NAHS currently has 31 people on GPMP's but perhaps over 140 people who would benefit or be eligible for admission to the CDM program there is little capacity to provide appropriate service without significant coordination and service approach changes. For these reasons NAHS has committed to expand its workforce, provide a greater range of responsive services and to shift its business model from acute care to Primary and Chronic Disease Care.

Flinders Program (Chronic Disease Self-Management) and evolution of NAHS model of implementation

As the first step in re-orientation of the NAHS business model to better reflect ICDM objectives an internationally recognised, evidence-based Chronic Disease Management program needed to be sourced and implemented. Through "Closing the Gap" initiatives of the Federal Government, Flinders University had developed a program largely based on the "Stanford CDM Model" (US) which incorporates cognitive behavioural therapy as a practice construct. Via a national tendering process, Puntukurnu Aboriginal Medical Service (PAMS) had obtained the rights to "roll out" the Flinders Program across regional and remote Western Australia. Based on its international standing, previously published success and local roll-out through PAMS, the Flinders Program was chosen by NAHS as its preferred system.

In September 2012 an MOU between PAMS and NAHS was signed enabling NAHS to access the necessary staff training and funding to commence the business model transition to CDM. The Flinders Program provides financial support of $120,000 per annum over three years for the employment of relevant staff. As a consequence NAHS was able to expand its Registered Nurse workforce enabling implementation of the program. In October 2012 training of all NAHS clinical staff (RN's and Health Workers) in the Flinders Program was commenced. A two-day education program was facilitated by PAMS Chronic Care Coordinators on-site and certification was achieved

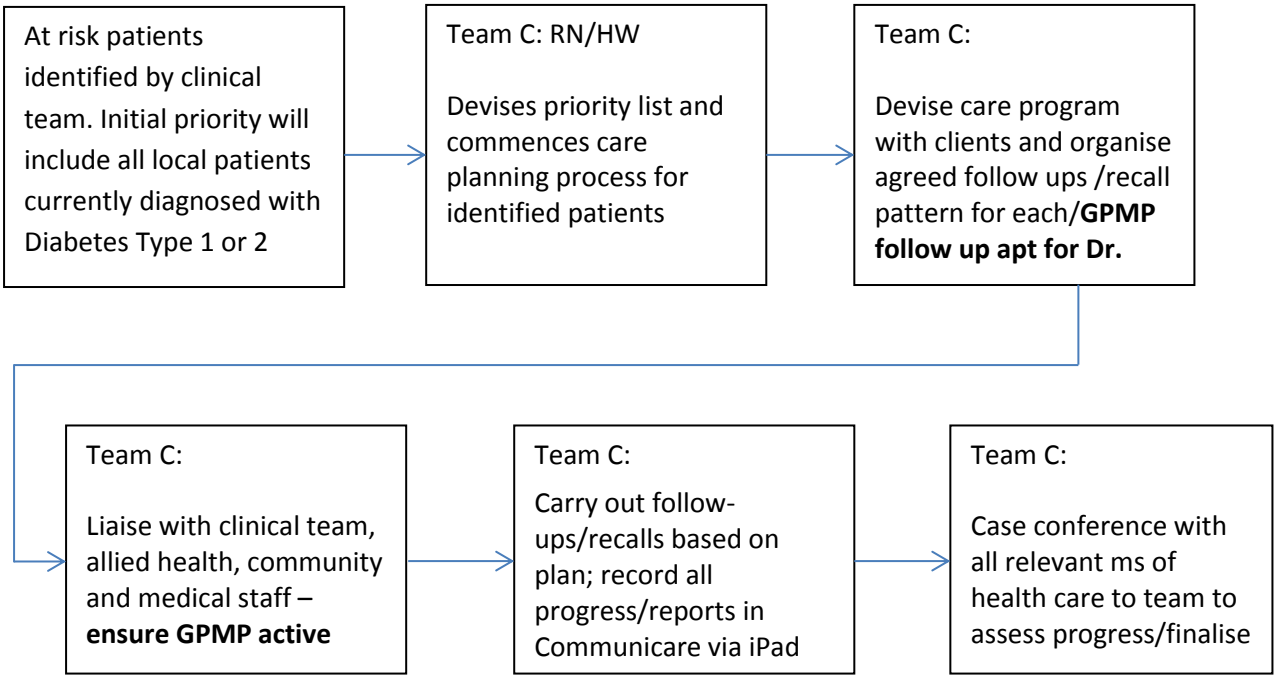
by the majority of staff. In February 2013 further training and program updates were again provided by PAMS CDM staff, enabling the new NAHS staff members to achieve the required level of program competence and to allow all staff to gain insight into Flinders Program changes. Program implementation was set for March 2012.

