Julia Creek MPHS Integrated Model of Care Project (IMOC)

Initiative Type

Model of Care

Status

Deliver

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https://clinicalexcellence.qld.gov.au/improvement-exchange/julia-creek-mphs-integrated-model-care-project-imoc

Summary

The Julia Creek Multi-Purpose Health Service (MPHS) Integrated Model of Care project aims to deliver an Integrated Model of Care (IMOC), which meets the current and future needs of the McKinlay Shire community. The IMOC project solutions were co-designed by a Local Management Team (LMT) which include North West Hospital and Health Service staff, GP Medical centre staff and

community representatives. A community survey, and mapping of all local and visiting services was completed to determine the gaps in the delivery of the health services and the needs of the community. The LMT meets weekly to discuss clinical presentations, case management, patient navigation and health promotion.

Key dates

Oct 2018

Oct 2019

Implementation sites

Julia Creek Multipurpose Health Service

Partnerships

McKinlay Shire council, Community Advisory Network, and Julia Creek Medical Centre and WQPHN

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Aim

The Integrated Model of Care Project (IMOC) project aims to achieve better health outcomes for the whole of the remote McKinlay Shire community by increasing access to a wide range of services, delivered by an integrated team, while focusing on engaging and empowering the consumers in the delivery of their care. The IMOC project also addresses the challenges of lifestyle of the community and the associated chronic conditions and high-risk occupations, by focused health education and promotion.

Benefits

The initial stages of the project have realised the following benefits:

- Case management of chronic disease and GP visits have increased
- Increased number of Telehealth presentations for specialist and other services
- Collaboration between services and team meetings have commenced
- Community numbers at meetings and auxiliary projects have increased
- Health education and promotion timetable, focused on local issues, commenced on January 1, 2020

Background

This Model of Care was developed to improve health outcomes for the McKinlay Shire community by delivering health services by one integrated team, focusing on person centred care and empowering the community in the provision of health care. The completion of the project was timed to coincide with the completion of the new Julia Creek Hospital integrated facility.

Solutions Implemented

Central to the Julia Creek IMOC are the principles of:

- Person centred care
- Health services working as one integrated team
- Achieving better health outcomes for whole community
- Empowering the community to take responsibility for their own health
- Utilising shared patient records and innovative technology

The IMOC project solutions were co-designed by a Local Management Team (LMT) which include NWHHS local staff, GP Medical centre staff and community representatives. A community survey, and mapping of all local and visiting services was completed to determine the gaps in the delivery of the health services and the needs of the community. The LMT meets weekly to discuss clinical presentations, case management, patient navigation and health promotion A local service providers group with representatives from NWHHS, Julia Creek medical centre, McKinlay shire council, local pharmacy, Queensland Ambulance Service, Queensland Police Service, and N&WRH meets quarterly to evaluate the model and advise on any enhancements A number of clinical pathways were developed and adopted to provide a clear vision of how the integrated team and patient/carers work together for best outcomes for identified issues. Advances in technology in the delivery of telehealth and other services are closely monitored and made available where possible to all consumers. A timetable of health education and promotion and advancement of health literacy has been adopted to target local issues and all service providers will participate in a co-ordinated manner. A guideline for visiting services was implemented to ensure communication with local providers, appropriateness of service and involvement of community is optimised A community engagement guideline has been developed to ensure ongoing community engagement in all aspects of health services. Organisational change to enable flexibility of staff across the MPHS to deliver services and upgrade skills has been implemented. The project became operational on 1 October 2019.

Evaluation and Results

- Data evaluation, from NWHHS and RHMS, of process and clinical indicators as well as telehealth, patient travel, preventable hospital admissions, case management of chronic disease, primary care initiatives, are utilised in the progression of the model.
- Input and analysis of information from the Community Advisory Network (CAN) and hospital auxiliary and annual community surveys will continue.
- The LMT will hold an annual meeting in August each year to review the model and manage any changes agreed upon by the team.
- Consumer and staff satisfaction surveys will continue annually.

Lessons Learnt

- Community engagement is essential to develop a health service that is both targeted and relatable to the community
- Successful change must involve collaboration of all participants
- Education is essential to promote community taking responsibility for their own health journey
- Best health outcome and service outcomes are achieved by collaboration of partners and ongoing evaluation and improvements