Aboriginal Transfer Of Care (ATOC).
Campbelltown Hospital - 2016.

Anau Speizer
CNC Chronic Care Aboriginal Health
South Western Sydney Local Health District
2017
Background

- Result of a 48 hours follow-up:
  - no scripts provided
  - medications not supplied.
  - scripts not filled as not eligible for Close The Gap (CTG) on hospital scripts.
  - unclear follow-up instruction.
  - unable to obtain appointment from GP.
  - higher re-admission rate compared to other hospitals in South Western Sydney.
Team Members of the Aboriginal Transfer of Care (ATOC)

The team comprises of:

- Patient Access to Care Team (PACT) Navigator
- PACT CNC and EEN
- Aboriginal Liaison Officer (ALO)
- Aboriginal Connecting Care Coordinator (ACCC)
ATOC Team Objectives

- Sound communication between the PACT, ALO and ACCC
- Case management of the patients is structured
- Transfer of Care is safe and organised
- The patient is aware of the plan and community services
- Overall strategy: to keep our ATOC patients well in the community and out of hospital.
ATOC Team
Patient of the
Aboriginal Transfer of Care Team

Please contact one of our team members during admission for any concerns identified by staff or the patient on:

Aboriginal Liaison Officer (ALO) - 0411 135 013
Aboriginal Chronic Care Coordinator - 0477 720 269
Patient Access to Care Team (PACT) Navigator - 0475 812 841
Patient Access to Care Team (PACT) CNC - 0419 440 785
Patient Access to Care Team (PACT) Nurse - 0409 824 227

At discharge please ensure patient has:

- A five day supply of new medications
- A copy of their discharge papers
- Scripts – if indicated
- The Aboriginal Liaison Officer’s contact details

Please contact the Aboriginal Liaison Officer to notify them of the pending discharge. If unavailable please contact the PACT CNC or another team member.
Reduced Readmissions

Chronic disease patients intervention

<table>
<thead>
<tr>
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<th>Pre ATOC admissions</th>
<th>Post ATOC admissions</th>
<th>Pre ATOC ED presentations</th>
<th>Post ATOC ED presentations</th>
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<tbody>
<tr>
<td>Percentages</td>
<td>45%</td>
<td>30%</td>
<td>20%</td>
<td>5%</td>
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Added Achievements and Bonuses

- Reduction in transfers of care against medical advice
- Improved identification of Aboriginal and Torres Strait Islander patients
- Improved continuity of care
- Improved links with Aboriginal community services
- Improved patient satisfaction
- Cluster of Aboriginal patients in local Residential Aged care Facility (RACF) – embraced by staff and management at RACF
While on a good thing........
Thinking outside the box

- Complex patients still representing
- Often required more than one Chronic Care team member to be involved
- Chronic Care CNC’s liaise well and interlink with each other
CHRONIC CARE HUDDLE

Pre Huddle Admissions: 135
Post Huddle Admissions: 71
Pre Huddle ED Presentations: 41
Post Huddle ED Presentations: 35
Challenges

- Coordinated care and services out of the area.
- Department of housing waiting list.
- Personal Care for complex patients <50yrs old.
- Staff awareness of service availabilities.
- Planning for rural area patients.
Future Plan:

- Case review once a month – complex patients.
- Data collection for report and future research.
- Evaluation of the program.
- Winter strategy for Chronic disease patients.
- Access Tele Health Service.
- Research project.
Conclusion

- “Huddles” are time efficient and practical.
- Person centred care is delivered to those most at risk of representing to hospital.
- Improved communication and improved information exchange has led to this improvement in healthcare.
Food for Thought

Health is everyone’s business

Working together to make a difference

NSW Government Health South Western Sydney Local Health District
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