Engaging community health nurses to facilitate a telehealth chronic disease model of care

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Darling Downs Hospital & Health Service

- NSW border south of Stanthorpe to west of Goondiwindi, north to Taroom, east to Murgon (90,000 square km's)
- Toowoomba is the major regional centre
- Services approximately 300,000
- Rural Division is divided into 3 clusters – Southern, Western and South Burnett
- 21 facilities ranging from solo nurse primary care centres to larger rural hubs of Warwick, Kingaroy and Dalby


N
W
E
S
Hospital
Outpatient Clinic
Multipurpose Health Service
Aged Care Facility
Taroom
Wandoan
Proston
Murgon
Cherbourg
Wondai
Kingaroy
Nanango
← To Roma
Miles
Chinchilla
Jandowae
Dalby
Glenmorgan
Meandarra
Tara
Oakey
Baillie Henderson Hospital
Mt Lofty
Toowoomba Hospital
To Ipswich →
Moonie
Millmerran
Warwick
Inglewood
Goondiwindi
Stanthorpe
Texas

Taking action to create a more integrated system of care

- My health, Queensland's Future: Advancing health 2026
- Queensland Clinical Senate
- Primary Health Networks
- Home Monitoring of Chronic Disease for Aged Care – CSIRO report
- Chronic conditions manual 1st edition2015

Our reality for rural facilities & communities

- No dedicated telehealth nurse
- Diverse role of Community Health Nurse
- Not all sites have a CHN
- Limited nursing resources
- Aging population and their needs
- Complex patients with Chronic Disease
- Distances to travel to city specialists

Engagement of Community Health Nurse

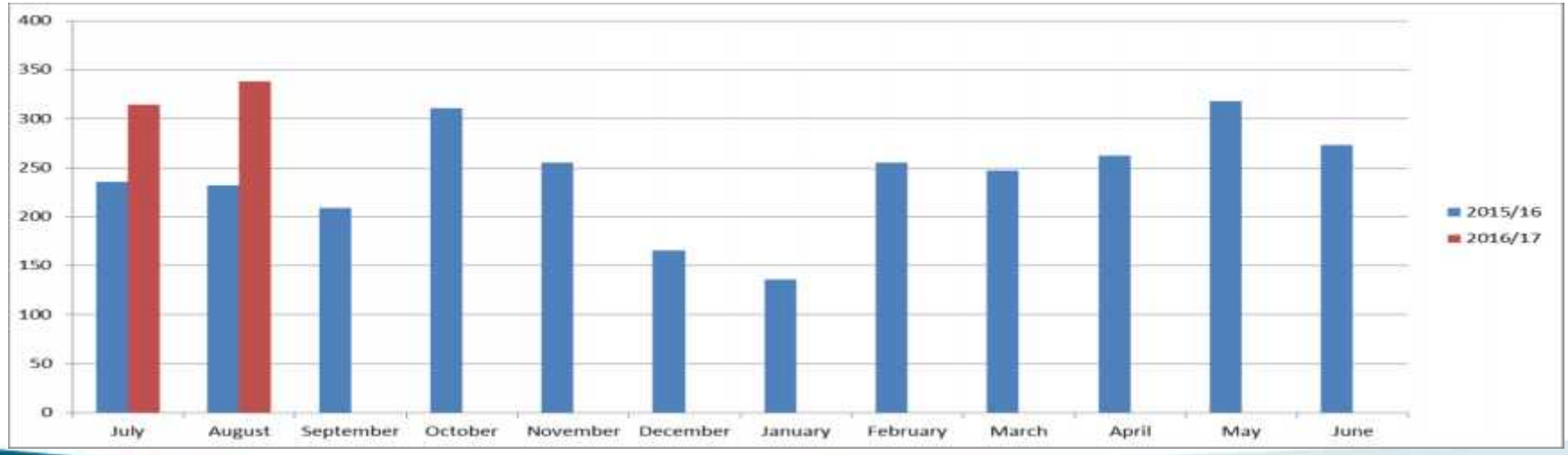
- My role & experience
- Care Coordination process from admission to discharge and beyond
- CHN role in discharge planning & discharge follow up phone calls
- GP – Hospital liaison

Non-admitted clinic types

- All specialities
- Nephology
- Cardiology & Cardiac Rehab
- Palliative care – end of life care
- Respiratory
- Diabetes

Telehealth data – DD Rural

Year	July	August	September	October	November	December	January	February	March	April	May	June	Total	YTD Compare
2015/16	236	232	209	311	255	166	136	255	247	262	318	273	2900	468
2016/17	314	338											652	652
16/17 v 15/16	78	106											-2248	184
% Increase	33%	46%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	-78%	39%



Recording telehealth activity

- Measure what we do & map services
- Trendcare allocation screen- Telemedicine, report available
- Service Profile – outline services/resources utilised
- HBCIS appointment scheduling

Chronic Disease Nurse Navigators

- Approval for 3 Nurse Navigators, 1 in each cluster commencing1.10.2017
- Aim is to assist the individual with chronic illness to improve general well being and sustained optimised health through supported self management and, when hospitalised, working in partnership to reduce rates of complication and extended hospitalisation

So until then….

- The CHN will continue to work with consumers
- Engage with GP's – Participation in chronic disease management plans
- Consider Tele-monitoring in the home
- Develop a Caseload model for nurse navigator

Telehealth is the vehicle to deliver evidenced based care to rural patients with chronic disease, improve general well being and provide a patient centred care focus.....