



# **Clarence Integrated Care Centre**

## **Proposed Service Model**

**Version: 1.0  
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# **1. Introduction**

## **I.1 Background**

Tasmania's Health Plan committed to the development of Integrated Care Centres (ICC) in 2007, with the Clarence ICC to be one of three located in Southern Tasmania. The catchment area for the Clarence ICC is the municipalities of Clarence, Sorell, Tasman and Glamorgan Spring Bay.

The purpose of the ICCs is to provide:

- Increased range and complexity of services in the community for people to safely access services closer to home.
- Improved coordination and integration of services across the primary health and acute care system to improve health outcomes.
- Reduced need for admission to hospital or the required length of stay through strengthened community based services.
- Provide a Centre for teaching, training and inter-professional learning for students and for health providers throughout the catchment area.

## **I.2 Integrated Care Centre Framework**

In 2010 a broad conceptual framework was developed to describe the ICC.

The development of the framework occurred in consideration of a range of principles guiding the development of ICCs.

### **I.2.1 Key Principles**

Key principles of this model include:

- Client centred care, providing safe high quality care in the most appropriate place, and where possible, closer to where people live.
- Focus on achieving single point of entry and assessment of care needs where possible to improve access to health services.
- Provision of services across the continuum of care, from health promotion, early intervention, to complex chronic conditions management, rehabilitation and strengthened interface with the hospital setting.
- Provision of targeted and evidenced based services and programs to address priority health issues across the continuum of care.
- Focus on developing a strong relationship with General Practice, in teaching, training and provision of care for people with chronic and complex needs within the community to ensure that the ICC is adding value to community based care.
- A focus on evaluation, research, education and inter professional learning.
- Focus on the development of partnerships across the ICC catchment area with key health service providers within the government, non government, private provider sectors and the community.

- Establishment of clinical governance and business systems to support the provision of integrated care.
- For Clarence ICC, to identify the relationship of the ICC with the GP Super Clinic to be co-located at the facility.

Diagram I has been developed to provide a visual representation of the framework, with a full scale version available at Attachment I.

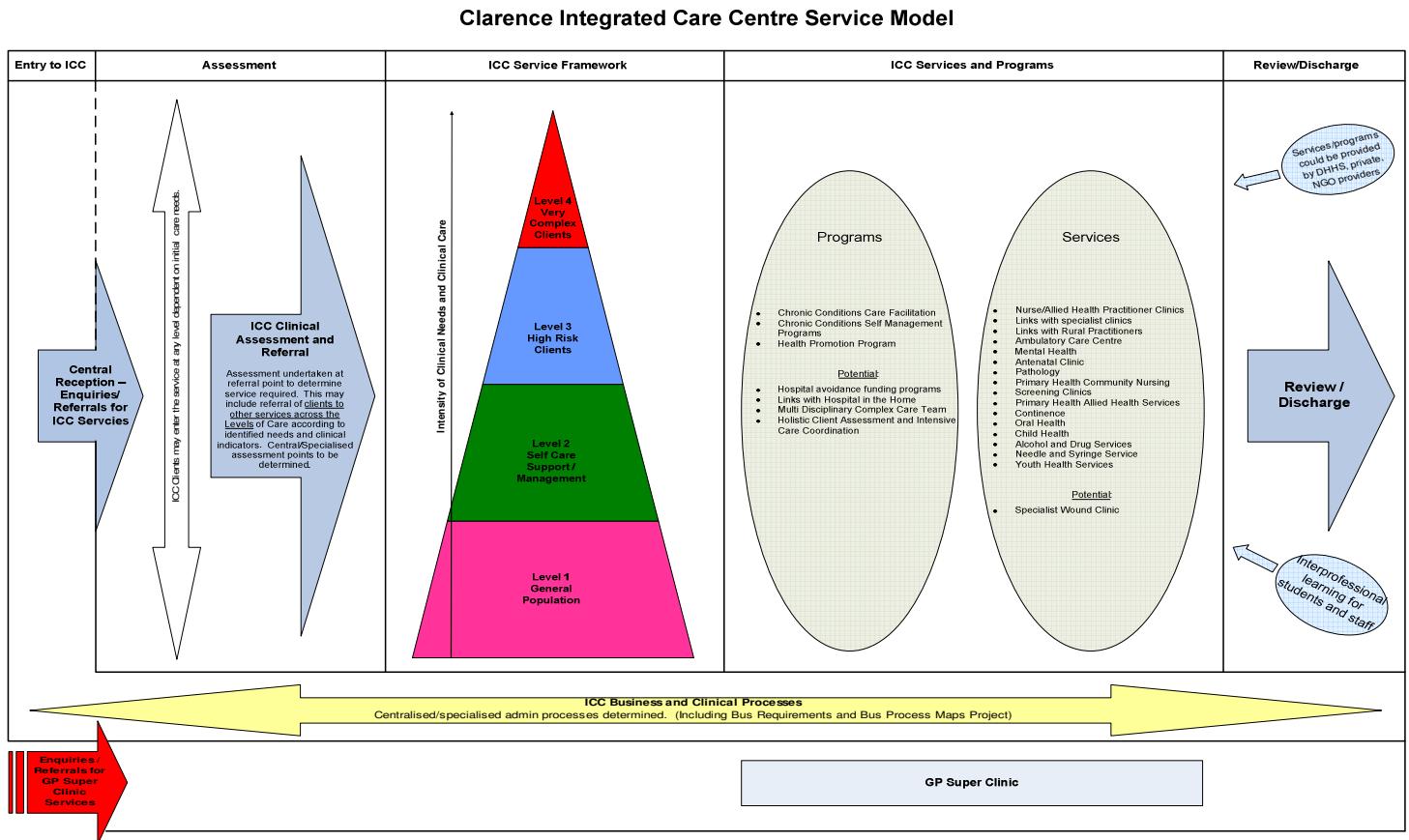


Diagram I: ICC Conceptual Framework

### I.3 Clarence ICC Service Clusters

Following the development of the framework work commenced on the models of care to be provided from the Clarence ICC.

This process included review of research undertaken to date for the ICC. Consultation was also undertaken with service providers who will be operating from the ICC to identify their views on current service demands, service gaps and ideas for future service initiatives within the ICC. This included a focus on the provision of partnership and integration in the provision of care.

From this consultation, a series of service clusters were identified as priorities for further investigation. These clusters were identified across the continuum of care and are identified on the diagram below, with a full scale version available at Attachment 2.

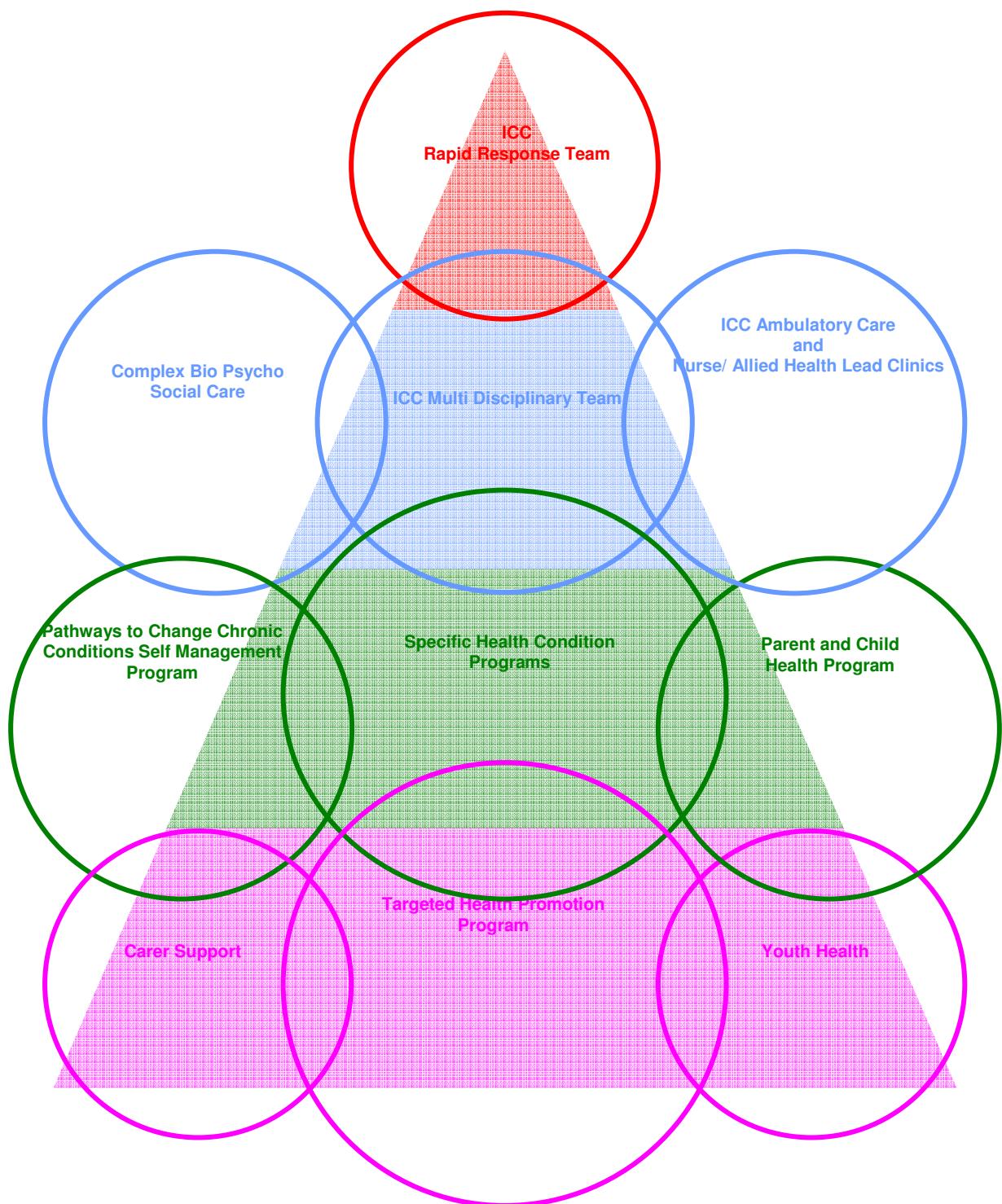


Diagram 2: ICC Service Clusters

These clusters have then provided the basis for work to identify the initial service model priorities in the development of the Clarence ICC.

## **2. Overview of Proposed Initial Service Model**

There have been many ideas contributed regarding the development of the Clarence ICC and the programs and services it could seek to provide. These ideas have demonstrated a strong commitment to client centred care and service improvement.

However, it is important to ensure that the development of new service models is sustainable and delivers improved health outcomes as a new part of the health service system.

Therefore it has been determined that the Clarence ICC will have a staged approach to its development, with a strong focus on the establishment of demonstration projects in order to support innovation and to test the sustainability and health outcomes of new services and programs.

The development of the initial service model has been developed based on the following principles noted above (1.2.1) and the following key considerations.

### **2.1 Key Considerations**

Key considerations in development of initial service model include:

- Focussing on immediate priority health issues and service demands across the continuum of care, where it is seen that the ICC could add value to existing service arrangements.
- Access to new and existing staffing resources to establish and sustain new services.
- Staged development of the building providing progressive access to the required facilities for provision of services.
- The need to ‘test’ new service models through demonstration projects, to ensure new services are achieving health outcomes, have integrated and functional administrative systems and are sustainable within existing resources.
- Readiness of identified service areas for service change and innovation, within the context of:
  - Existing service demands.
  - Existing linkages or partnerships between Primary Health and Acute Care services providing a strong foundation for expansion.
  - Identified evidenced based services ready for trial.
- Ensuring staff have access to appropriate training and development as part of service development.
- Ensuring that appropriate administrative and business systems are established and available to support existing and new service models.
- Actively seeking to identify opportunities to trial service connections in rural areas as part of demonstration projects.
- To ensure that education and training for students, DHHS staff and partner service providers are developed as integrated components of all services established in the ICC.

