POPULATION HEALTH & AMBULATORY CARE SERVICE DESCRIPTION

1. Child and school health

Population Health provides an early years service that targets children and their families from the antenatal period through to 4 –5 years. There is extensive evidence that this period is critical in optimising health status through the life course. The focus of service delivery is on enhancing parent/family/child relationships, early identification and intervention for risk factors or developmental problems.

Child Health Nurses are the main early years service providers with some input from allied health staff. They provide some universal services to all families, eg. home visit within two weeks of birth, clinic visit for assessment of key child development stages. In addition, selective and indicated programs for those with risk factors/social disadvantage or for those identified as having specific parenting or developmental problems.

The school health service aims to optimise the mental, physical, social and emotional health and well being of school aged children, their families and the school community. Some children have special health considerations due to disability. Population health uses interventions and programs that capitalise on critical development periods to achieve maximum improvement in children.

2. Aboriginal and Multicultural health

Population Health targets Aboriginal, new migrants (predominantly on humanitarian refugee programs) and other disadvantaged groups such as young mothers, homeless. The main service providers include generalist community health nurses, child health nurses, Aboriginal and ethnic health workers. They provide some direct services to clients, including health promotion, prevention, early detection of illness and early intervention services. Maternal health and mother-child bonding is a priority area particularly in Aboriginal and refugee migrant women. In addition, population health plays a major role in advocacy, community development and building partnerships, often working with other sectors to co-ordinate primary health care services that are culturally sensitive.

3. Health Promotion

Health promotion can be regarded as a combination of educational, organisational, economic and political actions designed with consumer participation, to enable individuals, groups and whole communities to increase control over, and improve their health through attitudinal, behavioural, social and environmental changes (Howat, P, et al, 2003).

Health Promotion advocates a coordinated, intersectoral approach that empowers individuals to adopt healthy lifestyles through the creation of supportive environments and health promoting public policy facilitated by

effective community action in collaboration with a proactive, outward looking health sector.

Across the North Metropolitan Area Health service staff employ multiple health promotion strategies with different community groups, building capacity and providing support and consultancy to a wide range of partners within heath and externally.

4. Youth & Sexual Health

A Clinical Nurse Specialist and Senior Social Worker provide a limited youth health service that aims to increase resiliency of young people age 12-25 years to optimise their health and wellbeing. The service partners with other youth service providers across sectors, organisations and communities to mobilise resources. The service advocates for and on behalf of young people, contributes to Youth Health planning and policy and provides education and prevention programs to youth, particularly young people who have special health needs due to their cultural or linguistic background, disability, gender, sexuality, or place of residence.

5. Child Development Centres

Child Development Centres (CDC) provide assessment and therapy services for children referred with developmental delay in one or more areas of functioning. This includes children with developmental delay, gross and fine motor co-ordination problems, perceptual problems, sensory difficulties, speech, language and voice problems and learning and attention difficulties. The team may also address some social/emotional and behavioural problems associated with these issues.

The CDC services are provided by a professional multidisciplinary team with a strong focus on health care that is flexible, individualised and designed to suit the needs of each child and his or her family. The CDCs have an early intervention focus and priority for services is given to younger children (less than six years), where effectiveness of therapy is greatest. The CDC teams work closely with families and others involved in the care of clients, such as teachers, community nurses, child care workers and Department of Community Development.

6. Community Physiotherapy Services

Community Physiotherapy Services (CPS) provide ~170 groups per week of self-management and exercise programs across the metropolitan area. The service targets adults at risk of, or with medical conditions that have been identified in literature as benefiting from exercise and self-management principles. Clients enter the service through referral from community and hospital based health professionals. The service collaborates with a number of agencies.

7. Diabetes

In collaboration with key stakeholders, the Diabetes teams develop and implement integrated diabetes services across the intervention spectrum to reduce morbidity and mortality associated with diabetes. The services

provide diabetes education, podiatry, dietetic and healthy lifestyle services and programs for people with diabetes, utilising best practice models of care. In addition, the services implement training programs and workforce development to health professionals who provide services to people with or at risk of developing diabetes. The services work in partnership with agencies and the community to develop culturally appropriate services for Aboriginal and CALD communities for both prevention and management of diabetes.

8. Communicable Disease Control

Staff investigate notifiable infectious diseases that occur in the population of the NMAHS. All new notified STI and HIV cases are managed by contact tracing nurses. In consultation with the referring doctor they trace contacts, counsel, and if required, test and treat according to DOH guidelines.

Regional vaccination programs complement vaccination programs delivered by Local Governments and Divisions of General Practice, including the implementation of the school based vaccination campaigns for Meningococcal C, Hepatitis B, Boostrix.

Staff provide consultancy, education and information to medical practitioners, community health staff, local government, schools and other agencies and the general public on communicable diseases, sexual health and immunisation.

9. Research and Epidemiology

This team facilitates access to, and utilisation of epidemiological, demographic and spatial data and evidence-based literature to inform planning, policy and practice. The team also conducts original research that contributes to evidence-based population health policy and practice eg. Virtual Infant Parenting randomised control trial. In addition, epidemiological, evaluation and spatial consultancy is provided to the NMAHS, social service partners and the community.

10. Chronic Management Team

Chronic Management teams are part of the Ambulatory Care Reform Initiative. They are a new group focused on patients with chronic diseases eg. COPD, cardiac failure and diabetes. The service aims to encourage and facilitate, community and general practitioner care of chronic diseases in the community, assisting patients who might otherwise be admitted to hospital, and to assist patients with post-hospital care.