NAHS Model of implementation

Based on the NAHS service review 2012 and input from management and clinical staff a unique approach to implementing the Flinders Program was designed. Whereas for most services a designated Flinders Program Care plan coordinator carries out all assessment and "admissions" to the care-continuum, NAHS devised a unique approach based around the need to deliver care in the community. Below is the NAHS model for implementing the Flinders Program:

- All NAHS RN and Health Worker staff are members of the CDM Care planning team
- Functional teams comprising 1 RN and 1 HW will carry out the assessments, care planning and follow ups from Tuesday to Friday each week (Team = Team C)
- Team C will rotate through standard clinic based work and Flinders Program care planning work
- Allocation to Team C will be on a weekly basis to facilitate participation by all members of clinical staff
- Flinders Program Care planning will take place in both the community and clinic, though community is the preferred option
- Where an Aboriginal Health Assessment (715) has not been completed it will be undertaken by the care planning team
- The 715 will be used as a basis for risk assessment and thereby facilitate entry into the Chronic Disease Management program
- Care planning will incorporate both the Flinders Program and General Practice Management Plans (721) into one seamless process using an electronic IT based Universal Care plan which sits within Communicare (NAHS Patient Data management system)
- Team C will liaise with Medical Staff on a daily basis and ensure that all patients entering in to the program (and who require a GPMP and TCA) are fully reviewed by the GP in a timely manner
- Case conference between all relevant members of clinical team will drive the identification, care plan updates, intervention and follow ups/recall

Chronic Disease Management Program Workflow



Team C: Functional elements

- ***Goal: 100 Flinders Program Care plans per annum***
- ***2013 Target: all people currently diagnosed with Diabetes***
- Each person admitted to the Flinders CDM Program ***must*** have a 715 and 721 ***and must*** also sign PIP consent form (if they have not done so already)
- Each person with a 715 / 721 ***must*** have a follow up appointment asap to see Dr. who will review plan and submit to Medicare
- Flinders Program/715/721 follow-ups: set as per individual needs but may have up to 15 with RN/HW
- ***First 10*** follow up visits by RN/HW can be recorded as a **10987** with assessment, intervention and goal related outcomes recorded directly into Communicare
- ***Final 5*** follow up visits by RN/HW can be recorded as a **10997** with assessment, intervention and goal related outcomes recorded directly into Communicare
- Doctors are to review 715, 721 at patient consult, then submit when satisfied
- Doctors are to formulate 723 at initial consult (above) and set medical review times (recalls) for GPMP and Team Care arrangements
- CDM review consults can be charged at 732 rate (> Level C) – patient can have 3 reviews per year or more if deemed necessary
- Team C will review 721, 723 immediately post submission and ensure that patient is listed for recalls related to the various allied health team members on their visits to Wiluna (e.g. check Podiatrist Schedule and ensure the specific recall occurs)

- Ideal times for 715/721/723 Dr. appointments are Wednesday (p.m.), Thursday and Friday
- Team C to liaise with Triage to ensure “walk up” patient numbers are low before bringing in clients

NAHS Health Service Program structure – Overview

Medical Services:

Primary Care (all)
24/7 Emergency Care
Out-of-hours Medical Care
Ante-natal care
Visiting Specialists
Medical student training

Nursing Services:

Primary Care (all)
24/7 Emergency Care
Ante-natal care
Flinders Program CDM

Social and Emotional Well Being Services:

Substance misuse
Acute Psych intervention
Counselling
Family /Dom violence
Suicide Prevention

Environmental Health Services:

Maintenance
Home safety
Community response
Infestation control

Allied Health Services:

Physiotherapy
Podiatry
Audiology
Ophthalmology
Population Health

Medical Services: Personnel

1. Doctor (SMO) 0.5
2. Doctor 0.25
3. Doctor 0.25
4. Registrar (provisional)
5. Medical Students

Nursing Services: Personnel

Clinical Manager
RN x 6
HW x 4

Social and Emotional Well Being Services: Personnel

Senior Mental Health professional (provisional)

Substance misuse officers x 2

Suicide Prevention (provisional)

Aboriginal Mental Health Worker – WACHS funded (non –NAHS)

Environmental Health Services: Personnel

Environmental Health Workers x 2

Referral:

Referral to the various services and disciplines can be made via/to:

Medical team
Nursing team
Allied Health team
Environmental Health Services
Specialist services

The NAHS medical team have oversight responsibility for the medical management of all clients.

Case conferencing will be used to ensure that all care relating to Allied Health, Specialist services and the CDM program is on-track and effective. Case conferences may involve all members of the Health care team or selected members depending on need.

Chronic Disease Management (Medicare Benefits Scheme – MBS) Items:

For each person being admitted to Flinders program they must also have the following Practice Incentive Payments and medical/nursing follow up with assigned item numbers:

Item Name	Item No.	$ Value per Item
PIP Incentive payment – consent (Nurse assist)	#	250
Tier one payment	#	100
Tier two payment	#	100
Medical:		
Health Assessment (Nurse assist)	715	208.10
GP Management plan (GPMP) (Nurse assist)	721	141.40
Team Care Arrangement (TCA) (Nurse assist)	723	112.05
Review GPMP (x4 per year)	732	70.65
Review TCA (x4 per year)	732	70.65
Case Conference Multi-D	735	69.25
Review Multi D Care plan	729	69.00
RN/HW follow up post 715 (10)	10987	24.00
RN/HW Support/monitoring (GPMP/TCA) (5)	10997	12.00
CDM - Diabetes specific		
Diabetes Cycle of care (Nurse assist)	2620 & 2517	36.30
ABPI baseline (Nurse assist)	11610	63.75
ABPI Rest v Exercise (ABPI <.8) (Nurse assist)	11612	112.40
Completion of Cycle of care (Nurse assist)	2251	70.30

"Nurse Assist" implies that Medical care is facilitated by nursing activity.

