Abstract

Title: Health Navigator - Improving healthcare and bolstering services offered in regional areas of WA - The First Six Months.

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WA Country Health Service (WACHS) in partnership with Silver Chain Group has developed a comprehensive chronic conditions service coordination self- management model, provisionally called the Health Navigator (HN) program. The initial priority chronic conditions to be targeted through the Health Navigator program are Diabetes, Chronic Obstructive Pulmonary Disease and Congestive Cardiac Failure.

Funding for the Health Navigator program is through the Royalties for Regions, Southern Inland Health Initiative (SIHI).

Aims of the Health Navigator program

- Minimise preventable hospitalisations and unplanned emergency presentations.
- Improve access for clients to appropriate and coordinated health care in local communities
- Support clients in a self-management approach

Silver Chain Virtual HN service

- Provides a centralised access - incoming referrals and communication.
- Utilises telehealth services for all client contact
- Undertakes preliminary holistic risk assessment/triage using Flinders tools to stream clients into *stratified care pathways* matched to their health needs.
- Act as a 'system navigator' to provide information and facilitate access to relevant education, care, treatment and follow-up
- Support clients and carers capacity to self-manage

Once assessed, those with the target chronic conditions are allocated to:

- Level Three: Low risk of disease progression/complications,
- Level Two: medium risk of disease progression/complications,
- Level One: high risk of disease progression/complications,

Key services:

- Generic/condition-specific education material about chronic condition, clinical and self-management.
- Information about available services to support chronic condition management
- Referral to appropriate health care providers and assistance in booking appointments and/or accessing services.
- Development of a personalised behaviour orientated "My Plan"

HN was launched in October 2013 Results so Far:

- Development and testing of the referral and assessment system and processes.
- Establishment of the evaluation process,
- Procurement and implementation of an Electronic Client Information Sharing System,
- Development of training and promotional materials and
- Communication and engagement with GPs.

Referrals to end of January 2014: 71(52 diabetic; 4 heart failure; 16 COPD)