Integrated Aboriginal Chronic Care (IACC)

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Introduction

The Integrated Aboriginal Chronic Care (IACC) project was developed in response to the identified need for a culturally appropriate service delivery model of chronic disease management and rehabilitation for Aboriginal clients. The project aimed to achieve a single point of entry for Aboriginal clients with a coordinated focus on the needs of the client to provide services that are more accessible for the Aboriginal community.]. The key issues that were identified included a poor awareness of available Aboriginal and non Aboriginal services by health staff , a lack of coordination and integration and the lack of uptake of services by Aboriginal clients.

The project was born over a simple cup of coffee between concerned health staff in the Aboriginal Medical services and the local Health district and through the lens of clinical redesign the project was born.

Partners

IACC is a successful integrated partnership between the Northern NSW Local Health District, North Coast Primary Health Network, local Aboriginal Medical Services and General Practice. This partnership works due to its unity in patient care, integrating resources, staff and clinical support and gaining and maintaining the trust of the Aboriginal chronic care patients.

Objectives

•Integration and Shared Care Planning of several similar services for Aboriginal chronic care clients across the LHD footprint reducing duplication, improving transparency, accountability and seamless responses to the needs of the patient.
•Coordination of various methods for similar services i.e. intake process/ criteria/ level of care/ capacity with a clear Model of Care,
•Improved communication between services all accessing the same client group via fortnightly 'Care Conferences', complex case conferencing and Case Management.
•Equity of access to services and all levels of empowering clients to streamline individual care plan with trust, ensuring both a clinical and cultural overview.
•All clients receiving all available services and resources sources therefore empowering individual control and judgment of their own care navigation.

Methods

The IACC navigators in our partnership identified issues and gaps, perceived and real, which had influence on a patient's transition between service providers. These gaps provided opportunities to improve networks with existing Aboriginal healthcare services.

The initiation of patient centred care with the "No Wrong Door" referral system is the lynch pin of the IACC program and has seen improved outcomes for Aboriginal Chronic Care patients in Northern NSW. IACC has capacity to empower its clients by ensuring the right care, in the right place at the right time is continually provided and is the fundamental element of Integrated Care.

"Increased awareness of other service providers and meetings are invaluable"

- Chronic Disease Management Service Coordinator, Ballina

True integration between Northern NSW Local Health District, North Coast Primary Health Network, Bulgarr Ngaru Medical Aboriginal Corporation, Bullinah Aboriginal Health Service, Bugalwena Aboriginal Medical Service, Jullums Aboriginal Medical Service and Rekindling The Spirit.

Lessons Learned

•Our clients identified challenges within our current health system and stated that they lacked adaptability and agility to incorporate the changing needs of patients with chronic and complex illness.

•There was identified inconsistency with how the Aboriginal Hospital Liaison Officer attended to a 48-Hour Follow Up, which required an integrated chronic care response.

•Ongoing symptom management was not being planned post-discharge, this is now being addressed by wrapping our arms around our clients.

•Historically there has been a significant breakdown in communication during transfer of care between services in particularly between hospital and community, shown to have a significant impact on patient outcomes. Communication is improving however much work is needed to ensure people are not falling through the gaps.

•Carers and family have a pivotal role in the care plan for Aboriginal chronic and complex patients in the community. Recognition of their role by acute and community health care provider remains minimal. There has been a shift in cultural thinking to include the family, carer and community.

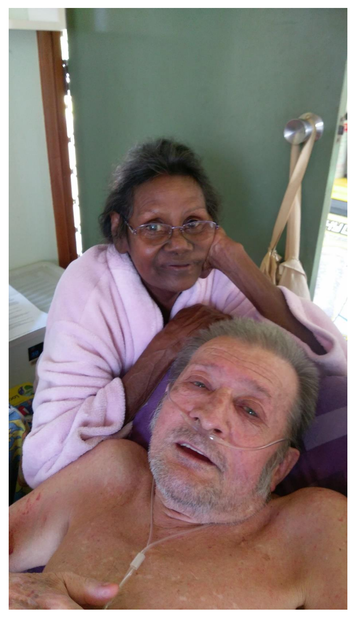
•Health care professionals' knowledge of available services and referral pathways influences care plan coordination. If it's minimal, so is follow up care. Part of the new Clinical Nurse Consultant's role will be to educate and upskill health professionals within the circle of care.

•Relationships built on trust ensures quality patient outcomes for our Aboriginal community. Together we can make a difference.

•The program has reduced duplication and improved transparency.

•Hospital admissions for this cohort have also reduced.

IACC empowers its clients by ensuring the right care, in the right place at the right time



They're Incredible, they are all working together, if we didn't have them, no one would go to the doctors, would be in and out if hospital and we wouldn't even get to the doctors or get medicines. Having these fellas working together really benefits us, it easy for us now"

- Patient

'We don't look after ourselves us old people, I was in and out of hospital with pneumonia and me other chronic problems, I just wasn't looking after myself good, until you fellas come out here and looked at things and just took it from there", I would have literally died if I hadn't got seen". - Patient

Impact/What's Next?

Impact:
- Integrated team response was well received and culturally appropriate.
- Care lead with one person contacting and liaising with the remaining IACC team, providing direction and leadership throughout.
- 48-hour follow up was acknowledged by all clients contacted as a positive initiative of health.
- Strengthened partnerships from grassroots to executive levels.
- Improved communication
- Shared care through care conferencing.
- Upskilled workforce
- Increased awareness
- Minimised confusion around clinical and cultural leadership

Transferability:
- The IACC team increased from 20 to 79 staff last year and has now expanded and collaborates with other services including:
  - NDIS(Bunjum)
  - Aboriginal Community Transport/Hart
  - Aboriginal Mental Health
  - MAC
  - QLD AMS.

Sustainability:
- IACC is now a permanent program with NNSW LHD Integrated Care funding.
- IACC is predominately Aboriginal & Torres Straight Islander grass roots/frontline staff.

"Working everyday in the GAPS we need to close in Aboriginal Health"

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Acknowledgements

So many people within the IACC partnership have demonstrated strong commitment to ensure the IACC service and the role of the Clinical Nurse Consultant, Integrated Aboriginal Chronic Care has become a permanent program that will ultimately grow and expand hopefully within the cancer and mental health arenas.

We acknowledge the traditional custodians of Australia and their continuing connection to land, sea and community. We respect the elders past and present and express our heartfelt apology for the injustices endured by Aboriginal people of our nation. We will continue to strive, day by day, for our thoughts and actions to reflect these truths and sentiments.