With these principles and considerations in mind, the following services and programs have been identified to operate from the Clarence ICC.

This information is provided both in terms of specific services to be provided, along with identified new integrated models of care, as per the service clusters identified and detailed in Diagram 2.

## **2.2 Education, Training and Research**

A specific role of the ICC is to focus on research, evaluation and continuing shared education and training with health providers across the catchment area.

Central to this work will be the development of strong linkages with the General Practice community. This includes working closely with the General Practice Division and associated general practice training organisations to ensure coordination of effort in initiatives supporting General Practice. However, these linkages will also be crucial at individual Practice level, to directly support patient care through access to shared learning opportunities for General Practitioners and their teams.

In developing each element of the ICC service model, working parties will be asked specifically to identify initiatives for services linkages and opportunities for inter-professional learning across the catchment area. This includes access to teaching and training at the ICC, but also the capacity to develop opportunities for learning in regional and rural areas, with a particular focus on 'case' based learning for General Practices and specialist health professionals from both the ICC and acute sector.

Opportunities to utilise a range of mediums for training, education and client care will be considered in identifying future ways of working together. Such mediums may include face-to-face, group, outreach services and use of information technology (such as video conferencing, and web based communication systems).

A key partner in the development of a learning focus will be the University community, particularly the University of Tasmania in their role as a key provider of health education and training. This partnership will be important for student training, health professional continuing education and inter-professional learning.

However, the partnership will also be vital to develop a strong research and evaluation focus at the ICC, through training and support in the development of evaluation frameworks for service models and the identification of appropriate research projects as ICC services develop.

Linkages with interstate Universities will also be important in providing student graduate learning opportunities and placements for health professions not currently offered at the University of Tasmania.

Future linkages with the vocational education and school education systems should also be considered in supporting and strengthening our future workforce.

## **2.3 ICC Services Summary**

The following services will be located at the Clarence ICC, and will be either based in the building, or provide services on a visiting basis.

Detailed service descriptions are provided at Attachment 3.

- Adult Community Mental Health Services
- Alcohol and Drug Services (ADS)
- CentrePath Pathology
- Child Health & Parenting Services (CHAPS)
- Clarence Ambulatory Care Centre (CACC)
- Community Health Social Work
- Community Nursing
- Continence Service
- Dietetics
- Health Promotion
- Needle & Syringe Program
- Occupational Therapy
- Oral Health Services
- Podiatry
- Physiotherapy
- Speech Pathology
- Women's Health Clinics
- Youth Health Services

## **2.4 ICC Programs Summary**

The following new integrated service programs will be provided at the Clarence ICC. More detailed information one each service model is provided in Section 4 of this document.

### **● Rapid Response Team**

- Provision of multi disciplinary response to clients referred from Emergency Multi Disciplinary Assessment Team (EMAT), Emergency Department (ED) or Ambulance Tasmania (AT) as needing clinical intervention but not hospital admission. Service response required within 24 – 48 hours.
- Further investigation to be undertaken on this service model.

### **● Multi Disciplinary Team (MDT)**

- Multi Disciplinary client review for assistance in assessment/monitoring/treatment for escalation of conditions
- Initial target group will be people who are identified as at risk of admission/re-admission to acute care in the immediate future due to a health incident or due to deterioration in health conditions symptoms. Initial focus on people aged 65+ with consideration of an additional focus on an additional age group of 50 – 65 following establishment of the multi disciplinary team.

### **● Complex Bio Psycho Social Care**

- To provide access to coordinated response for people with complex bio-psychosocial conditions, who at times present with challenging behaviours and/or are at continuing risk of disengagement with the health and human service system.
- Initial focus will be:
  - People with mental health and/or addiction issues.
  - People with mental health and/or addiction issues associated with a chronic health condition that is of focus within the initial stages of ICC service model development.

### **● Ambulatory Care Centre**

- Provide nurse lead ambulatory care services for people with chronic and complex conditions.
- Focus on clients from the ICC catchment area who are currently accessing the RHH Ambulatory Care Centre and for whom it is safe to receive follow up treatments at the Clarence Ambulatory Care Centre (CACC).
- Client access to Renal Self Dialysing Service.

## ● **Nurse/Allied Health Lead Clinics**

- To provide a range of clinic based services for people accessing existing services within the ICC or those with specific chronic conditions targeted by the ICC. Identification of targeted services provides an opportunity for reducing inappropriate presentations to ED for care that can be provided within a community based setting.
- Initial clinics in focus will be:
  - Community Nursing Clinic
  - Continence Clinic
  - High Risk Wound Clinic
  - Sprains and Strains Clinic

## ● **Specific Health Issue Programs**

- To provide structured evidence based services and programs to provide early intervention and management of priority health conditions.
- Initial focus includes:
  - Injury Prevention (falls prevention)
  - Musculo Skeletal Conditions (lower back pain)
  - Chronic Respiratory Conditions
  - Nephrology Conditions
  - Diabetes
  - Future access to rehabilitation gym

## ● **Parent and Child Health Program**

- To provide a coordinated approach to provision of health care for parents and children.
- Initial areas of focus will be:
  - Peri-natal Depression – antenatal screening and access to services for those identified as high risk
  - Oral Health - screening/early intervention program such as 'Lift the Lip'

## ● **Pathways to Change Self Management Program**

- Provision of programs to support clients to improve management of their chronic condition.
- Initial Focus will be:
  - People with Type 2 diabetes, as per the 12 month demonstration project 'Pathways to Change'.
  - Community Nursing is also involved in telephone coaching with people with COPD through a targeted program with RHH.

- **Targeted Lifestyle Risk Factor Health Promotion Program**
  - Promotion of health and well-being, screening and early intervention programs, targeting lifestyle risk factors impacting on health using the SNAPPS Framework - smoking, nutrition, alcohol and drugs, physical activity, and psycho social health.
- **Youth Health**
  - Provide enhanced youth health services for young people in the ICC catchment area.
- **Carer Support**
  - Provision of support for carers and families supporting people with a chronic condition.

## **2.5 Service Model Implementation Working Groups**

Each of these service models will be further defined as demonstration projects by working parties. In some cases this work will be linked in with existing working parties focused on specific conditions or service models.

In cases where such a group is not readily identifiable, a working group will be established. The Working Groups and membership has been detailed at Attachment 4. The Terms of Reference for the Working Groups is located at Attachment 5.

## **2.6 Interim Governance Arrangements**

In line with the staged development of the building and the ICC service model, interim organisational arrangements have also been proposed to support the establishment of the ICC.

This includes:

- **Multi Disciplinary Team Clinical Lead** – to provide clinical leadership to support the development of key new service models in the ICC, along with the establishment of training and inter-professional learning opportunities as a key part of the ICC role.
- **ICC Centre Coordinator** – to provide leadership in the development of operational functions and local health service planning of the Centre, including tenancy arrangements, operational policies and procedures, quality improvement, OH&S and linkages with local services.

Linked with these positions will be an

- **Administrative Assistant** to provide general administrative support for the ICC, including minutes of meetings, assistance with implementation and monitoring of the Centre's operational policies and procedures and provide additional support to the front of house staff in preparations for health promotion and health program events.

This role has a separate function, but will work closely with the Customer Service Officers at the ICC who will be providing 'front of house' administrative support for the operation of the specific ICC services and programs.

- **Allied Health Assistant** to provide additional health service resources to assist allied health professionals with the implementation of the ICC programs.

The roles of these positions will be located within the ICC Program Team during the interim period to ensure close connections with the implementation of the ICC service model.

The roles will also be considered within the context of longer term governance arrangement needs as the service model develops, along with potential linkages with other ICC organisational arrangements as these facilities are developed at Glenorchy and Kingborough.

The organisational structure for the interim governance arrangements are noted at Attachment 6.

## **3. Detailed ICC Programs Information**

The following information provides a detailed summary of the new service models for integrated programs at the ICC.

	<h2>ICC Rapid Response Team (RRT)</h2>
ICC Level	4
Program Purpose	<ul style="list-style-type: none"> <li>Hospital avoidance/diversion - To provide an immediate response for people as an alternate and immediate service option to hospitalisation.</li> </ul>
Target Population Group	<p>Specific Health Priorities:</p> <ul style="list-style-type: none"> <li>Ageing</li> <li>Musculo Skeletal (falls)</li> <li>Neurological conditions</li> <li>COPD</li> <li>Wound Care</li> <li>Continence Issues</li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>To be determined.</li> <li>Program is not to be delivered within the initial development of the ICC due to need for: <ul style="list-style-type: none"> <li>Additional health professional resources will be needed to meet required response timeframes for effective assessment/intervention.</li> <li>Further analysis of demand will also assist in determining whether this program is required for an ICC catchment or area health service basis.</li> </ul> </li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>Provision of multi disciplinary response to clients referred from Emergency Multi Disciplinary Assessment Team (EMAT), Emergency Department (ED) or Ambulance Tasmania (AT) as needing clinical intervention but not hospital admission.</li> <li>Service response required within 24 – 48 hours.</li> <li>It is likely that this program will build on the systems developed through the ICC Multi Disciplinary Team (MDT) Program, with the RRT providing an immediate response component.</li> </ul>
Program Services	<ul style="list-style-type: none"> <li>Assessment/review of priority health needs – nursing and allied health.</li> <li>Immediate access to the range of multi disciplinary services as described under Program Services within the MDT.</li> <li>Could be incorporated within existing service roles, with members of the team allocated to 'rapid response' service for particular days – this would allow for rotation through service and integration within existing service areas.</li> <li>The MDT could be trained to undertake generic assessment (where clear assessment is not provided with referral) as per EMAT team arrangements and from there, coordination of specific care requirements.</li> <li>Initial purpose for referral could determine lead health professional.</li> </ul>

	<ul style="list-style-type: none"> <li>• Care plan determined and a time limited ‘package of care’ provided.</li> <li>• Client then discharged to primary care provider and required services.</li> <li>• Hours of operation to be determined, in line with demand peaks for referring services.</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>• Multi disciplinary services as listed in MDT.</li> </ul>
Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>• Clients who are attended by AT or who present to ED/EMAT whose health needs are assessed as being at immediate risk of hospital admission, but with immediate service response, required care can be provided in the community, thereby avoiding hospital admission.</li> <li>• Appropriate for care in the community clients who have been referred by EMAT, ED or Ambulance Tasmania, GP or Medical Specialists due to exacerbation of one or more elements of their health condition and who are at risk of hospitalisation without immediate assessment/intervention.</li> </ul>
Referral Sources	<ul style="list-style-type: none"> <li>• Referral based service: <ul style="list-style-type: none"> <li>▪ Primary referring services: EMAT, ED</li> <li>▪ RHH Assessment and Planning Unit (APU)</li> <li>▪ Ambulance Tasmania</li> </ul> </li> <li>• Potential referring services as service model develops: General Practitioners, Aged Care Assessment Services.</li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>• Increased community nursing and allied health resources to enable response and intervention within required timeframes.</li> <li>• Access to Allied Health Assistant as part of implementation of care plan.</li> <li>• Customer Service Officer resources to support required intake, documentation, discharge of client and relevant communication requirements with clients, carers and health professionals.</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>• Nil available for immediate response.</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>• Vehicles, mobile phones, electronic equipment – computers, fax for client documentation.</li> </ul>
Staff development requirements	<ul style="list-style-type: none"> <li>• Multi disciplinary training for skill development for general assessment as per MDT professional development.</li> </ul>
Inter-professional learning opportunities	<ul style="list-style-type: none"> <li>• All professional staff undertaking a rapid response role will require a sound understanding of the functions of each service area.</li> <li>• Initial needs assessment tool will need to include elements from each health profession to ensure a comprehensive assessment of priority needs is completed, as per multi disciplinary team systems.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>• It is anticipated that the RRT will initially be focused on areas within close radius of the Royal Hobart Hospital, due to high risk of admission for clients.</li> </ul>

