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

Anau Speizer

CNC Chronic Care Aboriginal Health

South Western Sydney Local Health District

2017

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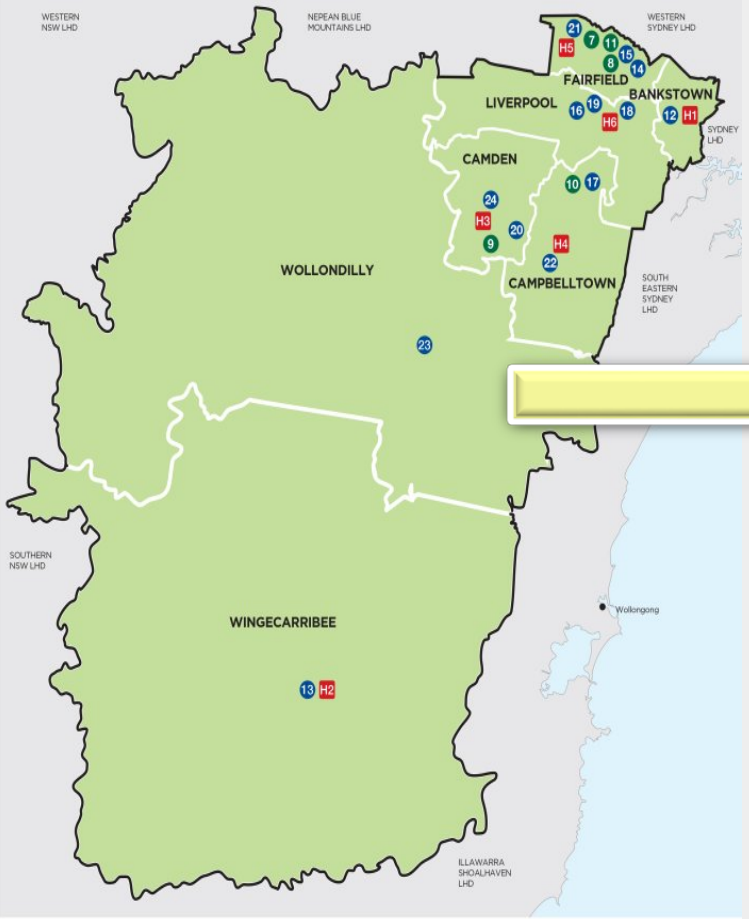
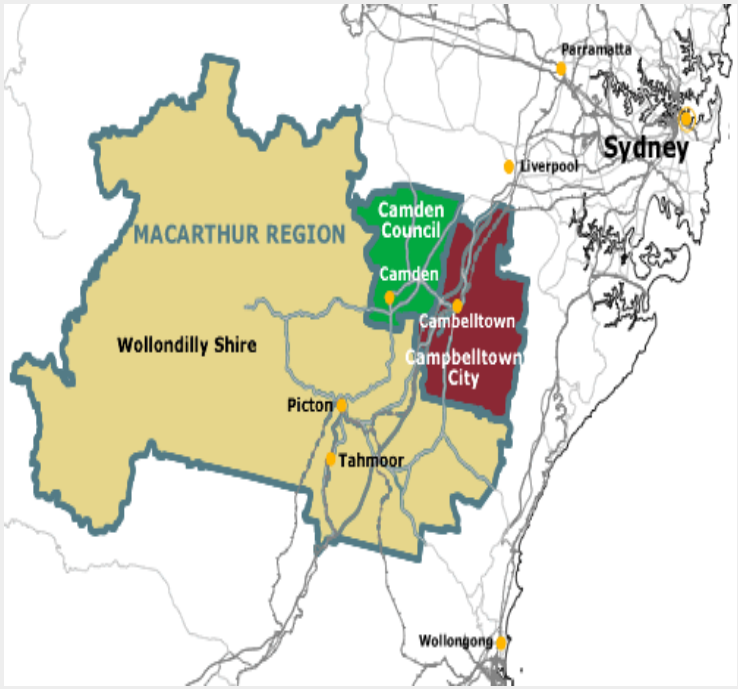


Hospitals
- H1 Bankstown-Lidcombe Hospital
- H2 Bowral and District Hospital
- H3 Camden Hospital
- H4 Campbelltown Hospital
- H5 Fairfield Hospital
- H6 Liverpool Hospital

