

Gold Coast Health Service District Adult Community Health

HEAL Program
(Health. Education. Activity. Lifestyle.)
Chronic Disease Management



Queensland Government

Queensland **Health**

Background

- Burden of Chronic Disease
- Qld Health directions and strategies
- Health round tables
- Multiple models - nationally and internationally
 - Multi-disciplinary Team (MDT)
 - Community or hospital based

Gold Coast Health Service District

What did we have?

- 3 Community Health Centres – Helensvale (north), Bundall (central), Palm Beach (south)
- 2 hospitals – Southport and Robina
- No specific Heart Failure service
- Respiratory Resource Centre
- Diabetes Resource Centre

What did we do?

- Working parties – hospital, community health, consumer reps, Non-Government Organisations and research staff
 - Heart Failure
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Type 2 Diabetes
- Steering Committee with Gold Coast Division GP's and GP representatives
- Patient survey

Where do we fit?

- GP remains Primary care provider
- HEAL Program fills the gaps in Secondary care arena / complexity
- Tertiary care remains with the acute / hospital setting

The Multi-disciplinary Team

Centre Based Staff

- Community Nurses
- Dietitian
- Indigenous Health Workers
- Occupational Therapist
- Physiotherapist
- Podiatrist
- Social Worker

Specialist Staff

- Exercise Physiologist
- Indigenous Health Chronic Disease Management Program Coordinator
- Medical staff
- Pharmacist
- Psychologist
- Specialist Nurse
- Speech Therapist

Patient Selection

Confirmed diagnosis of COPD or Heart Failure

First stage of implementation (HF Nov 2006, COPD Mar 2007)

- Frequent presenters
- Specialist Outpatient Department (SOPD) referrals
- Inpatient referrals
- Community Hospital Interface Program (CHIP) referrals

Second Stage of implementation (July 2007)

- Commenced referrals from all GPs, NGOs and self referrals

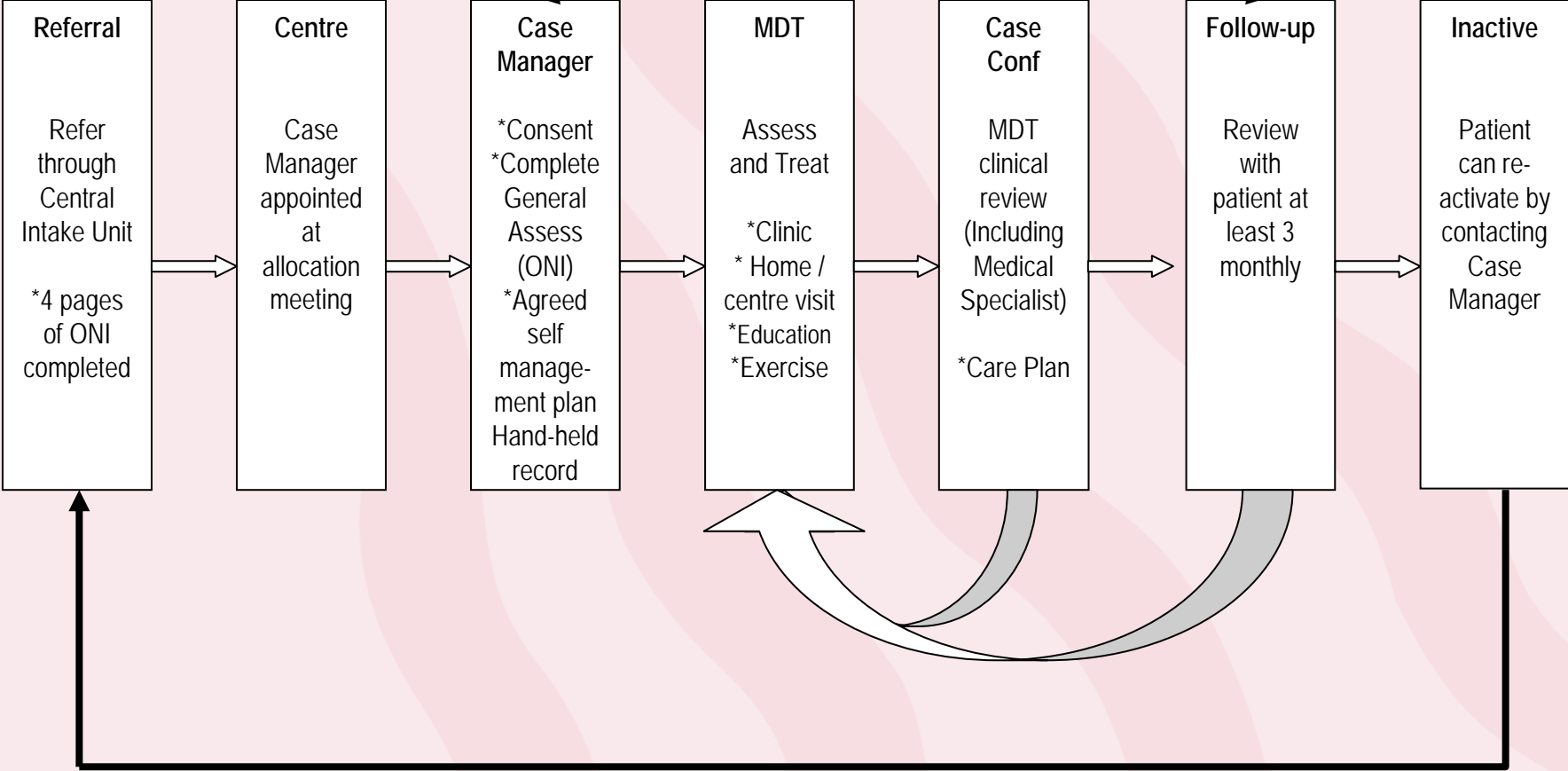
What do we have?

- MDT Clinics in Community Health Centers including medical specialists to substitute SOPD
- Rapid response to GPs referrals
- Improved communication with GPs
- Case Managers co-ordinate services across acute and community services and GPs
- Education and Exercise programs with emphasis on self management, goal setting and goal attainment
- Home visits
- Regular review and follow up
- Validated tools for assessment – clinical and quality of life

Clinics / Programs

- 2 Heart Failure clinics each week
- 1 COPD clinic each week
- Indigenous Health Heart Screening clinic
- Multiple Sclerosis Fitness Program
- Pulmonary Rehabilitation
- Cardiac Rehabilitation
- Diabetes Exercise
- COPD Collaborative with Division of GP's

GP will be kept informed of patient's progress throughout the program until the patient returns to the GP's sole care



Results to date

Heart Failure

- Patient satisfaction high
 - Focus group May 2007
- Collation of data is ongoing
- GP survey – good response to Program

Future Directions

- Chronic Kidney Disease – Dec 2007
- HEAL Program Exercise and Education – Pilot Jan 2008
- Type 2 Diabetes

Who to contact

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