# CHILD HEALTH OUTREACH PROGRAM

## AMPE MWARRE-ILEME

25 GAP ROAD – (OLD I.T BUILDING)

# THE CHOP TEAM
## INTEGRATED SERVICES

- Shontel De Graaff – RN & Team Leader
- Toni Braitling - RN
- Sarah Inglis – RN
- Kelly-Anne Kenny – Aboriginal Family Support Worker
- Dr Deb Bird
- Manager- Claudia Griffiths (RN)

# PROGRAM AIMS

- To promote the health and wellbeing of Indigenous children living in Alice Springs with a chronic complex illness through:
  - Case management, intensive outreach clinical care and support
  - Culturally-appropriate care and support to empower families in the management of their children's healthcare needs
  - Addressing social determinants that impact upon the health of families and children in Central Australia
  - Access to and awareness of healthcare services, including referrals to allied health services and other agencies.

# WHO IS ELIGIBLE FOR CHOP?

- Is client an Aboriginal or Torres Strait Islander person?
- Are they primarily a town resident?
- Is the client between the ages of 0 and 15 years?
- Has the client got a chronic or complex illness?
- Do the family of the client and/or the family require additional support in managing this chronic or complex illness/condition?
- Is the family aware of the referral? (*Referrals to CHOP require consent from the primary carer.)*

**Must answer YES to ALL questions!**

# WHAT IS A CHOP CLIENT?

- **Low birth weight**
- **Premature**
- **Diabetes**
- **Respiratory disease**
- **Cardiac Disease**
- **Renal Disease**
- **Failure to thrive**
- **ARF/Rheumatic Heart Disease**
- **Cancer**
- **Diagnosed developmental delays**
- **Other chronic conditions**

# OTHER CONDITIONS WE CO-ORDINATE/MANAGE

- (Multiple conditions for same client)
- Sexual health
- Diabetes > Diabetes in Youth clinics
- Hearing
- Dental
- Eyes

# WHY DOES CHOP WORK?

- We are an outreach service
- Medication at home – BLA's/ Azithromycin/pharmacy medications drop offs/ monitoring scripts
- Help with transport if needed (90% of our clients need our help getting to appointments)
- We can assess and refer on to more appropriate services if not suitable to CHOP (diabetes, dietician etc)
- Education and regular GP appointments at ASH and CAAC
- Regular weights and monitoring

