Nganampa Health Council Chronic Disease Program Annual Report 2012

Tess Ivanhoe Project Officer

The Nganampa Health Council Chronic Disease Program was introduced in late 2010, in response to the Australian Government Primary Health Care Strategy and the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

Overview of the Program

Over the last two years the Program has evolved and presently focuses on three key objectives:

- Maintaining good health by early identification of risk factors
- Early identification and timely management of chronic diseases
- The prevention of complications in people with established diseases

The overall principles guiding the Program are to:

- Improve the way chronic disease is managed in the organisation
- Develop processes that are consistent, coordinated and sustainable and impact positively on patient outcomes
- Focus on proactive preventive health care delivery
- Support patient self management
- Further develop high quality evidence based and protocolised care, supported with robust documentation, care plans and recall systems
- Develop strategic partnerships and relationships with relevant stakeholders

The Practice Incentive Payment

The Practice Incentive Payment (PIP) was introduced by the Australian Government to support eligible general practices and Aboriginal Community Controlled Health Services, to provide better health care to Aboriginal and Torres Strait Islander people, including best practice management of chronic disease. This program provides extra funding to services for enrolled clients with at least one chronic disease. There are currently 610 clients enrolled with Nganampa Health Council, representing aproximately 75% of adults with a chronic disease.

Year	Pop > 15yrs	Est. clients with chronic disease (50%)	PIP enrolled	%
2010 /11	1373	686	350	51%
2011/12	1637	818	610	74.5%

Adult Health Checks

The Adult Health Check (AHC) is the cornerstone activity of the Program and is an assessment tool that has been contextualised to be culturally appropriate for use on the APY Lands. The AHC is not a screening tool but rather an assessment tool that allows the clinician to assist the client identify risk factors that may impact on their long term health. In the 2011/12 year a total of 396 AHC were completed, representing approximately 24% of the adult population.

Year	Pop > 15 yrs	No. AHC	%
2010/11	1373	226	16.5%
2011/12	1637	396	24.1%

Care Plans

Since the commencement of the Program, there has been a significant increase in the number of clients with Care Plans, whether this is a generic non-claimable Care Plan or a General Practice Management Plan (GPMP). There are currently approximately 400 generic Care Plans and 82 GPMPs in place. Care Plans provide a framework that guides health care delivery in a coordinated manner and assists all clinicians in supporting timely and appropriate health care.

Supporting, Mentoring and Up Skilling Staff

This Program also provides support to the visiting Specialist Physician and various visiting locum Medical Officers. This administrative, logistical and clinical support provided by the Project Officer ensures a coordinated approach to health care, assists in prioritising the work, and contributes to client follow-up and ongoing management. The Project Officer provides mentoring, up skilling and other support to frontline clinical teams, thereby contributing to the more effective integration of the Program's work into daily and routine clinic work practices.