Clarence Integrated Care Centre

Case 1

At 51 years old, Joe has Type 2 Diabetes and went to discuss his need for more physical activity with his GP.

Joe's GP (case manager) referred him to the physiotherapy service at the Clarence Integrated Care Centre to talk about exercise programs to help him maintain or improve his general fitness.

As part of this discussion the physiotherapist asked Joe a number of questions to see if there were other services that could help him improve his health and wellbeing.

The assessment showed that Joe understood his diabetes well and was keen to improve his health and wellbeing. The physiotherapist helped Joe develop an exercise program that suited his lifestyle. Joe was discharged from the centre and a care summary was sent to his GP.

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Case 2

Sandra is a 38-year-old woman who spent 12 years caring for her mother who was very ill with heart problems.

After her mother died 12 months ago, Sandra had found it hard to find a new focus and lost contact with a number of friends and sporting groups to which she belonged before her mother's illness.

Sandra's GP (case manager) was concerned that Sandra's health was deteriorating to the point where she was at risk of developing similar health problems to her mother. The GP referred Sandra to the Clarence Integrated Care Centre for help with a health and wellbeing program.

Sandra met with a care facilitator at the centre who assessed her health needs. From this assessment Sandra and the facilitator decided it would help to link her with a health coach to identify changes to her physical activity and diet. They also decided that it might be useful for Sandra to talk to someone about her grief.

Sandra worked with the health coach for the next three months and made some lifestyle changes, including linking up with the walking group and nutrition information programs run from the centre. After some time, she also took up with her sporting groups again.

Sandra also met regularly with a social worker to talk about the loss of her mother and new life goals.

Sandra met with the care facilitator after three months and they determined that she was happy to continue her new lifestyle independently and would re-connect with staff if she felt the need. Sandra was discharged from the centre and a care summary was sent to her GP.

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Case 3

David is a 53-year-old man with chronic obstructive pulmonary disease. David recently had a number of hospital admissions within a short time because of worsening symptoms that meant he couldn't cope at home.

Hospital staff and David's GP (case manager) identified that David was often reluctant to ask for any help until he felt really unwell because as he didn't want to bother anyone. Therefore, when he did make contact with his GP, the only option was hospital admission.

After a discussion with the GP, hospital staff referred David to the Clarence Integrated Care Centre to help him in manage his condition to prevent the need for regular hospital admissions. Following an assessment at the centre, David was linked with a community nurse (care coordinator) who worked with David to alert him to symptoms of worsening health.

The care coordinator worked with the GP to ensure David was prescribed with appropriate medication to respond early to signs and symptoms of infection, and provided support and education about when to use this medication to prevent his condition worsening. David also worked with the community physiotherapist on exercises to teach him to detect any changes to his breathing capacity, and he undertook health coaching to help him set goals to improve his health and wellbeing.

David worked on these strategies for 12 months and reported feeling much more in control of his health. His GP reported that David was pro-active in making contact with him when his symptoms changed and that his hospital admissions were greatly reduced.

At this point, David was discharged by the care coordinator and a care summary was sent to the GP.

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Case 4

Edna is a 78-year-old lady who was referred by her GP (case manager) to the wound clinic at the Clarence Integrated Care Centre because her leg was not healing well.

Talking with the community nurse about her wound, Edna reported that she was hurt after falling at home and that she seemed to be doing that a lot lately.

Edna went on to say that she didn't get out or cook for herself much because she lived on her own. However, she said she loved to read her morning paper to keep up with what is happening. Following this conversation, the community nurse suggested a number of services that might help Edna.

The community nurse organised for an occupational therapist to visit Edna at home to assess her living environment and help put things in place to reduce her falls. Following this visit, the occupational therapist organised for rails to be fitted at Edna's front and back steps and also in the bathroom to help her move about safely.

The occupational therapist also organised a referral for Home Help Services to visit Edna to help her with house work.