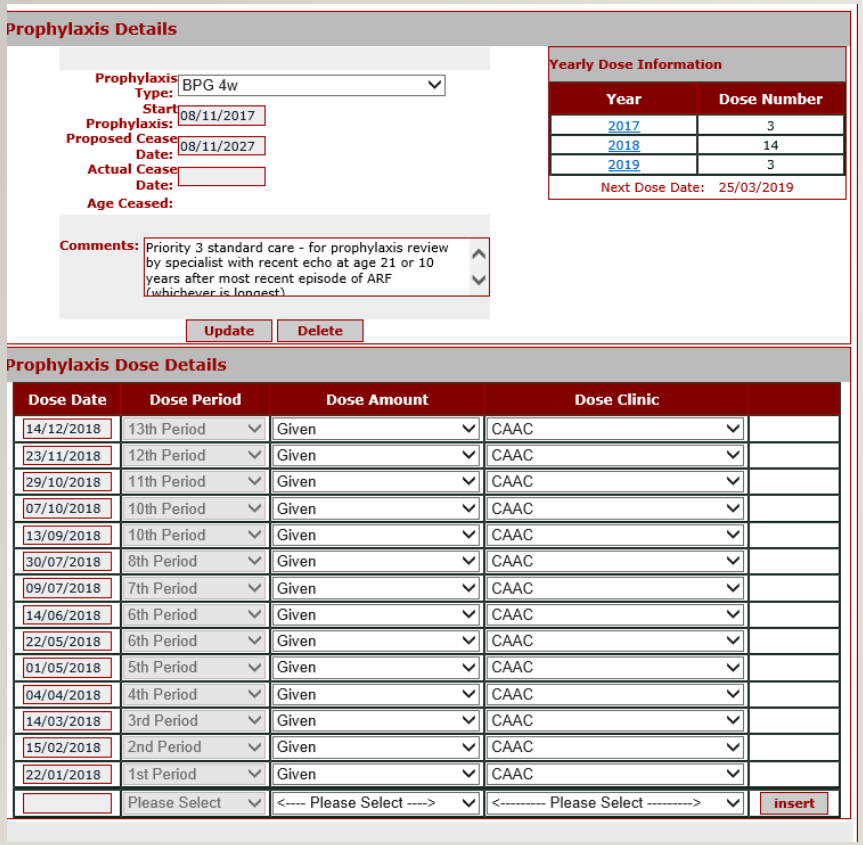
# THE CHOP CLIENT- AN EXAMPLE

Tommy, 10 year old male, recently diagnosed with RHD. His family live out of town, and have no access to transport. He is referred from ASH to CHOP for RHD management and follow up. CHOP accepts the referral and completes a home visit to engage with family and their needs. The following is an indicator of the follow up and management needed for **one** RHD child:

- 21-28 day BLA administration
- Dental assessments every 3/6/12 months depending on Priority (as per RHD register).
- Skin checks
- Cardiac appointments
- Paediatric appointments
- CHOP appointments
- ECHO
- USS

This is just for one client. We currently have approximately 20 ARF/RHD clients, each needing this management and follow up.

# AN EXAMPLE OF A SUCCESSFUL (RHD) CHOP CLIENT



**Prophylaxis Details**

Prophylaxis Type: BPG 4w
Start Prophylaxis: 08/11/2017
Proposed Cease Date: 08/11/2027
Actual Cease Date:
Age Ceased:

Comments: Priority 3 standard care - for prophylaxis review by specialist with recent echo at age 21 or 10 years after most recent episode of ARF (whichever is longest)

Update | Delete

**Yearly Dose Information**

| Year | Dose Number |
|---|---|
| 2017 | 3 |
| 2018 | 14 |
| 2019 | 3 |

Next Dose Date: 25/03/2019

**Prophylaxis Dose Details**

| Dose Date | Dose Period | Dose Amount | Dose Clinic | |
|---|---|---|---|---|
| 14/12/2018 | 13th Period | Given | CAAC | |
| 23/11/2018 | 12th Period | Given | CAAC | |
| 29/10/2018 | 11th Period | Given | CAAC | |
| 07/10/2018 | 10th Period | Given | CAAC | |
| 13/09/2018 | 10th Period | Given | CAAC | |
| 30/07/2018 | 8th Period | Given | CAAC | |
| 09/07/2018 | 7th Period | Given | CAAC | |
| 14/06/2018 | 6th Period | Given | CAAC | |
| 22/05/2018 | 6th Period | Given | CAAC | |
| 01/05/2018 | 5th Period | Given | CAAC | |
| 04/04/2018 | 4th Period | Given | CAAC | |
| 14/03/2018 | 3rd Period | Given | CAAC | |
| 15/02/2018 | 2nd Period | Given | CAAC | |
| 22/01/2018 | 1st Period | Given | CAAC | |
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- 14 BLA's given in one year √
- Dental up to date √
- Annual flu vaccination √
- Immunisations √
- Regular ECHOs, HB checks, health checks √
- Annual GP/Paeds appointment √
- Regular Cardiology appointments √

# CHOP CLINIC DAYS

## WEDNESDAY AND THURSDAY MORNINGS 0830/0930 - 1230

- Run by Dr Deb + the rostered RN of the week
- CHOP provide transport to and from clinic appointments
- Health checks, care plans, IMMS, ASQ's, sexual health, specialist referrals, housing letters, medication prescriptions etc

# OUR ACHIEVEMENTS- A FEW EXAMPLES

- 100% of our clients are up-to-date and regular with their RHD injections (20 children)
- Most of our clients have had regular health checks (including screening for Anaemia and iron deficiency) and referred (and taken to) audiology, eye-clinic and Diabetes in Youth clinics.
- We endeavour to screen every child up to 4 years old on CHOP for developmental delays using the ASQ
- Sexual health screening (and contraception implementation for teenaged-women on our program)
- Early Learning, Pre-school readiness and school enrolments and ongoing monitoring of attendance
- Successful donation scheme set up for winter clothing for the children.
- Territory Families and in-house referrals and notifications leading to intensive support services for families experiencing neglect/poor social circumstances
- Roll-out of the 'Temporary Medical Intervention' program for school children needing acute medical care
- CHOP in-services and meetings held within CAAC and at external services to educate people about our program
- Effective referral process to rural/remote community nurses when our transient children head out bush to ensure continuity of care
- Supporting clients with letters for Territory Housing.

# QUESTIONS?