Key program development tasks	<ul style="list-style-type: none"> <li>• Confirm priority health issues currently presenting at ED, EMAT and AT that would be appropriate for RRT.</li> <li>• Confirm resource needs for catchment or area based service provision.</li> <li>• Confirm clinical guidelines and tools required for RRT.</li> </ul>
Membership Proposed Working Party	<ul style="list-style-type: none"> <li>• Multi Disciplinary Team Clinical Lead</li> <li>• Assistant Director of Nursing, Primary Health</li> <li>• RHH services representatives, including ED and/or EMAT</li> <li>• Director, Allied Health Professional Services</li> <li>• Allied Health Professional Services Representative</li> <li>• Nurse Unit Manager, Eastern Shore Community Nursing</li> <li>• Representative Ambulance Tasmania</li> <li>• ASSAT Representative</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>• As per program description.</li> <li>• Increased range of health conditions for which RRT is appropriate.</li> <li>• Linkages with rural areas for consultation/assessment for people at risk of admission.</li> </ul>

	<h1>ICC Multi Disciplinary Team (MDT)</h1>
ICC Level	3
Program Purpose	<ul style="list-style-type: none"> <li>Hospital avoidance/diversion.</li> <li>To provide improved access to coordinated multi disciplinary resources within the community for people who are at risk of presentation to Emergency Department and/or hospital admission.</li> </ul>
Target Population Group	<ul style="list-style-type: none"> <li>People who are identified as at risk of admission/readmission to acute care in the immediate future (within 28 days) due to a health incident or due to deterioration in health conditions symptoms.</li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>The target group will initially be people aged 65+ and will be capped at any one time.</li> <li>Stage 1 of the program will be limited to residents of the Clarence Municipality, with stage 2 to include residents of Sorell, Tasman and Glamorgan Spring Bay Municipalities.</li> <li>Consideration of an additional focus on an additional age group of 50 – 65 following establishment of the multi disciplinary team.</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>Provision of multi disciplinary case review and intervention for people who are at risk of admission to hospital within 30 days due to health incident or deterioration in symptoms.</li> <li>Purpose of the program is to provide one point of entry into multi disciplinary resource to provide: <ul style="list-style-type: none"> <li>Comprehensive and timely assessment of person's needs.</li> <li>Recommended care plan for the person, included projected timeframe for completion of care plan.</li> <li>Either care by services at the ICC or in partnership with existing care providers working with the person (e.g. private providers/non government organisations).</li> <li>Discharge of person from the MDT to primary care provider following case review, and/or following completion of treatment plan within the ICC. Discharge may include continuation with individual services or programs within the ICC.</li> </ul> </li> </ul>
Program Services	<ul style="list-style-type: none"> <li>Assessment/review of priority health needs – nursing and allied health.</li> <li>Provision of a time limited 'package' of care determined by care plan.</li> <li>Access to medication review.</li> <li>Dementia screening.</li> <li>Access to Oral Health Services for review/intervention.</li> <li>Access to allied health services for review and/or treatment (if treatment is not accessible by other community based/private services).</li> </ul>

	<ul style="list-style-type: none"> <li>• Access to Ambulatory Care Centre/Community Nursing clinic for clinical treatment (e.g. rehydration, wound management).</li> <li>• Access to Falls Prevention Program (e.g. OTAGO Program) and referral to comprehensive cognitive and falls screening program (e.g. FLIP)</li> <li>• Environmental assessment – home based.</li> <li>• Access to medical specialist aged care clinics.</li> <li>• Access to relevant health promotion groups and activities.</li> </ul>		
Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>• People who have fallen once.</li> <li>• Nutrition issues, including: weight loss, challenges with eating, malnutrition, dehydration.</li> <li>• Increasing presentations to General Practice or presentation to ED/EMAT not requiring hospital admission.</li> <li>• Observed reduction in ability to manage activities of daily living.</li> <li>• Observed changes in cognitive function and/or mood.</li> <li>• Social issues including living alone, recent loss of carer or spouse, or under stress.</li> </ul>		
Referral Sources	<ul style="list-style-type: none"> <li>• General Practitioner</li> <li>• Medical Specialist Aged Care Clinics</li> <li>• Nurse Practitioner, Aged Care</li> <li>• Clinical Lead Physiotherapist, Aged Care</li> <li>• Emergency Multi Disciplinary Assessment Team (EMAT)/Emergency Department (ED)</li> <li>• Aged Care Assessment Team</li> <li>• ICC Services – nursing and allied health</li> </ul>		
Services Involved	<table border="1"> <tr> <td> <ul style="list-style-type: none"> <li>• Community Nursing</li> <li>• Nurse Practitioner (Aged Care)</li> <li>• Clinical Lead Physiotherapy (Aged Care)</li> <li>• Oral Health Services</li> <li>• Occupational Therapy</li> <li>• Physiotherapy</li> <li>• Podiatry</li> <li>• Social Work Services</li> <li>• Aged Services South Assessment Team (ASSAT)</li> <li>• Ambulatory Care Centre</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>• Aged Care Assessment Team (ACAT)</li> <li>• Alcohol and Drug Services</li> <li>• Continence Service</li> <li>• Partnerships – Community Pharmacists</li> <li>• Dementia screening/care</li> <li>• Dietitian (TBC)</li> <li>• CentrePath</li> <li>• Mental Health Services – Adult Mental Health Services/Older Persons Mental Health Team</li> </ul> </td> </tr> </table>	<ul style="list-style-type: none"> <li>• Community Nursing</li> <li>• Nurse Practitioner (Aged Care)</li> <li>• Clinical Lead Physiotherapy (Aged Care)</li> <li>• Oral Health Services</li> <li>• Occupational Therapy</li> <li>• Physiotherapy</li> <li>• Podiatry</li> <li>• Social Work Services</li> <li>• Aged Services South Assessment Team (ASSAT)</li> <li>• Ambulatory Care Centre</li> </ul>	<ul style="list-style-type: none"> <li>• Aged Care Assessment Team (ACAT)</li> <li>• Alcohol and Drug Services</li> <li>• Continence Service</li> <li>• Partnerships – Community Pharmacists</li> <li>• Dementia screening/care</li> <li>• Dietitian (TBC)</li> <li>• CentrePath</li> <li>• Mental Health Services – Adult Mental Health Services/Older Persons Mental Health Team</li> </ul>
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New Resources Required	<ul style="list-style-type: none"> <li>• 1 FTE – Community Nurse as primary contact point for the MDT: <ul style="list-style-type: none"> <li>▪ Undertake screening of referrals, assessment of primary needs, coordination of multi disciplinary case assessment/review and actioning of recommended care plan.</li> <li>▪ Includes liaison with referring health professional and multi disciplinary involvement from additional non-ICC health</li> </ul> </li> </ul>		

	<p>professionals (private/non government providers).</p> <ul style="list-style-type: none"> <li>▪ Shared facilitation of targeted group activities as needed associated with the care needs for the target group.</li> <li>▪ Liaison role with aged care health professionals (ASSAT/ACAT).</li> </ul> <ul style="list-style-type: none"> <li>• Access to Allied Health Assistant to assist with initial intake and provision of care based on health professional assessment.</li> <li>• Community based access to: <ul style="list-style-type: none"> <li>▪ Nurse Practitioner, Aged Care</li> <li>▪ Clinical Lead Physiotherapist, Aged Care</li> </ul> </li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>• Access to all services based at the ICC, for participation in the multi disciplinary team program. <ul style="list-style-type: none"> <li>▪ Aged Services South Area Team (ASSAT)</li> <li>▪ Aged Care Assessment Team</li> </ul> </li> <li>• Access to Customer Service Officers to support the operation of the program.</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>• ICC service resources.</li> <li>• Potential access to vehicles.</li> <li>• Specific additional equipment/resources to be determined.</li> </ul>
Staff development requirements	<p>Initially aged care related, including:</p> <ul style="list-style-type: none"> <li>• Orientation to aged care services.</li> <li>• Dementia screening skills and assessment tools.</li> <li>• Familiarisation of all staff with each health professional area.</li> </ul>
Inter-professional learning opportunities	<ul style="list-style-type: none"> <li>• All professional groups will need to have a sound understanding of the roles and responsibilities of each service area.</li> <li>• Initial needs assessment tool will need to include elements from each health profession to ensure a comprehensive assessment of priority needs is completed.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>• Over time the program will provide an opportunity for rural services to be able to refer a person to a comprehensive multi disciplinary team for assessment/review.</li> <li>• Care could then be provided on a shared care arrangement as necessary with local providers with appropriate review/intervention by the MDT as required.</li> <li>• Linkages with community Pharmacists.</li> </ul>
Key program development tasks	<ul style="list-style-type: none"> <li>• Confirm clinical criteria.</li> <li>• Confirm/develop clinical pathways including relevant administrative and clinical tools.</li> <li>• Confirm format of team – e.g. frequency of meetings, etc.</li> <li>• Confirmation of falls program – OTAGO program.</li> </ul>
Membership Proposed Working Party	<ul style="list-style-type: none"> <li>• Multi Disciplinary Team Clinical Lead</li> <li>• Assistant Director of Nursing, Primary Health</li> <li>• RHH services representatives, including ED and/or EMAT</li> </ul>

	<ul style="list-style-type: none"> <li>• Director, Allied Health Professional Services (Chair)</li> <li>• Statewide and Mental Health Services Representative</li> <li>• Allied Health Professional Services Representative</li> <li>• Nurse Unit Manager, Eastern Shore Community Nursing</li> <li>• Representative Ambulance Tasmania</li> <li>• ASSAT Representative</li> <li>• Clinical Facilitator, Integration, Primary Health</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>• Increase the limit of people participating in the program.</li> <li>• Increase the range of population groups and/or health conditions that the team focuses on. Possible priority target areas include: <ul style="list-style-type: none"> <li>▪ Neurological conditions</li> </ul> </li> <li>• Development of the MDT to include Rapid Response component for assessment/intervention within 24-48 hour period, as per RRT description.</li> <li>• Development of team to provide services to rural areas, including consideration of outreach clinics to rural areas in partnership with local providers.</li> </ul>