- Nurse completes physical assessment components
  (Hx, obs, urinalysis, bloods, ABPI, BGL, etc. /social &emotional wellbeing)

- For GPMP/TCA nurse completes all components and submits data to Dr. for review and ratification

- Appointment schedule for GPMP, TCA, Cycle of care, case conference, review of multi D plan are to be arranged according to established schedule by RN/HW in Team C

Claiming periods:

Description	*Item No*	*Minimum claiming period**
Preparation of a GP Management Plan (GPMP)	721	12 months
Coordination of Team Care Arrangements (TCAs)	723	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	3 months
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	3 months

*CDM services may be provided more frequently in exceptional circumstances; http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=721

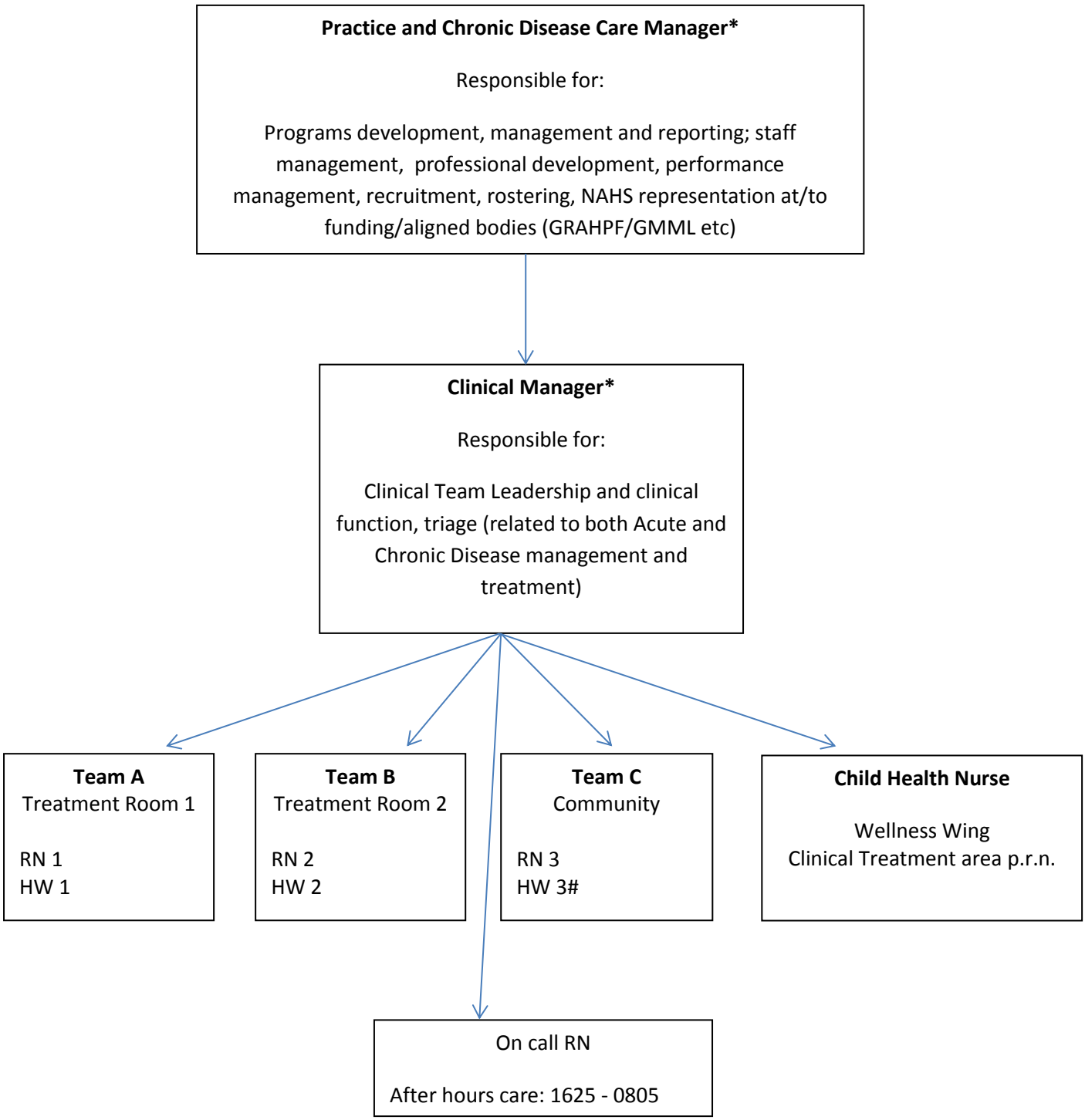
Clinical Team Structure 2013

The following Clinical Team Structure (CTS) and function has been designed for implementation of the Chronic Disease Management program as well as the Ambulatory care, Emergency care, Disease Prevention and Healthy Lifestyle service delivery imperatives of the NAHS.

