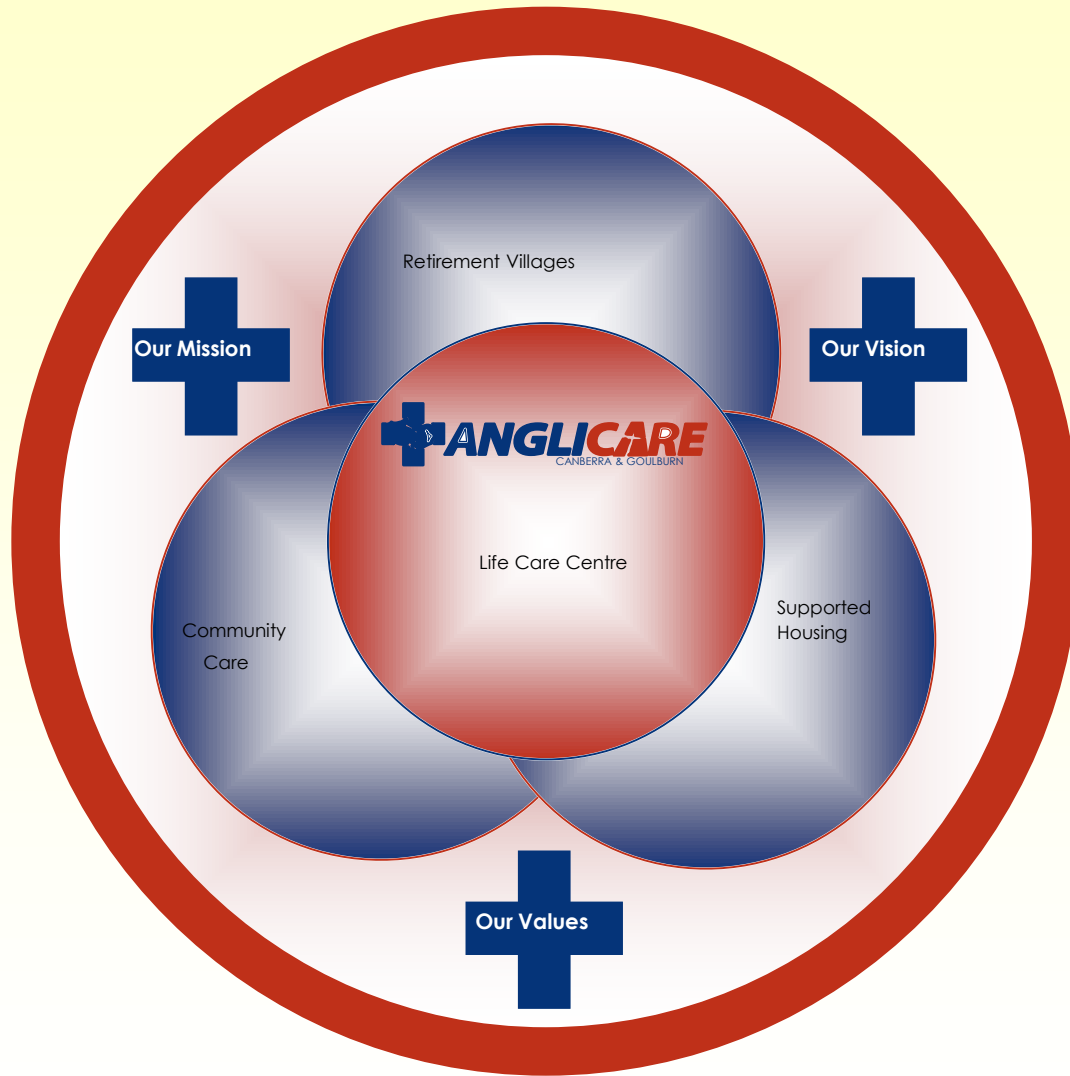
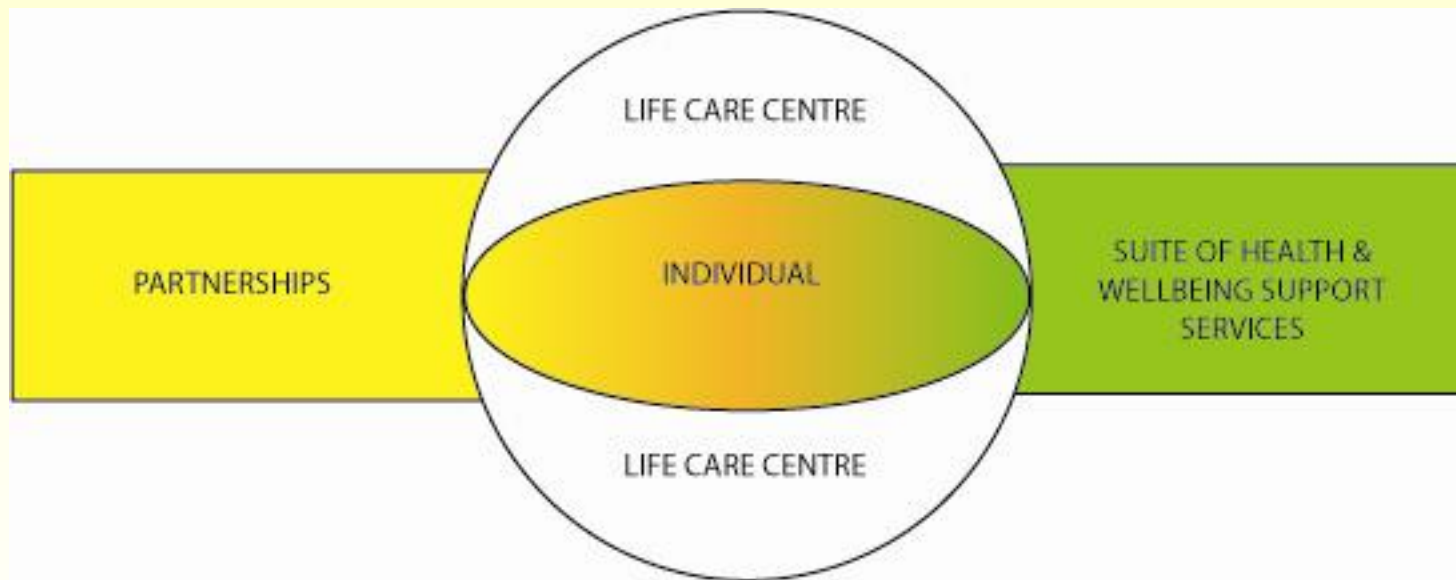