<b>ICC Complex Bio Psycho Social Care Program</b>	
ICC Level	3
Program Purpose	To provide access to coordinated response for people with complex bio-psycho-social conditions, who at times present with challenging behaviours and/or are at continuing risk of disengagement with the health and human service system.
Target Population Group	<ul style="list-style-type: none"> <li>• People who have: <ul style="list-style-type: none"> <li>▪ Primary health issues of mental health and/or addiction issues.</li> <li>▪ People with complex chronic conditions with a resulting mental health and /or addiction issue.</li> <li>▪ People whose social situation is impacting on their capacity to manage their chronic health condition.</li> <li>▪ People with challenging behaviours that put them at risk of disengagement with the health and service system.</li> </ul> </li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>• People with mental health and/or addiction issues.</li> <li>• People with mental health and/or addiction issues associated with a chronic health condition that is of focus within the initial stages of ICC service model development.</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>• Provision of a coordinated assessment, consultancy and/or intervention from specialist mental health and addiction services.</li> <li>• The program to be established under the principles of the DHHS Agency Collaboration Strategy to ensure an appropriate and timely response for people with challenging bio-psycho-social health issues.</li> <li>• Key functions of the program could include: <ul style="list-style-type: none"> <li>▪ Coordinated management of clients of existing specialist services who have mental health and addiction co-morbidities.</li> <li>▪ Consultancy or shared care arrangements for primary health providers or the ICC MDT who have assessed clients as requiring specialist advice or intervention as part of a care plan for a chronic condition.</li> <li>▪ Assessment and preparation of an agreed pathway for clients presenting to the ICC with challenging behaviours that place them at risk of disengagement with health services.</li> <li>▪ Development of local service linkages and coordination with other human service providers (DHHS and external), particularly Housing Tasmania, for coordinated care.</li> <li>▪ Joint interventions to ensure the safety and skill development for staff involved with challenging clients.</li> <li>▪ Development of innovative service models for clients who find it challenging to engage with services via usual processes.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>▪ Investigation of the expansion of the existing service Mental Health Services initiative, embedding occupationally focused rehabilitation providers within the service team to increase focus and resources on employment opportunities for people.</li> </ul>
Program Services	<ul style="list-style-type: none"> <li>• Assessment of primary bio-psycho-social health needs.</li> <li>• Preparation of care plan.</li> <li>• Provide direct care, consultancy or shared care services with primary health providers.</li> <li>• Engagement with ICC programs to provide specialist early intervention input into programs and services (e.g. participation in health promotion programs focusing on bio-psycho-social elements of health).</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>• Adult Mental Health Services</li> <li>• Alcohol and Drug Services</li> <li>• Needle and Syringe Program</li> <li>• Community Health Social Work Services</li> <li>• Human Services</li> <li>• MDT services as necessary</li> </ul>
Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>• People with addiction and mental health co-morbidities.</li> <li>• People with challenging behaviours that put them at risk of disengagement with the health and human service system.</li> <li>• People who have been assessed by a primary health provider as having mental health, addiction and/or social issues that are impacting on their capacity to manage their chronic health condition.</li> <li>• People assessed by a primary health care provider as needing specialist consultancy and/or intervention.</li> </ul>
Referral Sources	<ul style="list-style-type: none"> <li>• Initially referrals will be received from: <ul style="list-style-type: none"> <li>▪ Providers of existing specialist services including Mental Health Services, Alcohol and Drug Services, Needle and Syringe Program, Community Health Social Work Services.</li> <li>▪ MDT and services within the ICC.</li> </ul> </li> <li>• During the second stage of the program's development: <ul style="list-style-type: none"> <li>▪ Royal Hobart Hospital for people who have co-morbidities and who have presented at ED or who are to be discharged following admission and for whom bio-psycho-social issues are the primary health issue.</li> </ul> </li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>• Access to Customer Service Officer and/or administrative resources to support any administrative processes required for the operation of specific services/programs developed.</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>• Existing service providers who will operate from the ICC.</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>• To be determined.</li> </ul>

Staff development requirements	<ul style="list-style-type: none"> <li>• To be determined.</li> </ul>
Inter-professional learning opportunities	<ul style="list-style-type: none"> <li>• Opportunity for capacity development for primary health providers through consultancy and shared care arrangements with specialist service providers.</li> <li>• Inter-professional learning opportunities through client focused care for people with bio-psycho-social co-morbidities.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>• Opportunity to develop the team as a consultancy service for rural health service providers.</li> <li>• Opportunity for the team to act as a catchment area point of coordination between rural health service providers and centrally based human services to ensure coordination of care.</li> <li>• Linkages with Department of Justice Programs.</li> </ul>
Key program development tasks	<ul style="list-style-type: none"> <li>• Confirm clinical eligibility criteria.</li> <li>• Confirm/adaptation of Agency Collaboration Strategy principles and processes.</li> </ul>
Membership Proposed Working Party	<ul style="list-style-type: none"> <li>• Representatives from:</li> <li>• Multi Disciplinary Team Clinical Lead</li> <li>• Mental Health Services</li> <li>• Alcohol and other Drug Services</li> <li>• Community Health Social Work</li> <li>• Needle and Syringe Program</li> <li>• Human Services, including Housing Tasmania, Disability Services</li> <li>• ICC MDT working party representative</li> <li>• Linkages with existing Steering Committee for peri natal depression initiative</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>• As per program description.</li> </ul>

	<h1>ICC Ambulatory Care Centre</h1>
ICC Level	3
Program Purpose	<ul style="list-style-type: none"> <li>Provide nurse lead ambulatory care services for people with chronic and complex conditions.</li> </ul>
Target Population Group	<ul style="list-style-type: none"> <li>People currently accessing ambulatory care services at RHH and for whom it is safe and accessible to receive these services at the ICC.</li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>Focus on clients from the ICC catchment area who are currently accessing the RHH Ambulatory Care Centre and for whom it is safe to receive follow up treatments at the Clarence Ambulatory Care Centre (CACC).</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>The CACC will be a nurse-led satellite clinic of the RHH Ambulatory Care Centre. The RHH Ambulatory Care Clinic will continue to admit and provide first treatment for clients at RHH. Following first treatment patients who are clinically appropriate for services at CACC will be referred for follow up treatment.</li> <li>It is envisaged that the CACC will operate 2-3 days per week initially.</li> </ul>
Program Services	<ul style="list-style-type: none"> <li>The CACC services to be provided include: <ul style="list-style-type: none"> <li>Antibiotic infusions.</li> <li>Bone strengthening infusions (Rheumatology).</li> <li>Venesections (de-iron and blood transfusions).</li> <li>Glucose tolerance tests (pregnancy and endocrinology).</li> <li>Infusaports (line care and monthly flushing).</li> <li>Methylprednisolone infusions for monthly routine stable Multiple Sclerosis clients.</li> <li>Tysabri for Multiple Sclerosis patients (required every 28 days for 2 years).</li> <li>Specialist endocrinology tests.</li> </ul> </li> <li>A Renal Self Dialysis Chair will also be located within the Ambulatory Care Centre for clients who need to undertake self dialysis within a health facility environment.</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>RHH Ambulatory Care Centre</li> <li>Eastern Shore Community Nursing Service</li> <li>Linkages with other ICC clinic services and chronic conditions services</li> <li>CentrePath</li> </ul>
Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>Clients assessed at RHH ACC as clinically appropriate for follow up care within an ACC environment.</li> <li>Clients with chronic kidney disease who are able to undertake self dialysis and require health facility resources.</li> </ul>

Referral Sources	<ul style="list-style-type: none"> <li>RHH Ambulatory Care Centre</li> <li>Renal Unit</li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>2 x Registered Nurses (develop to 2 FTE)</li> <li>Access to Band 3 Administrative Assistant (linked with Administrative Team Leader role, with potential to develop over time to 1 FTE)</li> <li>1 x Hospital Aide/Cleaner to be allocated to CACC</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>Existing RHH ACC staff member identified to lead development of CACC.</li> <li>Access to RN position available within ICC Community Nursing Clinic</li> <li>Access to administrative resources.</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>As per RHH clinical requirements and established within CICC facility development.</li> </ul>
Staff development requirements	<ul style="list-style-type: none"> <li>Training and orientation of CACC staff within RHH ACC and then based from CACC.</li> </ul>
Inter-professional learning opportunities	<ul style="list-style-type: none"> <li>Opportunity for Community Nurses from across catchment area to have continuing rotation of staff through ACC.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>Provision of ACC services for clients across the catchment area.</li> <li>Potential for shared care/capacity development of Community Nurses in rural areas to provide some elements of care.</li> <li>Investigation of potential for some linkages/rotation with non government nursing staff.</li> </ul>
Key program development tasks	<ul style="list-style-type: none"> <li>Confirm treatments to be provided within CACC.</li> <li>Confirm initial number of sessions.</li> <li>Adaptation of existing RHH ACC client pathways to be adapted for CACC use.</li> </ul>
Membership Proposed Working Party	<p>Joint working party with Nurse/Allied Health Lead Clinics (see next section)</p> <ul style="list-style-type: none"> <li>STAHS Continuing Care Assistant Director of Nursing</li> <li>RHH Ambulatory Care Centre Nurse Unit Manager</li> <li>Assistant Director of Nursing, Primary Health (Chair)</li> <li>Nurse Unit Manager, Eastern Shore Community Nursing</li> <li>Nurse Unit Manager, Statewide Continence Service</li> <li>Allied Health Professional Services Managers - physiotherapy, podiatry</li> <li>Access to Clinical Facilitator, Innovation Unit, Community Nursing Model of Care</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>Development of CACC to extended hours (9pm weekdays) as per RHH ACC operations, dependent upon client demand.</li> <li>Increasing role in continuing professional education with nurses across catchment area, including use of ACC rotations and Telehealth technology.</li> </ul>

<b>Nurse/Allied Health Lead Clinics</b>	
	
ICC Level	2 - 3
Program Purpose	To provide a range of clinic based services for people accessing existing services within the ICC or those with specific chronic conditions targeted by the ICC. Identification of targeted services provides an opportunity for reducing inappropriate presentations to ED for care that can be provided within a community based setting.
Target Population Group	<ul style="list-style-type: none"> <li>• Existing clients for whom clinic based services are appropriate as an alternative to in-home care.</li> <li>• People with chronic conditions targeted by the ICC.</li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>• Clients of existing community nursing, allied health and continence services.</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>• Provision of a range of clinic based services for existing clients of ICC services as a centre based alternate option for care.</li> <li>• Development of future clinic based services that provide an alternate service option for people currently presenting to ED for care.</li> <li>• Alternate service option for people currently receiving clinical care on an outpatient basis at RHH.</li> </ul>
Program Services	<p><b>Community Nursing Clinic</b></p> <ul style="list-style-type: none"> <li>• Provide a range of clinical interventions for existing clients and the development of new client centred services. Including:           <ul style="list-style-type: none"> <li>▪ Wound care and community nursing interventions provided to community based clients.</li> <li>▪ Potential provision of an outreach clinic to Risdon Vale Community Health Centre, dependent upon client demand.</li> </ul> </li> </ul>
	<p><b>Continence Clinic</b></p> <ul style="list-style-type: none"> <li>• Provision of existing specialist assessment and intervention services.</li> <li>• Development of shared care arrangements with Community Nursing as part of clinic services.</li> <li>• Investigation of capacity to provide a rapid response service for clients currently attending ED for such procedures.</li> </ul>
	<p><b>High Risk Wound Clinic</b></p> <ul style="list-style-type: none"> <li>• Provision of joint community nursing and podiatry clinics for high risk ulcers and wounds.</li> <li>• Development of a specialist wound care consultancy service for the ICC catchment area, for DHHS, and non government and private providers. This may include the trialling of information technology to provide wound care consultancy services to rural areas.</li> </ul>

