Port Lincoln Aboriginal Health Service Inc: a joint initiative with CKAHS in chronic diseases self-management

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Background information about Port Lincoln

- Port Lincoln is a seaside town with a population of approximately 15000.
- Port Lincoln has an economic base of:
  - agriculture
  - aquaculture.

The Port Lincoln Aboriginal Health Service is...

- a Community Controlled Organisation established in 1992. Rapid growth since establishment
- recently acquired accreditation as a health service provider
- funded by the Commonwealth Department of Health and Ageing through OATSIIH.
- services an Aboriginal community of approximately 800, however there are 1500 registered clients on our client recall system
- employ 30 full-time/part-time staff.

The Health Service consists of 4 teams:

- Administration Team
- Health Team
- Social and Emotional Well-being Team
- Family Preservation Team.

Clinic Services...

- Primary Health Care
- Sessional GP Clinic
- Immunisation
- Ante Natal/Post Natal
- Chronic Disease Management
- Sexual Health
- Eye Health/Hearing Health
- Point of Care.

**Community Services...**
- Men and Women Programs
- Aged Care
- Allied Health Services
- School Education Programs
- School/Kindy Screenings
- Hospital Liaison

**Other Services...**
- Substance Misuse program
- Social and Emotional Well-being program
- Counselling
- Family support
- Education and Awareness
- Alternative Care and Family Preservation
- PATS
- Camps/Recreational Activities

**History of CDSM at PLAHS...**
- Completed Partners in Health – Shared Care Initiative in September 2002
  - (12 month trial).
- Commenced current Commonwealth Funded CDSM project mid-year 2002.
Description of CDSM project...

- Chronic Disease has a significant impact on Aboriginal people. This project looks specifically at Aboriginal people with chronic disease and other factors that may impact on their health outcomes.

- It is a three year project which has been recognised within our strategic plan with the purpose of becoming part of our core business following completion of the project.

The project is a joint partnership between...

- Ceduna Koonibba Aboriginal Health Service
- Port Lincoln Aboriginal Health Service

Outline of project...

- Implement strategies for clients to actively participate in management of their illness.
- Improve health outcomes for the local Aboriginal community.
- Increased access to health services for Aboriginal people.
- Improve social and emotional well-being of Aboriginal people.

Why Care Plan?

- A co-ordinated approach to Indigenous health care within the service.
- A useful strategy for a client and service providers in the management of chronic disease.
- Clients have opportunity to prioritise their own health needs.
- Includes other issues for the client not just the medical problem.
- Promotes healthy lifestyle changes.
- Assists in promoting client self-confidence and motivation.
- Enables the clients to have more control over their health.
- Sharing of health information between service providers and health staff.
Integrate CDSM into ongoing health programs...

- CDSM program will provide a holistic approach to health care whilst catering to the individual clients health needs.

- Training of the Health Team/Social and Emotional Well-being Team in self-management concepts and chronic disease management.

- Incorporate CDSM with Point of Care project. POC is a research project that identifies clients with Cardiac disease, Renal disease and Diabetes.

- Identified clients will then be invited to participate within the CDSM project. Services will be tailored to the individual client needs.

- Diabetes Participatory Action Research group/Elders Ambassador group is an established group that has identified goals for the community around Diabetes. These areas are:
  - Nutrition
  - Understanding
  - Education of young people
  - Support of family and community

- Early identification of chronic disease through existing health education programs and health screening in the local schools, TAFE, Women’s Group and employment agencies.

- The Social and Emotional Well-being Team at PLAHS will be involved with the CDSM project by incorporating their work around mental illness/substance misuse into the care-planning process.

Project initiatives to date...

- Community consultation

- Letter of introduction to community members, allied health staff and GPs.

- Development of questionnaires to gather information from community members and health professionals.

- Establish links with Service Providers, GPs, Community members and other stakeholders.

- Information sessions to community members, allied health staff and other relevant stakeholders.
Focus groups with community members and allied health providers.

Development of Monthly CDSM newsletter and Program information Pamphlet.

From experience...

- The care planning process requires adequate time and the whole team needs to share the same vision.
- Majority of problems and goals are focused on social issues.
- Social Issues become priority which often compounds the chronic disease.
- Can create dependency on service providers—fine balance between duty of care and primary health care approach.

Future directions...

- Risk Management—early identification of disease
- Support Groups for clients and families.
- Health assessments.
- Tele psychiatry.
- Case conferencing.
- Increased community awareness of chronic disease.
- Increased access to health services for Aboriginal people.
- Employ our own full time GP.
- Social care plans.