The CTS aims to:

- re-orient NAHS business and clinical function to reflect the21st century DoHA directives and MBS incentives related to Chronic Disease Management
- restructure staffing arrangements to ensure adequate numbers of staff are available to perform required work in a safe and efficient manner
- re-align staff function to facilitate implementation of the Chronic Disease Medical and Self-Management (Flinders)Programs
- improve patient outcomes across all spheres of health care
- improve responsiveness to the current and future needs of the community
- better provide for cultural safety
- improve patient flow
- improve the individual's experience of health care at the Nangganawili Aboriginal Health Service (NAHS)
- provide for a greater range of services that can be delivered at the NAHS clinic and in the community
- improve baseline Medicare revenue to NAHS
- better delineate responsibility for tasks and roles to be carried out within the NAHS clinic and community
- improve child and family health assessment and outcomes
- improve working relationship with Social and Emotional wellbeing services
- improve focus for environmental health team
- establish closer working relationship between the HACC program and NAHS

Clinical Team Structure 2013



* See position descriptions attached re: responsibilities, accountability and line management

If only 2 HW's available then no Community Based HW for that day/period

Specific Team Duties

The purpose of this team allocation organisational approach with delineated responsibilities, duties and tasks relates to the need for continuity in NAHS clinical function alongside efficient operation of the Chronic Disease Management and Flinders Programs. There are no major changes to RN or HW function other than the addition of a specific team C whose role and responsibility is necessitated by the implementation of the CDM and Flinders Programs.

The team structure, function and duties are subject to 3 monthly reviews at NAHS clinical team meetings. Suggestions, changes, problems and functional review points can be forwarded to Practice Manager at any point in the 3 monthly cycle of review via the established QI forms.

Team A: (clinical treatment room 1)

- Allocated as Emergency Response Team (daily)
- Checks and restocks TR 1 (p.m.)
- Checks/restocks Emergency room/Trolley daily (a.m.)
- Check/restock Emergency packs monthly (a.m.)
- RN – as per established RN responsibilities
- HW – as per established HW responsibilities

Team B: (clinical treatment room 2)

- Allocated to triage relief (breaks only Mon/Wed; Thur/Fri all day)
- Assists with Minor Procedures (MP) (daily)
- Checks and restocks TR 2 (p.m.)
- Checks restocks Medical Consult/MP rooms (daily)
- School liaison/minor tx 0830 – 0930 (if RN nos < 3)
- RN – as per established RN responsibilities
- HW – as per established HW responsibilities

Team C: (Community) ^

- School liaison/minor tx 0830 – 0930 (Mon – Fri when RN nos >3)
- CDM (care plans/health checks/recalls) 0930 – 1530 (Tuesday – Friday)
- Write ups/add recalls; check/print Dr recall 1530 – 1630 (Tuesday – Friday)
- Check and tidy X-ray and plaster room (daily)
- RN – as per established RN responsibilities
- HW – as per established HW responsibilities

^ may be recalled, re-allocated, used for “back-fill” etc. where clinic need arises

Daily Work Structure – Clinic Teams

0800	**Work day commences**
0805 – 0820	Morning meeting • Handover from on-call nurse • Team allocation • Specific activities/duties as necessary • Breaks allocation • Clinical matters
0820 – 0945	a.m. work Checks as per team responsibility
0945 – 1000	**Tea break 1**
1000 – 1015	**Tea break 2**
1015 – 1145	Mid a.m. work
1145 – 1245	**Lunch break 1**
1245 – 1345	**Lunch break 2**
1430 – 1445	**Tea break 1**
1445 – 1500	**Tea break 2**
1600 – 1630	Checks and restocking of stations/cleaning/clearing
1625	**On call nurse commences** • handover of relevant patients by day staff • Checks security/call system

Daily work structure

0800	**Work day commences**
0805 – 0820	Morning meeting as above Specific: lead recall discussion – flagged patients for discussion only
0830 – 0930	School visit – liaison, minor treatment, child assessment/review **(Mon-Fri)**
0930 – 0945	Tea break
0945 – 1230	**Community visits to include: (Tues-Fri)** • CDM universal care plans/follow ups (Flinders program/721/723) • Aboriginal Health Assessments (715) • Recalls for clinic attendance
1230 – 1330	**Lunch break**
1330 – 1530	Continue community visits (afternoon tea break – 15 mins prn)
1530 – 1630	Check and print recall list for next day – liaise with Dr./Clinic Teams for this Short verbal report of activity to PM/CDCM Check and tidy X-Ray/ plaster rooms/renal suite (daily)

NB: this team will take responsibility for checking, adding/subtracting and printing recalls for following day. This process must include liaising with Drs and clinic team so that printed doc accurately represents latest required patient activities. This team will also be required to assist with Immunisation program, in-school health checks (e.g. Trachoma screening), children's visits to clinic from school for specific health checks and education (in conjunction with child health nurse). They may be recalled to the clinic in response to changing client presentation numbers. Team C will communicate with Triage nurse regularly in order to maintain reasonable flow of recall patients. They may also be called upon by Triage nurse or reception staff to visit homes to provide relevant information e.g. Medicare numbers, Health Care card details etc. to clinic staff – this can be entered into system directly via the Team C iPad Communicare portal.