	<b>Sprains and Strains Clinic</b> <ul style="list-style-type: none"> <li>Investigate the establishment of physiotherapy clinics for assessment and treatment of minor injuries that require initial assessment and single treatment only or referral to another service provider.</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>Eastern Shore Community Nursing</li> <li>Statewide Community Continence Services</li> <li>Allied Health Services – Podiatry, Physiotherapy</li> <li>Access to nurse and allied health clinical consultant positions</li> </ul>
Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>Clinical criteria for each clinic to be based on existing service requirements, with new criteria to be developed for new clinic models including high risk wound clinic, rapid response, continence service, shared care arrangements between continence, community nursing, and sprains and strains clinic.</li> </ul>
Referral Sources	<ul style="list-style-type: none"> <li>As per existing service referral arrangements.</li> <li>Services within CICC.</li> <li>ED.</li> <li>RHH clinical services providing outpatient care.</li> <li>Residential aged care providers for rapid response continence clinic.</li> <li>Self referral to sprains and strains clinic.</li> <li>Linkages/referral pathways for RHH High Risk Wound Clinic</li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>1 FTE Level 1 Registered Nurse (potential to work across ACC and Community Nursing Clinic)</li> <li>1 FTE Community Nurse Level 2</li> <li>Access to allied health services</li> <li>Access to Allied Health Assistant</li> <li>Investigate Continence Clinic expansion requirements for human resources.</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>Existing Community Nursing Service</li> <li>Access to Customer Service Officer and administrative resources required for the operation of the Clinics</li> <li>Existing weekly Continence Clinic</li> <li>Access to CNC, Continence Nurse, RHH</li> <li>Access to RHH Wound Specialist Nurse</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>As per facility design requirements.</li> <li>Telemedicine technology to trial rural wound care linkages.</li> </ul>
Staff development requirements	<ul style="list-style-type: none"> <li>Skill development on specific new clinical interventions.</li> </ul>

Inter-professional learning opportunities	<ul style="list-style-type: none"> <li>Potential linkages with ACC.</li> <li>Joint clinic opportunities for community nursing, podiatry, physiotherapy and continence service.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>Potential consultancy linkages for rural areas for wound care and shared care continence service arrangements.</li> </ul>
Key program development tasks	<ul style="list-style-type: none"> <li>Confirmation of clinic based interventions to be provided by Community Nurses.</li> <li>Confirmation of capacity to provide intravenous fluids based on referral from GP.</li> <li>Confirmation of capacity to provide rapid response continence clinic.</li> <li>Adaptation/development of existing clinical pathways and procedures for ICC use.</li> </ul>
Membership Proposed Working Party	<p>Joint working party with Ambulatory Care Centre</p> <ul style="list-style-type: none"> <li>STAHS Continuing Care Assistant Director of Nursing</li> <li>RHH Ambulatory Care Centre Nurse Unit Manager</li> <li>Assistant Director of Nursing, Primary Health (Chair)</li> <li>Nurse Unit Manager, Eastern Shore Community Nursing</li> <li>Nurse Unit Manager, Statewide Continence Service</li> <li>Allied Health Professional Services Managers - physiotherapy, podiatry</li> <li>Access to Clinical Facilitator, Innovation Unit, Community Nursing Model of Care</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>Consider the future establishment of a Nurse Practitioner position in Community Nursing for clinic based services.</li> <li>Increased range of nurse and allied health lead clinic based services for chronic conditions and post acute care.</li> </ul>

 <h1>Specific Health Conditions Programs</h1>	
ICC Level	2 - 4
Program Purpose	To provide multi disciplinary structured evidence based services and programs to provide early intervention and management of priority health conditions.
Target Population Group	<ul style="list-style-type: none"> <li>• People with one or more chronic health conditions.</li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>• Initial priority health conditions for the ICC will be: <ul style="list-style-type: none"> <li>▪ Musculo skeletal conditions – lower back pain.</li> <li>▪ Injury Prevention - falls prevention/response.</li> <li>▪ Diabetes.</li> <li>▪ Chronic Respiratory Conditions.</li> <li>▪ Renal Disease.</li> </ul> </li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>• The range of services and programs provided will vary according to the health condition and ICC multi disciplinary resources available.</li> <li>• Assessment, care planning and coordination for people with one or more chronic health conditions.</li> <li>• Provision of individual care, group sessions or program participation according to priority health needs.</li> <li>• Liaison with health providers outside the ICC, including General Practice, private health providers and non government organisations regarding health care plan.</li> <li>• Review and discharge from specific health condition program, which could include continued participation in some existing ICC services or referral to other providers.</li> </ul>
Program Services	<p><b>Injury Prevention – Falls Prevention/Response</b></p> <ul style="list-style-type: none"> <li>• Initial focus on provision of falls program in conjunction with MDT for target group of people 65+, utilising evidenced based program such as OTAGO.</li> <li>• Seek to develop early intervention falls program for people under 65 who may be at risk of falls or have had their first fall. Program could be individual or group based.</li> </ul> <p><b>Musculo Skeletal Health Conditions – Lower Back Pain</b></p> <ul style="list-style-type: none"> <li>• Pilot site for STAHS Musculo Skeletal Service Model Working Party focusing on the establishment of consistent clinical guidelines and service provision for the assessment and early intervention for people with lower back pain.</li> </ul>

	<p><b>Diabetes</b></p> <ul style="list-style-type: none"> <li>• Link to wound care clinic by Community Nursing for diabetes clients.</li> <li>• Links to podiatry screening for diabetes related issues.</li> <li>• Links to Chronic Conditions Self Management Program.</li> <li>• Provision of information sessions and health information, both through ICC staff and non government providers.</li> <li>• Level 2 care - provision of clinic sessions by credentialed Diabetes Nurse Educators (RHH and/or Diabetes Tas), referrals coordinated by ICC for pre-pregnancy counselling, Type 2 diabetes and previous GDM, high risk diabetes, pre-diabetes, Type 2 diabetes, established or newly diagnosed.</li> <li>• Level 3-4 care – provision of individual clinic sessions for people with Type 2 diabetes with co-morbidities. Referrals coordinated through ICC.</li> <li>• Level 4 care - sessions by credentialed Diabetes Nurse Educator for ongoing case management for people with complex Type 2 diabetes.</li> <li>• Level 4 care - sessions by Nurse Practitioner – for people with established Type 2 diabetes with metabolic co-morbidities for ongoing case management.</li> <li>• Follow up for/preparation of review of care plan by above-mentioned clinics provided by ICC staff in conjunction with diabetes specialist health professionals.</li> </ul> <p><b>Chronic Respiratory Disease</b></p> <ul style="list-style-type: none"> <li>• Focus on Chronic Obstructive Pulmonary Disorder.</li> <li>• Continuation of existing health coaching self management program currently operating through Eastern Shore Community Nursing.</li> <li>• Establishment of smoking cessation clinic for people assessed as being at risk or early stages of COPD.</li> <li>• Consider pilot of hospital in the home service for people with COPD.</li> </ul> <p><b>Renal Disease</b></p> <ul style="list-style-type: none"> <li>• Establishment of a key contact Community Nurse role for people who are undertaking self dialysis at CICC. This would be linked with the Community Nursing Clinic and include a self management component.</li> <li>• Community Nurse will act as liaison with Renal Services, including the Chronic Kidney Disease Coordinator/Educator and support any clinic services that may operate at the site.</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>• Community Nursing</li> <li>• RHH Diabetes Education Unit</li> <li>• Nurse Practitioner, Diabetes</li> <li>• Allied Health Professional Services</li> <li>• Diabetes Tasmania</li> <li>• RHH Respiratory Services</li> <li>• Renal Unit</li> </ul>
Clinical Eligibility	To be determined for each specific health condition, but general focus is on people:

Criteria	<ul style="list-style-type: none"> <li>Assessed as at high risk of a chronic condition.</li> <li>Newly diagnosed with a chronic condition.</li> <li>Having complex care issues and/or co-morbidities.</li> </ul>
Referral Sources	<ul style="list-style-type: none"> <li>To be determined by each specific health condition, with emphasis on strong linkages with specialist services to ensure robust clinical governance.</li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>1 FTE – Community Nurse/Allied Health professional as primary contact point for the Specific Health Conditions Program.</li> <li>Access to specialist service providers to operate clinics – e.g. Nurse Practitioners, credentialed health professionals.</li> <li>Partnerships with NGO providers.</li> <li>Access to Allied Health Assistant.</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>Community Nursing staff</li> <li>Allied Health Professionals</li> <li>Access to Customer Service Officers required for the operation of the program</li> </ul>
Equipment/Resources Required	<ul style="list-style-type: none"> <li><b>Rehabilitation Gym</b> - Access to gym equipment to enable access to equipment on a booked basis and for time limited physical activity program linked to care plan.</li> <li>Gym access would be for people who do not have access to alternate physical activity arrangements.</li> <li>Gym equipment to be monitored by Allied Health Assistant.</li> <li>Funding would need to be identified for required gym equipment.</li> <li>Consider opportunity to employ an Exercise Physiologist to provide resources for chronic conditions and provide improved opportunities for student placements in this profession.</li> </ul>
Staff development requirements	<ul style="list-style-type: none"> <li>Develop knowledge and skills related to specific health condition.</li> <li>Orientation to specialist services to develop understanding of service system and linkages with service providers.</li> <li>Skill development in group facilitation as necessary.</li> </ul>
Inter-professional learning opportunities	<ul style="list-style-type: none"> <li>Opportunities for linkages between the acute and primary health sectors in the provision of evidenced based health services for specific health conditions.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>Opportunity to provide advice and support for people working in rural areas with clients who have specific health conditions.</li> <li>Potential service provider rotations for specific health condition programs.</li> <li>Opportunity to work with local providers to develop some programs.</li> <li>Work to develop linkages with the fitness industry across the catchment area regarding client ongoing access to physical activity resources.</li> </ul>
Key program development	<ul style="list-style-type: none"> <li>Confirm nature of services to be provided e.g. clinic based, individual program, group work.</li> </ul>

tasks	<ul style="list-style-type: none"> <li>• Confirm clinical eligibility criteria.</li> <li>• Identify and develop partnerships with relevant non government providers for specific health conditions.</li> <li>• Confirm frequency of sessions to be provided by specialist providers e.g. Nurse Practitioners.</li> </ul>
Membership Proposed Working Party	<ul style="list-style-type: none"> <li>• Linkages with STAHS Diabetes Service Model Working Group</li> <li>• Linkages with STAHS Musculo Skeletal Service Model Working Group</li> <li>• Linkages with STAHS Cardio Respiratory Service Model Working Group</li> <li>• Linkages with Pathways to Change project governance arrangements</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>• Increased range of services provided for specific health conditions, with a focus on increasing complexity of care provided in the community.</li> <li>• Increased range of specific health conditions catered for through the ICC.</li> <li>• Increased focus on prevention and early intervention for people at risk of chronic conditions.</li> <li>• Increased use of Telehealth to facilitate linkages with people with chronic conditions in rural areas and health care providers.</li> <li>• Increased use of hospital in the home to address more complex care needs for people with some chronic health conditions.</li> <li>• Increased focus on partnerships with relevant funded non government providers for the provision of health promotion, screening and early intervention services.</li> </ul>