ACG Life Care Centres (LCCs)

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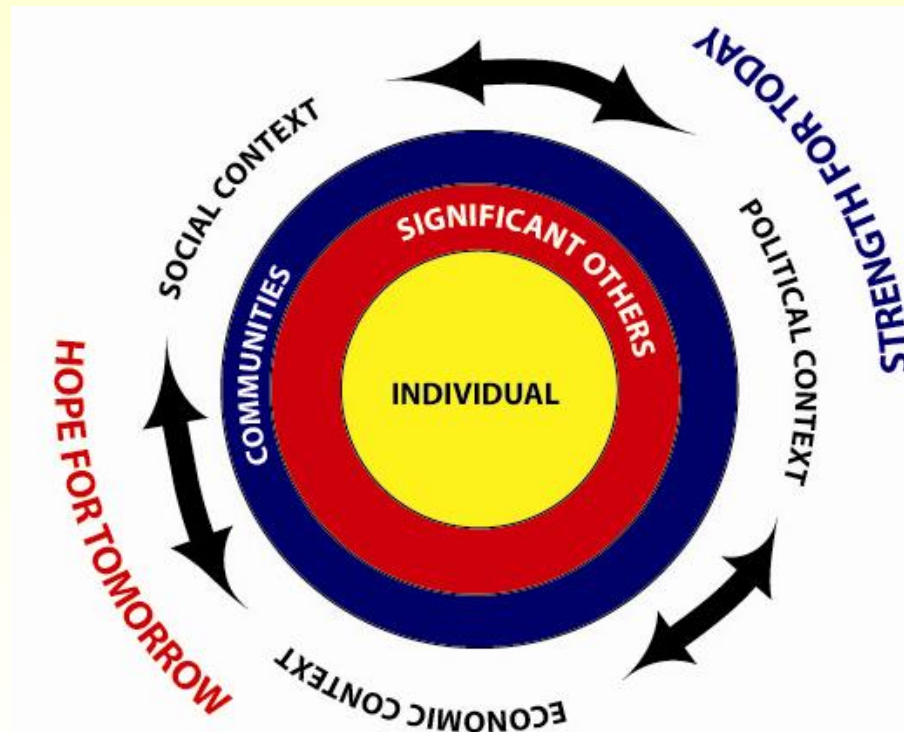
ACG Ageing at Home



Ageing at Home (AAH)

- Ageing at Home (AAH) is best achieved utilising primary health care principles. These principles are:
 - Continuity of coordinated, multidisciplinary care from the same team over time;
 - Service delivery is from a community setting, for example an ACG LCC;
 - Goals directed to managing chronic illness, preventive health support and services, rehabilitation and treating common illnesses;
 - Values that embrace equity, access, universalism, responsiveness to client concerns, and stewardship of resources;
 - Increased client focus;
 - Accentuation of the capacity of each person.