Patient Flow process:

1. Patient presents to reception and is logged in to the system by reception who check for address, Medicare, Health Care card details – if these are not up to date then receptionist is responsible for ensuring that details are updated whilst patient is in clinic. If required Reception can request Triage Nurse to contact Team C who will attempt to get details from patients home where appropriate or possible

2. Patient is triaged by Triage Nurse/Registered Nurse:

    - Checks patient details
    - Checks for FP-CDM, 715, 721, 723, Cycle of care, Immunisation status
    - Assigns level category of care/Triage level
    - Provides Colour code card
    - Alerts relevant team if assessments need to be completed
    - Alerts Team C if details are required from home

3. Nurse/Health Worker takes patient to clinic room and completes the following:

        - Observations
        - Short history
        - Enter data in to Communicare
        - When entering data check for other health issues or outstanding care e.g. FP-CDM, 715,721
        - Undertake to complete outstanding care issues

4. When there are no clients in waiting room and the clinic is quiet then recalls become the priority – Triage nurse to contact Team C and alert them

5. If recalls are not possible then re-stocking, checking, organising and education are the priorities

6. Please ensure you are working in your assigned team and that other staff members, especially your immediate Team mate, is aware of your activity

Portfolios of responsibility:

Each RN and HW will be given a portfolio of responsibility. These portfolios represent areas of specific clinical need/activity as determined by the NAHS review 2012. Implementation of these portfolios will be iterative. In the first instance during 2013 the following will occur:

1. Allocation of Portfolios to RN's and HW's (April)
2. Professional development plan for each HW/RN related to their portfolio (May/June)
3. Performance management system implementation using the above PD as a baseline (July)
4. Contribution to NAHS inservice program by staff in relation to their POR (July – Dec)

Portfolio details follow:

Portfolio of Responsibility:

RN 1 – INTEGUMENT, WOUND, INFECTION CONTROL

Evidence:

Based on the Communicare data in Report 1 Stream 1 (2012), integumentary conditions are the most prevalent of all conditions seen at NAHS (> 600 July 2011 to April 2012). These conditions include: Infestations (Lice and Scabies), Dermatological conditions (general), Wounds – acute and chronic, Skin infections (including Ring Worm etc) and Burns. Infestation by scabies and lice can lead to longer term, even chronic health problems therefore reducing community prevalence of these infestations and ensuring early treatment and follow up will help to reduce the burden of disease or chronic disease in Wiluna Shire.

General description:

This RN POR incorporates prevention, treatment and management of integumentary infestations/infections, wounds and general skin dysfunction. Involvement in prevention programs designed to reduce skin infestations is an essential element of this role. This primary intervention is an "in-community" type and involves all age spectra. Measurement of infestation prevalence and incidence, education of client groups (pre-school, school and adults), community based follow-ups, in-clinic treatment/advice, cooperation with all members of the broader health team (Medical and Population health etc) and coordination of nursing care secondary to medical intervention are fundamental features of activity. This role also incorporates monitoring and training of all clinic staff in relation to infection control and ensuring that all clinical activity and resources comply with the relevant Australian Infection control standards. Assessment, planning and treating chronic wounds will also be core to the function of the RN in this POR.

Aims of role:

- Reduce community prevalence of Integumentary infestations/dysfunction
- Reduce morbidity associated with Integumentary infestations/dysfunction
- Facilitate an across life-span approach to prevention and management of Integumentary infestations/dysfunction
- Implement and maintain best practice approaches to wound and other skin disease management within NAHS
- Educate and update all NAHS staff (6 monthly) in relation to Integumentary infestations/dysfunction assessment, treatment and management
- Ensure all the NAHS clinical activity complies with relevant Australian Infection Control standards
- Educate and update all NAHS staff (6 monthly) in relation to infection control
- Liaise and work cooperatively with all other relevant service providers on matters and activities concerning integumentary health

Key Performance Indicators:

- 2012-13: establish baseline of infestation occurrence at community and clinic level in cooperation with Chronic Disease Management coordinator
- Year by year reduction of skin infestation within community (early childhood, school, home, clinic) as measured by epidemiology and Communicare data
- Contribute to written report on whole-community status of skin infestation (yearly)
- Evidence of consultation with Medical and Allied Health staff (NAHS and Population health etc) in relation to integumentary dysfunction matters
- 6 monthly updates for the NAHS staff in relation to skin infestation or other skin disorders/dysfunction, including wound management
- 6 monthly updates for the NAHS staff in relation to Infection control
- 1 x yearly attendance at relevant training in relation to managing skin infestation or other skin disorders/dysfunction, including wound management (in-person or online training); formal evidence of same
- 1 x yearly attendance at training in relation to infection control (in-person or online training); formal evidence of same
- Evidence of checks and maintenance of relevant equipment

Portfolio of responsibility:

RN 2 – DIABETES

Evidence:

According to the GRAHPF 2010 data (based on ABS/WA health data), Aboriginal people in the Goldfields region of WA have a death rate 18.8 times than that of non-Aboriginal people in relation to Diabetes and Diabetes is the leading cause of death. Given that Wiluna shire is part of this larger region it is imperative that this major health issue be addressed in a formal manner. Currently there is no data describing the number of people in the wider Wiluna Shire community who are suffering Diabetes or are pre-Diabetic. In the period July 2011 to April 2012 there were 35 diabetes related conditions treated at the NAHS clinic. Information did not indicate how many individuals were represented in the data set. There is also evidence in Communicare that Diabetes health checks are being carried out in the NAHS clinic but there is no data to indicate whether all people with Diabetes in the community are represented in this group and there is no way of measuring this as the total number affected is unknown.