	<h1 style="text-align: center;">Parent and Child Health Program</h1>
ICC Level	2
Program Purpose	To provide a coordinated approach to provision of health care for parents and children.
Target Population Group	<ul style="list-style-type: none"> <li>• Mothers during pregnancy.</li> <li>• New parents.</li> <li>• Young parents.</li> <li>• Children.</li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>• Screening for people assessed as being at risk of perinatal depression in line with work of the Perinatal Steering Committee, with a particular focus on improved screening for women during pregnancy and also improved access for people identified as at high risk through existing screening and assessment processes undertaken by Child Health and Parenting Services.</li> <li>• Early intervention for childhood development issues focussing initially on oral health.</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>• Service collaboration for improved coordination of services for parents and children. Initial areas of focus will be on perinatal depression and early intervention for child health e.g. oral health project such as 'Lifting the Lip'.</li> </ul>
Program Services	<ul style="list-style-type: none"> <li>• Pilot projects to be developed from Steering Committee for Perinatal Depression.</li> <li>• Oral Health project such as 'Lifting the Lip' to be identified by services.</li> <li>• Consider development of shared care approach to individuals and families identified as 'high risk'.</li> <li>• Consider development of child development clinics, including partnership with non government providers, such as St Giles.</li> <li>• Parenting groups provided by CHAPS to be able to draw upon other disciplines to work on identified issues falling out of this group.</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>• Child Health and Parenting Service (including C U @ Home Program)</li> <li>• Women's and Children's Service, RHH Antenatal Clinics</li> <li>• Mental Health Services (adult and child and adolescent)</li> <li>• Alcohol and Drug Services – complex care unit</li> <li>• Oral Health Services</li> <li>• Allied Health Services</li> <li>• Community Pharmacists</li> <li>• Youth Health Services</li> <li>• Non government providers of children's services</li> </ul>

Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>• To be determined by Steering Committee pilot projects.</li> <li>• Early intervention oral health to be determined by project.</li> </ul>
Referral Sources	<ul style="list-style-type: none"> <li>• To be determined by project groups.</li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>• Linkages with Community Pharmacists for oral health project.</li> <li>• Access to Customer Service Officers for existing services and new ICC programs.</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>• Existing health care providers at Clarence ICC.</li> <li>• Access to Community Integration Role commencing within RHH Women's and Children's Service in 2011.</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>• To be determined.</li> </ul>
Staff development requirements	<ul style="list-style-type: none"> <li>• To be determined by project groups.</li> </ul>
Inter-professional learning opportunities	<ul style="list-style-type: none"> <li>• Opportunities for orientation and education to other service areas involved in children's health, particularly in identifying and giving care giving information.</li> <li>• Opportunities for all services, including adult focused services, to increase understanding of children's development issues and thereby increase 'opportunistic' health promotion and early intervention when working with parents.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>• Opportunities for rural linkages as part of both perinatal depression and also Oral Health project.</li> </ul>
Key program development tasks	<ul style="list-style-type: none"> <li>• Confirm pilot project from Perinatal Depression Steering Committee.</li> <li>• Confirm oral health project and undertake project development work.</li> </ul>
Membership Proposed Working Party	<ul style="list-style-type: none"> <li>• Linkages with the Perinatal Project Steering Committee and Project Officer</li> <li>• Child Health and Parenting Service (including C U @ Home Program)</li> <li>• Women's and Children's Service, RHH antenatal clinics</li> <li>• Mental Health Services (adult and child and adolescent)</li> <li>• Oral Health Services</li> <li>• Youth Health Services</li> <li>• Access to non government providers of children's services</li> </ul>

Future Vision	<ul style="list-style-type: none"> <li>• As per program description.</li> <li>• Structured coordination of services for 'high risk' families.</li> <li>• Over time seek opportunities to co-facilitate the CHAPS New Parents Group with other health professionals.</li> <li>• Improved range of early intervention strategies for parents and children.</li> <li>• Opportunity for neo-natal follow up clinics to occur within the ICC.</li> </ul>
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	<h1 style="color: #4CAF50;">Pathways to Change</h1> <h2 style="color: #4CAF50;">Chronic Conditions Self Management Program</h2>
ICC Level	2
Program Purpose	Provision of programs to support clients to improve management of their chronic condition.
Target Population Group	<ul style="list-style-type: none"> <li>• People with chronic conditions.</li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>• People with Type 2 diabetes, as per the 12 month demonstration project 'Pathways to Change'.</li> <li>• Community Nursing is also involved in telephone coaching with people with COPD through a targeted program with RHH.</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>• Provision of a range of self management programs and services for clients assessed as benefiting from improved self management skills.</li> <li>• Programs will include: telephone coaching to assist with goal setting and review, access to information sessions relating to chronic conditions, and access to group sessions to enhance peer support.</li> <li>• The program will focus on the development of partnerships with key service providers also funded for self management strategies for specific health conditions.</li> <li>• Access to relevant groups and programs within the ICC to support self management e.g. exercise groups.</li> </ul>
Program Services	<ul style="list-style-type: none"> <li>• Access to health coaching for individuals based on face to face and phone contact. The purpose of this time limited program is to assist clients to identify goals and work towards achieving these goals.</li> <li>• Access to group sessions to facilitate peer support amongst people with a chronic condition.</li> <li>• Access to health information sessions for the clients, carers and family regarding living with the chronic condition.</li> <li>• Access to advice and referral for chronic condition issues.</li> <li>• The focus of ICC programs will be to target chronic conditions where there is not an identified self management provider.</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>• Initially Community Nursing and Allied Health Services have been involved in the project and will continue with the demonstration project.</li> <li>• It is anticipated that Pathways to Change will develop to include all services operating within the CICC to participate in the chronic conditions self management program.</li> <li>• Services may be able to develop chronic conditions special interest areas to focus on knowledge and skill development for working with clients.</li> </ul>

Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>Initially people with Type 2 Diabetes who are at a minimum of six months diagnosis (or earlier at the discretion of the assessor), who may have stable or non stable diabetes, with HbA1c &lt;15 within the last six months.</li> <li>People must have consented to participate and be prepared to participate in telephone coaching, undertake goal setting, and provide constructive feedback to the project.</li> </ul>
Referral Sources	<ul style="list-style-type: none"> <li>General Practitioners</li> <li>Acute Services</li> <li>ICC Services</li> <li>Self Referral</li> <li>Family/Carers</li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>1 FTE Community Nursing position to: <ul style="list-style-type: none"> <li>Establish demonstration project.</li> <li>Coordinate intake/assessment and referrals.</li> <li>Review and evaluate the program.</li> <li>Continue the planned expansion of the project.</li> </ul> </li> <li>Increase the number of trained self management workers from all services within the ICC.</li> <li>New partnerships with non government providers in self management.</li> <li>Coordination of ongoing self management workers training, peer support, and staff development.</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>Access to Customer Service Officer and administrative resources to support program operations.</li> <li>Existing trained self management workers.</li> <li>Existing Pathways to Change project officer to continue as mentor for new Community Nursing role.</li> <li>Access to Allied Health Assistant.</li> <li>Access to Exercise Physiologist if position is available.</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>Nil.</li> </ul>
Staff development requirements	<ul style="list-style-type: none"> <li>Access to psychology services (MHS) to provide continued mentoring and up-skilling in motivational interviewing.</li> <li>Continuing training and skills development in chronic conditions self management strategies.</li> <li>Continuing training, development and service linkages with chronic conditions special interest areas for service providers.</li> <li>Skill development in group work.</li> </ul>
Inter-professional learning	<ul style="list-style-type: none"> <li>Targeted knowledge and skill development for specific chronic conditions provides opportunities to act as key contact for other service providers.</li> </ul>

opportunities	<ul style="list-style-type: none"> <li>• Opportunities for shared learning focused on chronic conditions self management.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>• Opportunities for program to develop across the catchment area, with training, peer support, and staff development provided through the CICC.</li> </ul>
Key program development tasks	<ul style="list-style-type: none"> <li>• As per project plan currently being developed by the Pathways to Change Project Team.</li> <li>• Existing governance arrangements to continue for demonstration project.</li> </ul>
Membership Proposed Working Party	<ul style="list-style-type: none"> <li>• Existing Pathways to Change governance arrangements.</li> <li>• Linkages with Specific Health Conditions governance arrangements</li> <li>• Linkages to existing Project Officer, Eastern Shore Community Nursing as mentor and clinical leadership.</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>• Expansion of chronic conditions self management program to a range of targeted chronic conditions.</li> </ul>

	<h1 style="color: #ff00ff;">Lifestyle Risk Factors Targeted Health Promotion Program</h1>
ICC Level	I
Program Purpose	Promotion of health and well-being, screening and early intervention programs, targeting lifestyle risk factors impacting on health using the SNAPPS Framework - smoking, nutrition, alcohol and drugs, physical activity, and psycho social health.
Target Population Group	<ul style="list-style-type: none"> <li>• General Population.</li> <li>• People assessed as at risk of chronic health condition.</li> <li>• People newly diagnosed with chronic condition.</li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>• To be determined based on priority health needs.</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>• Provision of a range of targeted events and activities focussed on improving individual and community knowledge and skills in health and wellbeing.</li> <li>• Provision of targeted screening programs, with appropriate clinical pathways, to support identification and early intervention for chronic conditions and modification of associated lifestyle risk factors.</li> </ul>
Program Services	<ul style="list-style-type: none"> <li>• Planned annual calendar of events.</li> <li>• Targeted and evidence based health promotion activities focused on priority health needs.</li> <li>• Targeted and evidence based screening programs for specific health conditions, with prepared client pathway and resources for a range of interventions dependent upon screening results.</li> <li>• Links with Healthy@Work and Feel Better RHH programs for staff.</li> <li>• Provision of a range of up-to-date health information in varying formats – e.g. paper, web based.</li> <li>• ICC participation in community health promotion events.</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>• All ICC services</li> <li>• Health Promotion Coordinator, Primary Health</li> <li>• Partnerships with funded non government providers</li> <li>• Local Government partnerships</li> <li>• Partnerships with other State Government agencies and funded Australian Government initiatives</li> </ul>
Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>• General population.</li> <li>• Target people at high risk of chronic health condition.</li> </ul>

Referral Sources	<ul style="list-style-type: none"> <li>• Self referral.</li> <li>• Service provider referral.</li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>• Access to Customer Service Officers and administrative staff to assist in coordination of specific health promotion displays, events, and groups.</li> <li>• Access to Allied Health Assistant to assist with health promotion events and groups.</li> <li>• Access to staff from MDT, Specific Health Conditions Programs and Pathways to Change.</li> <li>• ICC Centre Coordinator</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>• Health Promotion Coordinator, Primary Health</li> <li>• Health Promotion Coordinator, Oral Health Services</li> <li>• Links with RHH Feel Better and DHHS Healthy@Work programs</li> <li>• ICC service providers</li> <li>• Funded non government organisations</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>• Dependent upon specific programs and activities.</li> </ul>
Staff development requirements	<ul style="list-style-type: none"> <li>• Access to health promotion staff development through funded health promotion coordination positions.</li> </ul>
Inter-professional learning opportunities	<ul style="list-style-type: none"> <li>• Shared learning through joint health promotion projects.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>• Establish health promotion links with rural areas and identify opportunities to develop joint projects across the catchment.</li> <li>• Strong linkages with health promotion and screening programs being undertaken within General Practice.</li> </ul>
Key program development tasks	<ul style="list-style-type: none"> <li>• Identify priority health needs for chronic conditions.</li> <li>• Develop proposed calendar of events for 2011, including health promotion displays, events, and activities.</li> <li>• Focus on engagement of all ICC services in health promotion initiatives.</li> </ul>