The community nurse also referred Edna to the community physiotherapist to help her with some exercises to improve her balance. Edna went on to join the local Living Longer Living Stronger group to improve her strength and fitness.

She also attended group information sessions on "healthy eating for one" run by the centre's dietitian.

The community nurse continued to meet with Edna and reported that with changes in her nutrition and more physical activity the wound was now healing well. Edna reported that she had more confidence at home again and had made new friends at the groups she was attending. She said they were now getting together to cook for each other regularly.

The community nurse provided a care summary to Edna's GP.

Case 5

Alan, a 28-year-old man with a primary diagnosis of schizophrenia, was referred to the Clarence Integrated Care Centre by the Royal Hobart Hospital for ongoing treatment following discharge.

The mental health team did an initial intake assessment and noted Alan needed ongoing blood tests to monitor treatment. Alan's case manager made the internal referral to the RHH ambulatory care unit. The service could be provided at the Clarence Ambulatory Care Centre, where regular blood testing was undertaken. The results were available to the treating psychiatrist as soon as they were completed via the electronic client record. Alan's mental health case manager coordinated overall treatment and care in consultation with the mental health multidisciplinary team and Alan's psychiatrist and GP.

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Case 6

Anne, a 34-year-old mother of three with a primary diagnosis of post natal depression, was referred to the mental health team at the Clarence Integrated Care Centre by her GP.

The referral was forwarded to the Mental Health Helpline, which provided an initial clinical triage and determined a high priority for Anne. Mental Health Crisis Assessment and Treatment staff undertook an initial assessment in Anne's home within 24 hours and organised a subsequent appointment with a psychiatrist. Anne was given a case manager from within the team and received daily support during treatment. On further assessment by the multidisciplinary team, it was decided Anne needed more help with parenting. The case manager contacted Child Health Nursing, which provided Anne with extra support and education and linked her with a parenting group at the centre. Anne recovered from her depression, was provided with relapse prevention education and was referred back to her GP for ongoing care.

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Case 7

Simon, a 22-year-old Sandford man, presented to the Alcohol and Drug Service (ADS) at St Johns Park with severe visual and auditory hallucinations.

Simon used "speed" and was also a known to consume alcohol heavily. He was initially assessed by ADS staff and they sought help for the hallucinations from the Mental Health Helpline, which provided an initial clinical triage assessment and asked the Community Mental Health Crisis team to respond within two hours. Simon was assessed at St Johns Park and taken to the RHH – Department of Psychiatry for treatment of his acute psychosis. Simon's psychotic symptoms did resolve. Discharge planning was done in consultation with ADS and Mental Health Services based at the Clarence Integrated Care Centre, which developed a collaborative care plan so Simon could be safely discharged from hospital back to his brother and community. Simon was seen regularly by his ADS and Mental Health Services case managers at the centre where his collaborative care plan was further developed with his input. Appointment times were coordinated to minimise travel impacts for Simon. Coordinated treatment from both services continued over a month. While the psychotic symptoms had resolved, his alcohol use was an ongoing concern. The centre case managers referred Simon to the ADS Inpatient Withdrawal Unit. On completion of a seven day admission, Simon started a three month alcohol and drug residential program.