General description:

This RN POR involves prevention, assessment, treatment, management and education of the Wiluna community and affected patients in relation to Diabetes type 1 and 2. An essential role component is the promotion of self-management for people with Diabetes. In cooperation with the Chronic Disease Management coordinator, the responsible RN would facilitate education programs across the lifespan and self-management support groups in relation to Diabetes. They will be responsible for face to face education within the community or patient group as well as updating all the NAHS staff in relation to Diabetes management. Whilst not essential it is desirable that this RN works towards becoming a Diabetes educator and maintains close professional links with the Australian Diabetes Association. In conjunction with Medical staff this RN will also undertake regular health reviews with affected patients or will ensure that these reviews take place when not available (i.e. in cooperation with Medical staff maintain a review schedule of recalls). Wherever possible this RN would be the direct point of contact for patients with Diabetes. This RN would also work closely with Allied Health Providers and visiting health professionals in relation to preventing treating and managing diabetes.

Aims of role:

- Reduce community prevalence of Diabetes
- Reduce morbidity associated with Diabetes
- Facilitate an across life-span approach to education, prevention and management of Diabetes; includes facilitating self management support group for patients affected by diabetes
- Implement and maintain best practice approaches to Diabetes management within NAHS
- Educate and update all NAHS staff (6 monthly) in relation to Diabetes assessment, treatment and management
- Ensure all the NAHS clinical activity complies with relevant Australian Diabetes Association standards
- Liaise and work cooperatively with all other relevant service providers on health matters and activities concerning patients at risk of, or affected by, Diabetes

Key Performance Indicators:

- 2012-13: establish prevalence of Diabetes at community and clinic level in cooperation with Chronic Disease Management coordinator
- Year by year reduction of morbidity associated with Diabetes within community as measured by epidemiology and Communicare data i.e. there will be a measured reduction in medically managed diabetes related complications
- Facilitation of Diabetes self-management support group with evidence of Diabetes stabilization amongst members of that group (reduction in HbA1c or average BGL in each individual)
- Contribution to written report on whole-community status of Diabetes (yearly)
- Evidence of consultation with Medical and Allied Health staff (NAHS and Population health etc) in relation to Diabetes prevention, assessment and management
- 6 monthly updates for the NAHS staff in relation to Diabetes prevention, management and treatment
- 1 x yearly attendance at relevant training in relation to managing Diabetes (in-person or online training); formal evidence of same
- Desirable: works towards becoming Diabetes Educator

Portfolio of responsibility:

RN 3 – RENAL/UROLOGY, CARDIOVASCULAR

Evidence:

Renal and cardiovascular diseases are second only to Diabetes as leading causes of death amongst Aboriginal people. Little is known about the total number of people in the Wiluna Shire who suffer from Renal or Cardiovascular disease but it is widely accepted that many early childhood diseases commonly found amongst Aboriginal children (ENT, lice/scabies) plus smoking and substance misuse can lead to health complications that later manifest as Renal and Cardiovascular health issues. In the period July 2011 to April 2012 Communicare shows 98 cardiovascular related conditions and 28 renal conditions were seen at the NAHS clinic. Whilst the actual number of patients who presented with these conditions is unknown, the conditions were of a serious nature and represented a significant threat to the health of those individuals. Urological conditions are also a major health concern - 83 urological conditions were recorded on Communicare in the above stated period.

General description:

This RN POR incorporates prevention, treatment and management of renal, urological and cardiovascular dysfunction. Involvement in education and prevention programs designed to reduce the occurrence of these health problems is an essential element of this role. This primary intervention is an "in-community" type and involves all age spectra. Measurement of renal and cardiovascular prevalence and incidence, education of client groups (pre-school, school and adults), community based follow-ups, in-clinic treatment/advice, cooperation with all members of the broader health team (Medical and Population health etc) and coordination of nursing care secondary to medical intervention are fundamental features of activity. This role also incorporates training of all clinic staff in relation to renal, urological and cardiovascular disease prevention, treatment and management thereby ensuring that all clinical activity and resources comply with the relevant Australian professional standards. Maintaining close alliance with the relevant professional bodies e.g. Australian Kidney Foundation and the Australian Heart Foundation is an expectation within this POR.

Aims of role:

- Reduce community prevalence of Renal and Cardiovascular dysfunction
- Reduce morbidity associated with Renal and Cardiovascular dysfunction
- Facilitate an across life-span approach to prevention and management of Renal, Urological and Cardiovascular dysfunction
- Implement and maintain best practice approaches to management of Renal, Urological and Cardiovascular dysfunction within the NAHS
- Educate and update all the NAHS staff (6 monthly) in relation to Renal, Urological and Cardiovascular dysfunction assessment, treatment and management
- Ensure all the NAHS clinical activity in designated fields complies with relevant Australian professional association standards
- Liaise and work cooperatively with all other relevant service providers on matters and activities concerning Renal, Urological and Cardiovascular dysfunction

Key Performance Indicators:

- 2012-13: establish baseline of Renal, Urological and Cardiovascular dysfunction occurrence at community and clinic level in cooperation with Chronic Disease Management coordinator
- Year by year reduction of Renal, Urological and Cardiovascular dysfunction within community (early childhood, school, home, clinic) as measured by epidemiology and Communicare data
- Written report on whole-community status of Renal, Urological and Cardiovascular dysfunction (yearly)
- Evidence of consultation with Medical and Allied Health staff (NAHS and Population health etc.) in relation to Renal, Urological and Cardiovascular dysfunction matters
- 6 monthly updates for the NAHS staff in relation to Renal, Urological and Cardiovascular dysfunction
- 1 x yearly attendance at relevant training in relation to managing Renal, Urological and Cardiovascular dysfunction (in-person or online training); formal evidence of same