Membership Proposed Working Party	<ul style="list-style-type: none"> <li>• ICC Centre Coordinator</li> <li>• Area Services Coordinator, Primary Health (Chair)</li> <li>• Eastern Shore Community Nursing Representative</li> <li>• Allied Health Professional Services Representatives</li> <li>• Health Promotion Coordinators from service areas</li> <li>• Youth Health representative</li> <li>• Administrative Assistant, ICC</li> <li>• Access to specialist service providers for health conditions, MDT and Pathways to Change (including DHHS and non government providers)</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>• Expanded targeted health promotion program for the catchment area with strong partnerships with funded non government providers.</li> </ul>

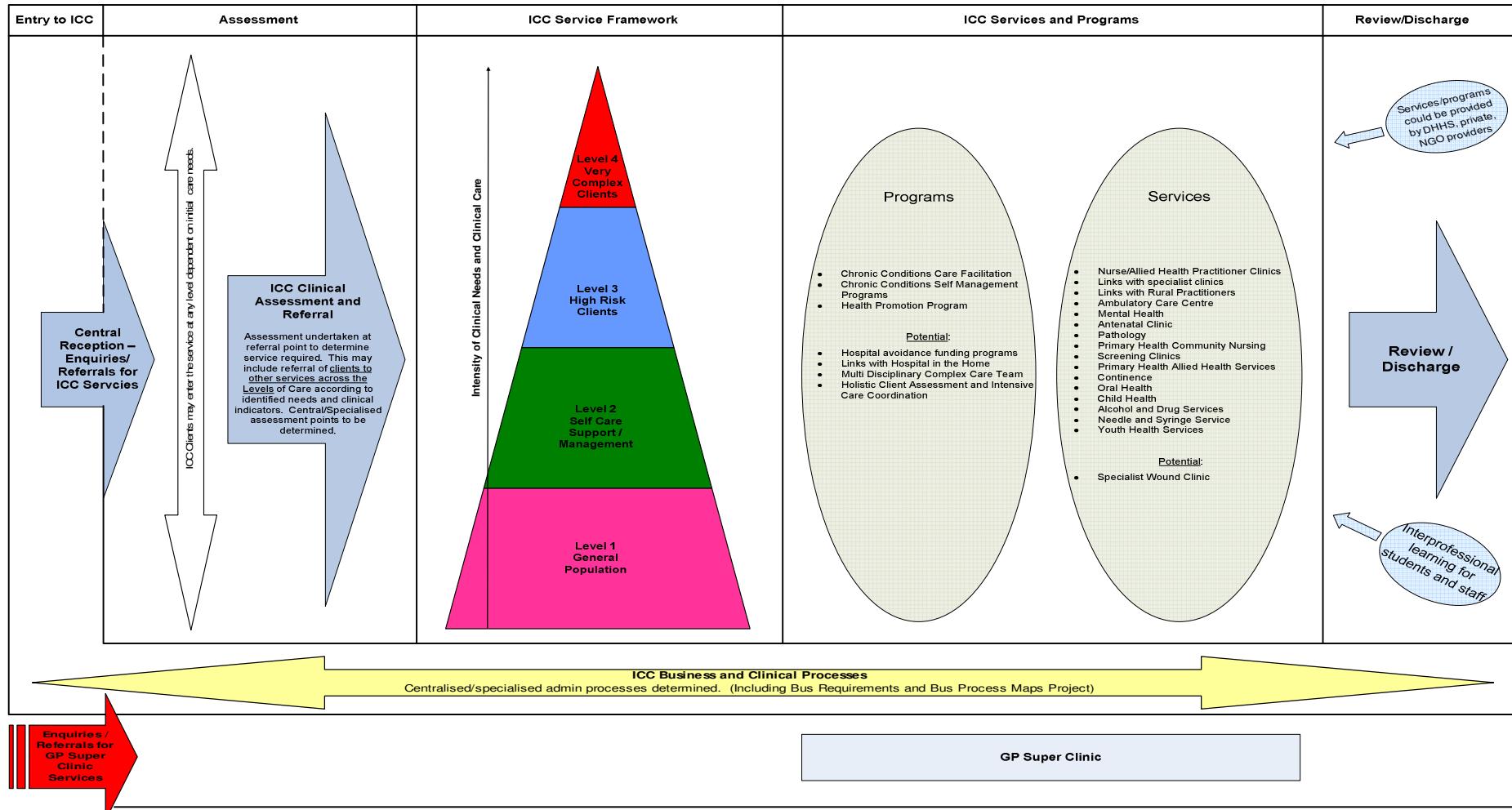
	<h1>Youth Health</h1>
ICC Level	I
Program Purpose	Provide enhanced youth health services for young people in the ICC catchment area.
Target Population Group	Young people.
Initial Target Population Group	<ul style="list-style-type: none"> <li>Young people in the Clarence Municipality.</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>Provision of youth focused area as part of the development of the ICC for the provision of planned youth health services. Services to be provided in partnership with local government and non government providers.</li> </ul>
Program Services	<ul style="list-style-type: none"> <li>Provide a youth friendly space in the Clarence ICC.</li> <li>Planned and targeted health promotion events.</li> <li>Assessment and referral services.</li> <li>Access to health promotion outreach programs and services.</li> <li>Coordination of youth services.</li> <li>Training and development for ICC service providers in working with young people.</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>STAHS Youth Health Services, Primary Health</li> <li>Clarence City Council</li> <li>Youth focused non government services</li> <li>All ICC services</li> </ul>
Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>Accessible to all young people.</li> <li>Access to specific youth services by existing eligibility criteria.</li> </ul>
Referral Sources	<ul style="list-style-type: none"> <li>Self referral.</li> <li>All ICC services.</li> <li>Private providers and non government services.</li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>Youth Worker hours from Clarence City Council.</li> <li>Increased presence of STAHS Youth Health Team in Clarence Municipality and broader catchment area.</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>Access to Customer Service Officers and administrative assistance with coordination of visiting services.</li> <li>Child Health and Parenting Program, including CU@Home.</li> </ul>

	<ul style="list-style-type: none"> <li>• Oral Health Services.</li> <li>• Child and Adolescent Mental Health Service.</li> <li>• Community Nursing Service.</li> <li>• Partnership with providers including Education Department Support Services and non government providers.</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>• To be determined.</li> </ul>
Staff development requirements	<ul style="list-style-type: none"> <li>• General staff development regarding working positively with young people.</li> </ul>
Inter- professional learning opportunities	<ul style="list-style-type: none"> <li>• Through youth health focused staff development.</li> </ul>
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>• Aim of the program is to develop links across the catchment area for services working with young people in rural areas.</li> </ul>
Key program development tasks	<ul style="list-style-type: none"> <li>• Development of partnership with Clarence City Council.</li> <li>• Development of partnership with youth focused government and non government providers.</li> </ul>
Membership Proposed Working Party	<ul style="list-style-type: none"> <li>• STAHS Youth Health Service</li> <li>• Area Services Coordinator, Primary Health (Chair)</li> <li>• Clarence City Council</li> <li>• Child Health and Parenting program</li> <li>• Oral Health Services</li> <li>• Mental Health Services – Child and Adolescent Mental Health Services</li> <li>• RHH Antenatal Clinics</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>• As per program description.</li> </ul>

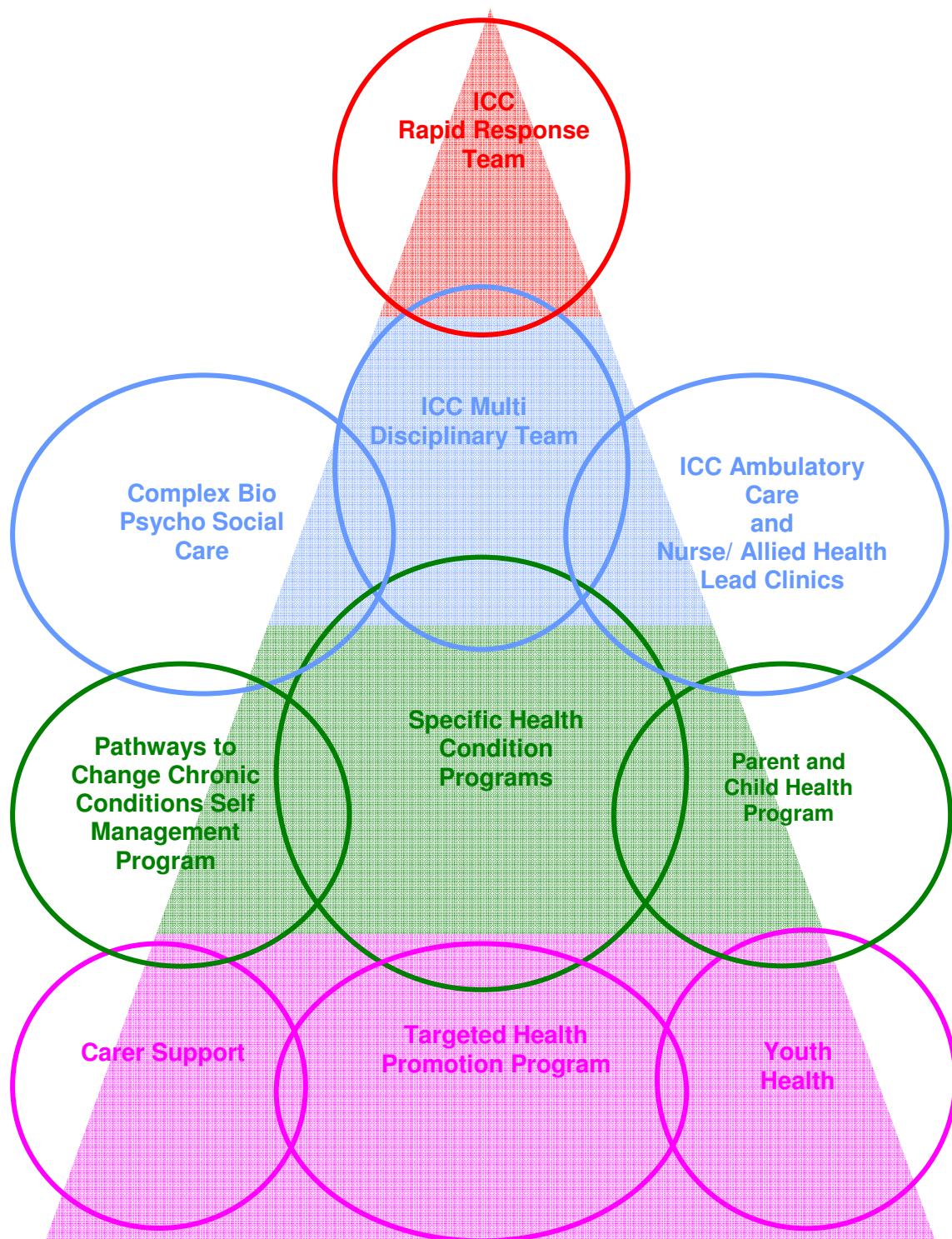
	<h2>Carer Support</h2>
ICC Level	I
Program Purpose	Provision of support for carers and families supporting people with a chronic condition.
Target Population Group	<ul style="list-style-type: none"> <li>All carers and families.</li> </ul>
Initial Target Population Group	<ul style="list-style-type: none"> <li>Carers linked with clients who are part of the MDT.</li> </ul>
Description of Program	<ul style="list-style-type: none"> <li>Provision of individual and group based carer support services.</li> </ul>
Program Services	<ul style="list-style-type: none"> <li>Access to service and health condition information.</li> <li>Access to individual assessment regarding carer needs.</li> <li>Access to individual counselling and advocacy services.</li> <li>Access to carer events and groups.</li> </ul>
Services Involved	<ul style="list-style-type: none"> <li>Community Nursing.</li> <li>Community Health Social Work.</li> <li>MDT providers.</li> </ul>
Clinical Eligibility Criteria	<ul style="list-style-type: none"> <li>People caring for a person with a chronic condition.</li> </ul>
Referral Sources	<ul style="list-style-type: none"> <li>MDT providers in the first instance.</li> <li>All ICC service providers as the program expands.</li> </ul>
New Resources Required	<ul style="list-style-type: none"> <li>Partnerships with carer support organisations.</li> <li>Access to Customer Service Officers and administrative assistance to assist with coordination of any programs/services developed.</li> </ul>
Existing Resources	<ul style="list-style-type: none"> <li>Community Nursing</li> <li>Community Health Social Work</li> </ul>
Equipment/ Resources Required	<ul style="list-style-type: none"> <li>Nil.</li> </ul>
Staff development requirements	<ul style="list-style-type: none"> <li>Familiarisation with carer support needs, assessment, and service networks.</li> </ul>
Inter-professional	<ul style="list-style-type: none"> <li>General shared learning through carer involvement and referral.</li> </ul>

