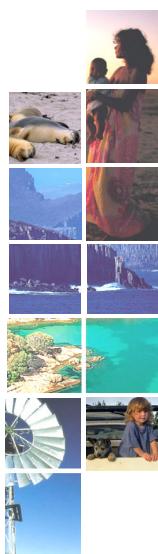


Port Lincoln Aboriginal Health Service Inc: a joint initiative with CKAHS in chronic diseases self-management

Judith Borg, Port Lincoln Aboriginal Health Service Inc

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 OATSIH.
- 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...

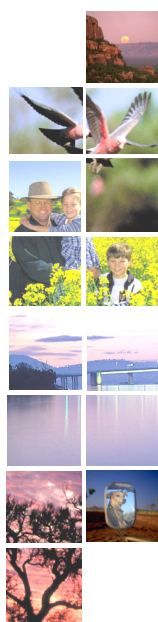
- Men and Women Programs
- Aged Care
- Allied Health Services
- School Education Programs
- School/Kindy Screenings
- Hospital Liaison

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...

- Aboriginal clients involved in Health Plus Co-ordinated Care Trial 1997-99.
- 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...

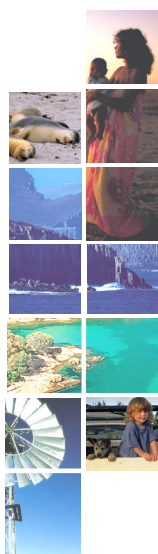
- Ceduna Koonibba Aboriginal Health Service
- Port Lincoln Aboriginal Health Service

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.

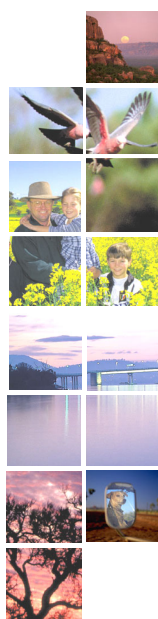


Integrate CDSM into ongoing health programs...

- 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...

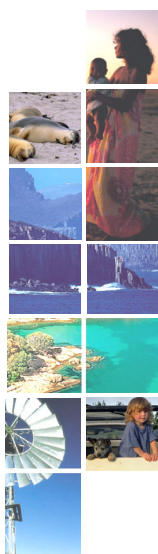
- Community consultation
- Letter of introduction to community members, allied health staff and GPs.
- Development of questionnaires to gather information from community members and health professionals.
- Establish links with Service Providers, GPs, Community members and other stakeholders.
- Information 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.