Portfolio of responsibility:

RN 4 – CHILD HEALTH, EYES/ENT, SEXUAL HEALTH

Evidence:

These three condition ranges are deliberately grouped together as they fundamentally relate to health issues in younger people. A large number of presentations to the NAHS clinic in the period July 2011 to Apr 2012 related directly to the management or treatment of people with Eye or Ear, Nose and Throat dysfunction (608 conditions seen as per Communicare). Child Health issues incorporate those aforementioned as well as Dental (oral) and immunization related interventions. The Federal Government provides incentives for achieving certain immunization targets for populations and whilst those targets are achieved in terms of presentations to the clinic the actual immunization status of the community is unknown or not represented in the available data. As children cross over into early adulthood, sexual health issues begin to feature more significantly. 34 sexual health related conditions were seen in the above noted period. There is also an ongoing sexual health program including supply of condoms and gender/culturally sensitive consultation.

General description:

This RN POR incorporates prevention, treatment and management of child health issues (including immunization), sexual health issues and eye/ENT diseases or conditions. Involvement in education and intervention programs designed to increase childhood immunisation is an essential feature of this POR. Liaising and working with Medical, early childhood and school staff, this RN will help to ensure that Commonwealth immunisation targets are met. This RN will also order/monitor/maintain vaccines according to relevant Australian standards. Additionally, this RN will work toward increasing parent/child-engagement with the NAHS clinic through a structured series of visits and activities by school children. Involvement in education, treatment and management of sexual health related issues will feature significantly in this role. This primary intervention is an "in-community" *and* in-clinic type and involves all age spectra. Finally, measurement of eye/ENT disease prevalence and incidence, education of client groups (pre-school, school and adults), community based follow-ups, in-clinic treatment/advice, cooperation with all members of the broader health team (Medical and Population health etc) and coordination of nursing care secondary to medical intervention are fundamental features of activity. This role also incorporates training of all clinic staff in relation to POR areas thereby ensuring that all clinical activity and resources comply with the relevant Australian professional standards. Maintaining close alliance with the relevant professional bodies e.g. Population Health, Medicare Locals is an expectation within this POR.

Aims of role:

- Reduce community prevalence of Childhood diseases, Sexual Health issues and eye/ENT dysfunction
- Reduce morbidity associated with Childhood diseases, Sexual Health issues and eye/ENT dysfunction
- Facilitate an across life-span approach to prevention and management of Childhood diseases, Sexual Health issues and eye/ENT dysfunction
- Implement and maintain best practice approaches to management of Childhood diseases, Sexual Health issues and eye/ENT dysfunction within the NAHS
- Educate and update all the NAHS staff (6 monthly) in relation to Childhood diseases, Sexual Health issues and eye/ENT dysfunction assessment, treatment and management
- Ensure all the NAHS clinical activity in designated fields complies with relevant Australian professional association standards
- Liaise and work cooperatively with all other relevant service providers on matters and activities concerning Childhood diseases, Sexual Health issues and eye/ENT dysfunction

Key Performance Indicators:

- 2012-13: establish baseline of Eye/ENT dysfunction occurrence at community and clinic level in cooperation with Chronic Disease Management coordinator
- Year by year reduction of STI's and Eye/ENT disease within community (early childhood, school, home, clinic) as measured by epidemiology and Communicare data
- Achievement of Commonwealth immunisation targets on a yearly basis
- Written report on whole-community status of Immunisation, STI's and Eye/ENT dysfunction (yearly)
- Evidence of consultation with Medical and Allied Health staff (NAHS and Population health etc) in relation to Immunisation, STI's and Eye/ENT dysfunction matters
- 6 monthly updates for the NAHS staff in relation to Immunisation, STI's and Eye/ENT dysfunction
- 1 x yearly attendance at relevant training in relation to managing Immunisation, STI's and Eye/ENT dysfunction (in-person or online training); formal evidence of same

Portfolio of responsibility:

RN 5 – RESPIRATORY/CANCER

Evidence:

In the period July 2011 to April 2012, 271 respiratory conditions were treated at the NAHS clinic. Most of these were acute conditions (lung infections) however there were a notable number of chronic conditions such as Asthma listed. Data from the GRAHPF (2010) indicates that chronic respiratory disease is also highly represented as a leading cause of hospital separations for Aboriginal people within the region. In the same period only one person was listed as being treated for Cancer at the NAHS however statistics from WA Health and the ABS (to 2010) indicate that Cancer remains a health risk for the Goldfields Aboriginal population. The relationship between tobacco smoking, respiratory disease and cancer is well established and programs to reduce tobacco use are already in place within the NAHS. Smoking remains a prevalent activity however and therefore lower respiratory disease will continue to be a significant health issue for the Wiluna Shire population.