learning opportunities	
Links with services across the ICC catchment area	<ul style="list-style-type: none"> <li>Potential to expand services and programs across service area, once developed.</li> </ul>
Key program development tasks	<ul style="list-style-type: none"> <li>Identify current carer support providers.</li> <li>Develop partnerships with providers.</li> <li>Develop carer assessment and referral component of MDT function.</li> </ul>
Membership Proposed Working Party	<ul style="list-style-type: none"> <li>Linkages with MDT Working Group initially and then as per complex bio psycho social care working group.</li> </ul>
Future Vision	<ul style="list-style-type: none"> <li>Expansion of service across a range of health conditions and service areas.</li> </ul>

**Clarence Integrated Care Centre Service Model**



## Clarence ICC Service Clusters



## Clarence ICC Services Descriptions

Service	Service Description
Adult Community Mental Health Services	<ul style="list-style-type: none"> <li>Specialist Community Based Mental Health Services including assessment, treatment and rehabilitation to adults aged 18-65 who have severe and persistent mental illness associated with significant disability predominantly Schizophrenia, Bipolar Disorder and Depression; and those severe disorders of personality where there is a clear benefit from treatment and support.</li> </ul>
Alcohol and Drug Services (ADS)	<ul style="list-style-type: none"> <li>ADS provides alcohol and other drug counselling to both young people and adults, and withdrawal services or pharmacotherapy to adult clients (18+).</li> </ul>
Physiotherapy	<ul style="list-style-type: none"> <li>Provides services to clients of all ages who may require assistance with: musculo-skeletal injuries or difficulties, falls prevention advice and interventions, movement or mobility difficulties commonly experienced by older people, cardiac and/or respiratory conditions, neurological conditions (such as stroke, Multiple sclerosis etc), women's health, pain management; and other medical problems.</li> </ul>
Social Work	<ul style="list-style-type: none"> <li>Social Workers see adults over 18 years of age with complex needs including managing: life changing events, social isolation, health issues, grief and loss. The service also provides: counselling, advocacy, support, solution focused exploration of problems, fresh perspectives for personal growth or continuing difficulties.</li> </ul>
Occupational Therapy	<ul style="list-style-type: none"> <li>Provides a 100% outreach service to clients living in the Rumney district. Common priority areas for occupational therapy intervention include: safety and independence in activities of daily living in the home, falls prevention, pressure care, sudden deterioration in function, carer crisis due to physical demands of care and need for equipment and/or advice; and issues related to Community Equipment Scheme equipment.</li> </ul>
Podiatry	<ul style="list-style-type: none"> <li>The Podiatry service manages Royal Hobart Hospital (RHH) inpatients, outpatients' services and community health centres across a broad range of clinical areas. Services provided include: biomechanical and gait assessment, orthotic prescription and manufacture, lower limb neurological and vascular assessment as part of diabetes management, footwear assessment and advice, assessment, treatment and management of foot ulcers, nail surgery; and pathological nail or skin anomalies.</li> </ul>
Dietetics	<ul style="list-style-type: none"> <li>The dietetic service is currently offered to the Rumney area for nutritional assessment, and management of clients with swallowing difficulties that have been referred to the Community Speech Pathologists.</li> </ul>
Speech Pathology	<ul style="list-style-type: none"> <li>A centre-based paediatric speech pathology service is provided for children 0 – 4 years old.</li> <li>An adult speech pathology service is provided for the Rumney region. The service treats people with acquired communication and swallowing difficulties due to a variety of aetiologies including stroke, progressive neurological conditions (eg MND and MS), head and neck cancers, and dementia.</li> </ul>

Continence Service	<ul style="list-style-type: none"> <li>The continence service is a specialist nursing service providing clinical assessment, treatment and management of incontinence to the Rumney district.</li> </ul>
CentrePath Pathology	<ul style="list-style-type: none"> <li>Fully bulk billing pathology collection for blood, urine, and swabs.</li> </ul>
Child Health & Parenting Services (CHAPS)	<ul style="list-style-type: none"> <li>The Child Health and Parenting Service offer health and developmental assessments to all children from birth to 4 years, and vision and hearing assessments in the Prep year at all schools.</li> </ul>
Clarence Ambulatory Care Centre (CACC)	<ul style="list-style-type: none"> <li>The Clarence Ambulatory Care Centre is a nursing based medical day care facility under the auspices of a Medical Director, for patients undergoing medical procedures and/or minor surgical procedures.</li> </ul>
Community Nursing	<ul style="list-style-type: none"> <li>Eastern Shore Community Nursing provides comprehensive nursing care, assessment, referral &amp; clinical management to clients of all ages in their home.</li> </ul>
Needle & Syringe Program	<ul style="list-style-type: none"> <li>Provides a comprehensive range of sterile injecting equipment to injecting drug users. Uses harm reduction strategies in relation to injecting drug use, brief interventions, and referrals.</li> </ul>
Oral Health Services	<p><i>Children:</i></p> <ul style="list-style-type: none"> <li>Children's dental care may include: examination and treatment planning, nutritional information and oral health counselling, taking and interpreting of radiographs (x-rays), scaling and cleaning teeth to remove calculus, applying fluoride to teeth at risk of dental disease, placing dental sealants, filling teeth (deciduous and permanent), extracting deciduous teeth when necessary; and referral to a Dentist or Orthodontist for further assessment.</li> <li>Age group 0 – 17 years 11 months.</li> </ul> <p><i>Adult: (may be provided in the future in the ICC)</i></p> <ul style="list-style-type: none"> <li>The Adult Dental Service provides a range of dental services including emergency dental care, general dental care and dentures.</li> <li>ICC will use existing referral pathways to adult services, with future plans to provide services at the ICC.</li> <li>Eligibility criteria and fees apply for the adult service.</li> </ul>
Women's Health Clinics	<ul style="list-style-type: none"> <li>Midwife clinics will be available every Wednesday from 9.40am – 3.30pm for women with routine low risk pregnancies.</li> </ul>
Youth Health Services	<ul style="list-style-type: none"> <li>There will be an increased range of youth health services available from the ICC provided by DHHS, Council, and non government organisations. This will also include the provision of targeted outreach youth health services in the community.</li> </ul>

## **Proposed ICC Service Model Working Groups Membership**

### **ICC Multi Disciplinary Team and ICC Rapid Response Team**

- Multi Disciplinary Team Clinical Lead (to be advised)
- Assistant Director of Nursing, Primary Health
- RHH service representative, including ED and EMAT
- Director, Allied Health Professional Services (chair)
- Statewide and Mental Health Services Representatives
- Allied Health Professional Services Representative (RHH)
- Allied Health Professional Services Representative (Primary Health)
- Nurse Unit Manager, Eastern Shore Community Nursing
- Representative Ambulance Tasmania
- ASSAT Representative
- Clinical Facilitator, Integration, Primary Health
- Nurse Practitioner Aged Care, Continuing Care

### **Lifestyle Risk Factors Targeted Health Promotion Program**

- ICC Centre Coordinator
- Area Services Coordinator, Primary Health (Chair)
- Eastern Shore Community Nursing Representative
- Allied Health Professional Services Representative
- Health Promotion Coordinators from service areas
- Youth Health representative
- Administrative Assistant, ICC
- Access to specialist service providers for specific health conditions, MDT and Pathways to Change (including DHHS and non government providers)

### **ICC Complex Bio Psycho Social Care Program and Carer Support**

- Multi Disciplinary Team Clinical Lead
- Mental Health Services
- Alcohol and Drug Services
- Community Health Social Work
- Needle and Syringe Program
- Human Services, including Housing Tasmania, Disability Services
- ICC Multi-Disciplinary Team working party representative
- Linkages with existing Steering Committee for peri natal depression initiative

### **Nurse/Allied Health Lead Clinics and ICC Ambulatory Care Centre**

- STAHS Continuing Care Assistant Director of Nursing
- RHH Ambulatory Care Centre Nurse Unit Manager
- Assistant Director of Nursing, Primary Health (Chair)
- Nurse Unit Manager, Eastern Shore Community Nursing
- Nurse Unit Manager, Statewide Continence Service
- Allied Health Professional Services Managers - physiotherapy, podiatry
- Access to Clinical Facilitator, Innovation Unit, Community Nursing Model of Care

## **Pathways to Change Chronic Conditions Self Management Program**

### **Specific Health Conditions Programs**

- Linkages with STAHS Diabetes Service Model Working Group
- Linkages with STAHS Musculo Skeletal Service Model Working Group
- Linkages with STAHS Cardio Respiratory Service Model Working Group
- Linkages with Pathways to Change project governance arrangements
- Linkages to existing Project Officer, Eastern Shore Community Nursing as mentor and clinical leadership.

### **Youth Health**

- STAHS Youth Health Service
- Area Services Coordinator, Primary Health (Chair)
- Clarence City Council
- Child Health and Parenting program
- Oral Health Services
- Mental Health Services – Child and Adolescent Mental Health Services
- RHH Antenatal Clinics

### **Parent and Child Health Program**

- Linkages with the Perinatal Project Steering Committee and Project Officer
- Child Health and Parenting Service (including C U @ Home Program)
- Women's and Children's Service, RHH, antenatal clinics
- Mental Health Services (adult and child and adolescent)
- Oral Health Services
- Youth Health Services
- Access to non government providers of children's services

Department of Health and Human Services

**Integrated Care Centre Service Model Working Group –**

.....(add specific service area)

**Terms of Reference****4.1 Background****4.2 Purpose**

To determine the agreed program scope, including clinical and operational requirements, for the establishment and implementation of the above-mentioned program as part of the Clarence ICC service model.

**4.3 Role and Function**

- Confirm the agreed service definition, including scope for the initial development of the service and future opportunities for service expansion/development.
- Identify required clinical guidelines and protocols required to support the quality and safety of the service, including source documents that may be used/adapted for the service model.
- Identify proposed referral, intake, review and discharge arrangements for analysis and inclusion as part of the broader ICC service model.
- Identify functional requirements for staff involved in the provision of the service.
- Identify key performance indicators to inform the evaluation of the service model, including a focus on client health outcomes and service demand management outcomes.
- Work with the ICC Team to identify appropriate business processes, including information management requirements as part of the broader STAHS service model.

**4.4 Membership**

Chair: To be nominated

Membership: As per attachment 4

Executive Officer: To be nominated

**STAHS ICC Program  
Interim Governance Arrangements**