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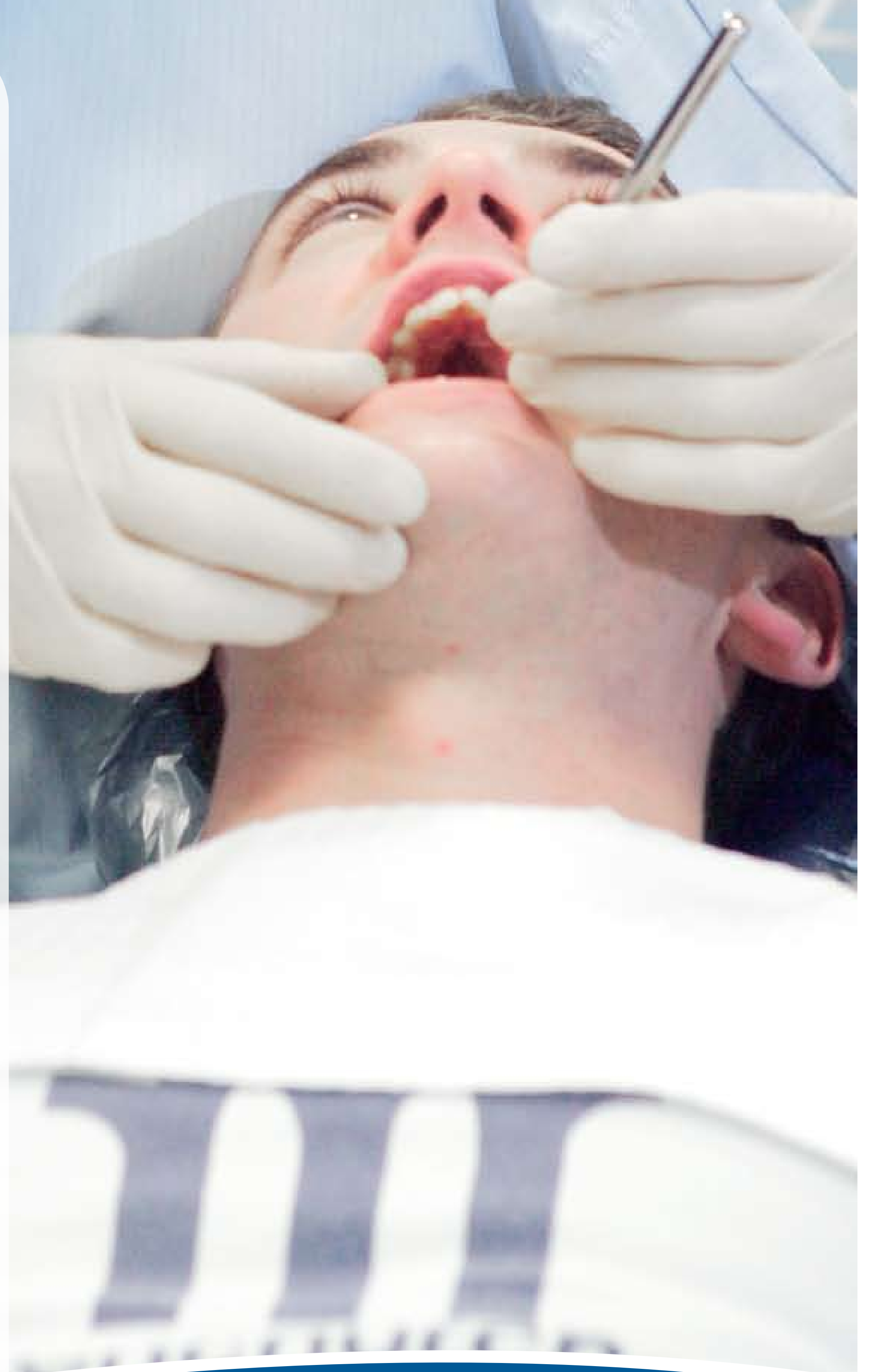

Case 8

Scott, a 17-year-old male high school student living in Rosny, was caught supplying school mates with ecstasy and was referred to the Alcohol and Drug Service (ADS) community team at St Johns Park.

Upon assessment it was found Scott was a regular ecstasy user and was mildly dependent on cannabis and nicotine. Scott was referred to the youth team for ongoing counselling. However, because he was unable to drive and preferred his parents were not aware of his treatment, Scott was referred to the Clarence Integrated Care Centre where he saw an ADS outreach worker from the youth team. The youth worker and the GP jointly discussed substance use health risks and pharmaceutical interventions for nicotine withdrawal with him. During these interactions it was found that Scott had dental problems due to grinding his teeth on ecstasy. This led to a referral to the centre's Oral Health Service. Because a range of services were offered close to Scott's school, it meant several health difficulties were managed with little impact on his social, personal and educational life.