The positioning of the individual in an ACG LCC



ACG LCCs Aims

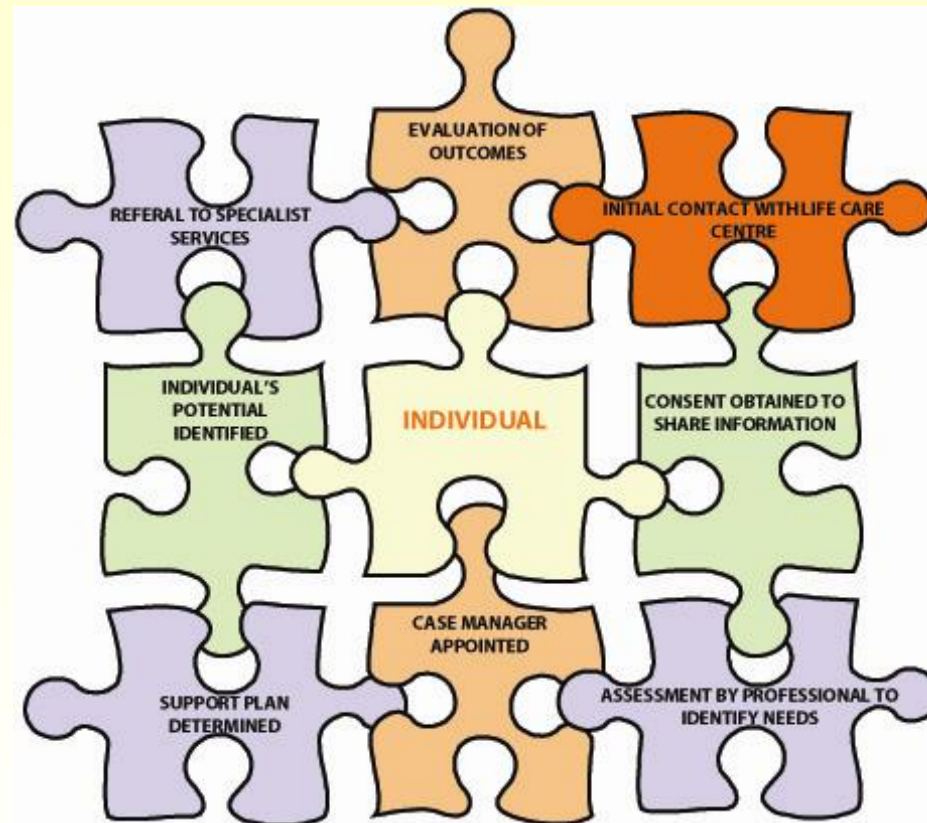
- Develop a process and place to enable older people, living in the community, to participate more fully in their local community.
- Educate the community and service providers about the potential and contributions of older people.
- Develop a core suite of primary health care services
- Utilise a model appropriate for children, families, the chronically ill, and older people with a wellness focus along an aged based continuum of care
- Develop integrated services/support based on best evidence
- Plan and deliver care in partnership with local parishes and communities
- Reduce the preventable use of acute and residential aged care services

ACG Health & Wellbeing Support Groups

- Community Wellbeing
- Community Connectedness
- Collaborative Inter-professional partnerships
- Social, Lifestyle. Health & Spiritual
- Legal & Financial



AGC LCC Cycle of Support



Challenges faced by ACG LCCs

- Changing demographic trends, in particular the ageing of the population
- Increasing levels of chronic disease across the age continuum as it is estimated that by 2020 chronic disease will account for 80% of the health care burden
- The consistently poor health of Special Needs Groups
- An increasing paucity of health care professionals
- Escalating costs associated with health care delivery
- Increasing competition for health care resources
- Increasing expectations of health care delivery systems
- Developing strong and sustainable partnerships
- Addressing the level of practice change that is required
- Reaching the most needy who are often invisible in a community
- Realignment of the organisational culture
- Supporting compliance

Enablers

- A shift in policy at a Federal, State and Territorial level that changes the focus away from residential aged care to community based care options.
- Development of MOUs with the Divisions of General Practice and individual GPs will assist seamless care delivery
- Co-location with parishes and other appropriate locations will serve as a feeder mechanism for ACG LCCs
- Information sharing amongst all agencies will reduce duplication of resource use
- Training and professional development will enhance care delivery and act as a retention mechanism for staff
- Staff secondments/exchange to other services will maintain currency of skill base of all levels of staff
- Shared governance structures will define boundaries and efficiencies.
- Improved data capture capacity
- Telehealth and Telemedicine
- Expectations of the baby boomers and Gen X
- New capital works that can be designed for multipurpose usage. For example, LCC, parish centre, community centre
- Outreach centre for local parish.
- New services attract staff.
- Communities of ministry
- Communities of practice

Key Tools

- Organisational development
- Workforce development
- Partnerships
- Leadership capacity
- Resourcing
- Client education
- Stakeholder education
- Implementation strategy



Outcomes

- Increased client choice of services
- Clients able to access supportive communities through parishes
- Increased accessibility
- Improved service coordination
- Care delivery is evidence based
- Enhanced well being
- Reduced admissions to the acute sector
- Timely response to those in most need
- Improved sensitivity to the needs of the local community that will in turn inform future service planning
- Rapid responsiveness to a change in a person health status and complexity
- Increase client education
- Improved control of chronic disease
- Improved client involvement
- Better interagency relationships and cooperation
- Better skilled workforce
- Improved organisational infrastructure
- Implementation of collaborative service delivery models
- Speedy referral services
- Interagency cross fertilisation of ideas
- Introduction of the ehealth record
- Identification of care pathways to community based services such as palliation, wound care and oncology.

Strength for Today
Hope for Tomorrow