General description:

This RN POR incorporates prevention, treatment and management of respiratory dysfunction and cancer. Involvement in education and prevention programs designed to reduce the occurrence of respiratory health problems and cancer is an essential element of this role. This primary intervention is both an "in-community" and in-clinic type and involves all age spectra. Measurement of tobacco use, lower respiratory disease/cancer prevalence and incidence, education of client groups (pre-school, school and adults), community based follow-ups, in-clinic treatment/advice, cooperation with all members of the broader health team (Medical and Population health etc) and coordination of nursing care secondary to medical intervention are fundamental features of activity. This role also incorporates training of all clinic staff in relation to lower respiratory disease/cancer prevention, treatment and management thereby ensuring that all clinical activity and resources comply with the relevant Australian professional standards. Maintaining close alliance with the relevant professional bodies e.g. Australian Asthma Foundation, QUIT, Cancer Council etc is an expectation within this POR.

Aims of role:

- Reduce community prevalence of tobacco use, upper/lower respiratory dysfunction and cancer
- Reduce morbidity associated with tobacco use, upper/lower respiratory dysfunction and cancer
- Facilitate an across life-span approach to prevention and management of upper/lower respiratory dysfunction and cancer
- Implement and maintain best practice approaches to management of upper/ lower respiratory dysfunction and cancer within the NAHS
- Educate and update all the NAHS staff (6 monthly) in relation to quit smoking campaigns/programs as well as upper/lower respiratory dysfunction and cancer assessment, treatment and management
- Ensure all the NAHS clinical activity in designated fields complies with relevant Australian professional association standards
- Liaise and work cooperatively with all other relevant service providers on matters and activities concerning management of upper/ lower respiratory dysfunction and cancer

Key Performance Indicators:

- 2012-13: establish baseline of Tobacco use, upper/ lower respiratory dysfunction and cancer occurrence at community and clinic level in cooperation with Chronic Disease Management coordinator
- Year by year reduction of Tobacco use, upper/ lower respiratory dysfunction and cancer within community (early childhood, school, home, clinic) as measured by epidemiology and Communicare data
- Written report on whole-community status of Tobacco use, upper/ lower respiratory dysfunction and cancer (yearly)
- Evidence of consultation with Medical and Allied Health staff (NAHS and Population health etc) in relation to Tobacco use, upper/ lower respiratory dysfunction and cancer matters
- 6 monthly updates for the NAHS staff in relation to Tobacco use, upper/ lower respiratory dysfunction and cancer
- 1 x yearly attendance at relevant training in relation to managing Tobacco use, upper/ lower respiratory dysfunction and cancer (in-person or online training); formal evidence of same

Glossary of terms: Chronic Disease Management

Item name/descriptor	Number	Description/definition
Chronic Disease (per Medicare)		A medical or other health related condition that has existed or is likely to exist for 6 months or longer; can also (for the purposes of this definition) relate to terminal illness
General Practice Management Plan	721	A detailed plan of action related to the Medical management of a patient who has one or more Chronic Conditions; can be prepared by nursing staff but must be reviewed and submitted by Medical staff. Generally a GPMP can be reviewed up to 4 times per year where indicated or as determined by Medical staff; Only one GPMP per year per patient can be formulated – typically a GPMP would be relevant and active for a maximum period of 2 years. In respect to NAHS, all patients with a Chronic Disease must have a 721 completed in conjunction with their Flinders Program assessment. For further information go to: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=721
Team Care Arrangements	723	A plan of action that incorporates different kinds of treatment s or services involving collaboration with at least two other health practitioners. The plan must include treatment and service goals for the patient, treatment and services that collaborating providers will provide to the patient, actions to be taken by the patient, arrangements to review TCA by a date specified in the document, and must be fully explained to the patient. TCA can be prepared by a qualified person other than the GP but must be reviewed by the GP in conjunction with patient. All patients with a Flinders Care plan and GPMP must also have TCA. For further information go to: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=721

NB: all item numbers and descriptors can be found by visiting the MBS website and searching on specific item numbers, key words or item names.

Link: http://www9.health.gov.au/mbs/search.cfm?pdf=yes

Clinical Manager:

The Nurse Manager position will be reviewed and altered in line with new workflow and practices. The title Nurse Manager will change to reflect the more specific clinical nature of the work to be performed by the person occupying this role. The following is a list of specific duties that will be reflected in the revision of the Nurse Manager position:

Duty	Detail	Time/Day
Handover	Discussion of day activities, specific clinical issues, recalls (only when Team C not activated)	0805 - 0820
Allocation	Clinical team allocation in line with CTS; may require adjustment according to staff numbers – where staff numbers are very low then Emergency response should be discussed; Team break organisation	0805 - 0820
Triage	Assessment of patients (see patient flow for details) ; allocation of patient dependency; manage clinical staff responses; Patient Assisted Transport (PATS)	0830 – 1630 (Mon-Tues) 0830 – 1430 (Wednesday)
Pharmacy order	Check stock, check expiration, send order to Pharmacy Pharmacy items “in” - add to pharmacy	1430 – 1620 (Wednesday) 1430 – 1620 (Friday)
Stores	Check, update (includes Pathology), restock or organise same, send order Receive stores (monthly) and add to stock	0830 – 1620 (Thursday) 0830 – 1620 (Thur/Fri)
Client resource	Social aspects of patient/community care, office work, team feedback, response to clinical issues	0830 – 1620 (Thur/Fri)

Attends: Clinical Review Committee
Clinical Staff meetings (monthly)
Management review committee

Contributes: Staff development and inservice program