Affiliated Health Organisations
- 7 Braeside Hospital
- 8 Karitane
- 9 Karitane @ Camden
- 10 Scarba - South Western Sydney
- 11 Service for the Treatment & Rehabilitation of Torture & Trauma Survivors (STARTTS)

Major Community Health Centres
- 12 Bankstown
- 13 Bowral
- 14 Cabramatta
- 15 Fairfield
- 16 Hoxton Park
- 17 Ingleburn
- 18 Liverpool
- 19 Miller
- 20 Narellan
- 21 Prairiewood
- 22 Rosemeadow
- 23 Tahmoor

Integrated Primary & Community Care Centres
- 24 Oran Park



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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 compare 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)

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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

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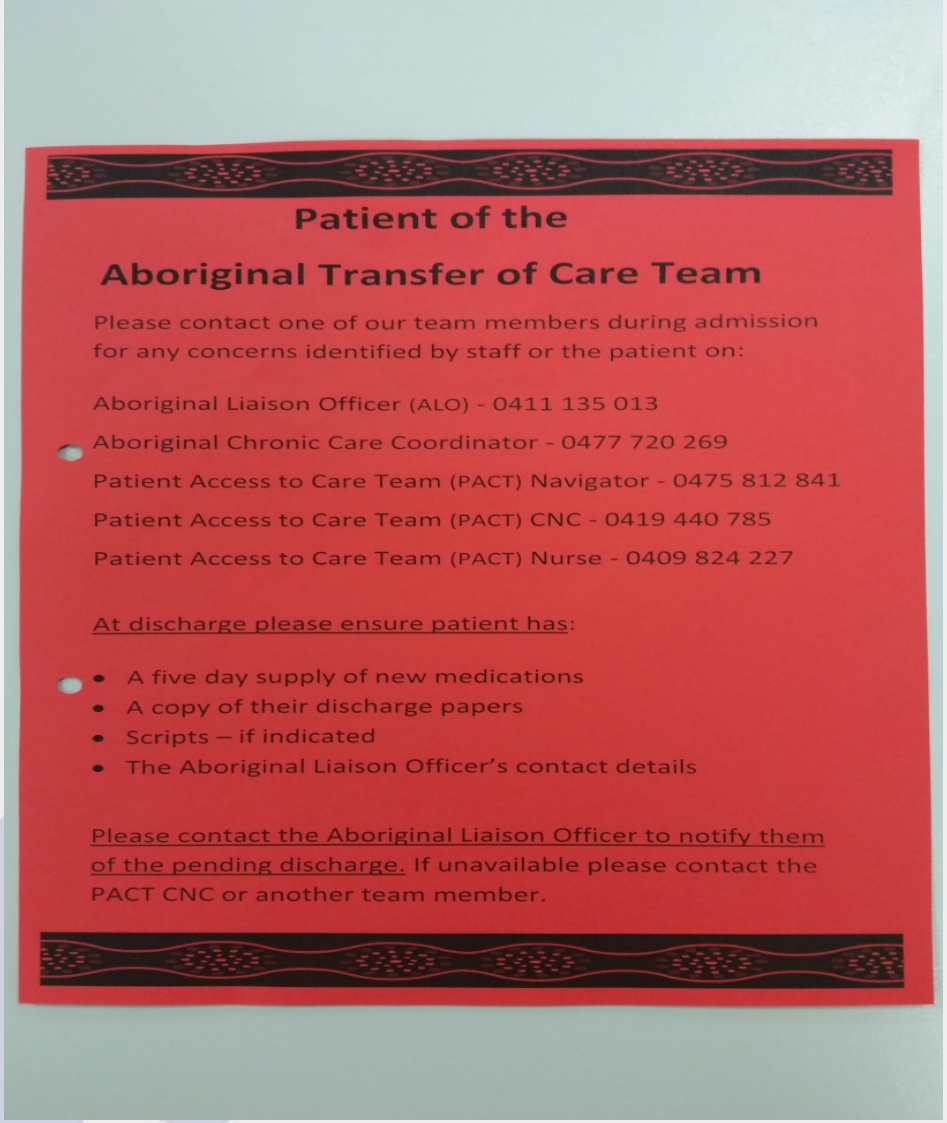

Patient of the

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.

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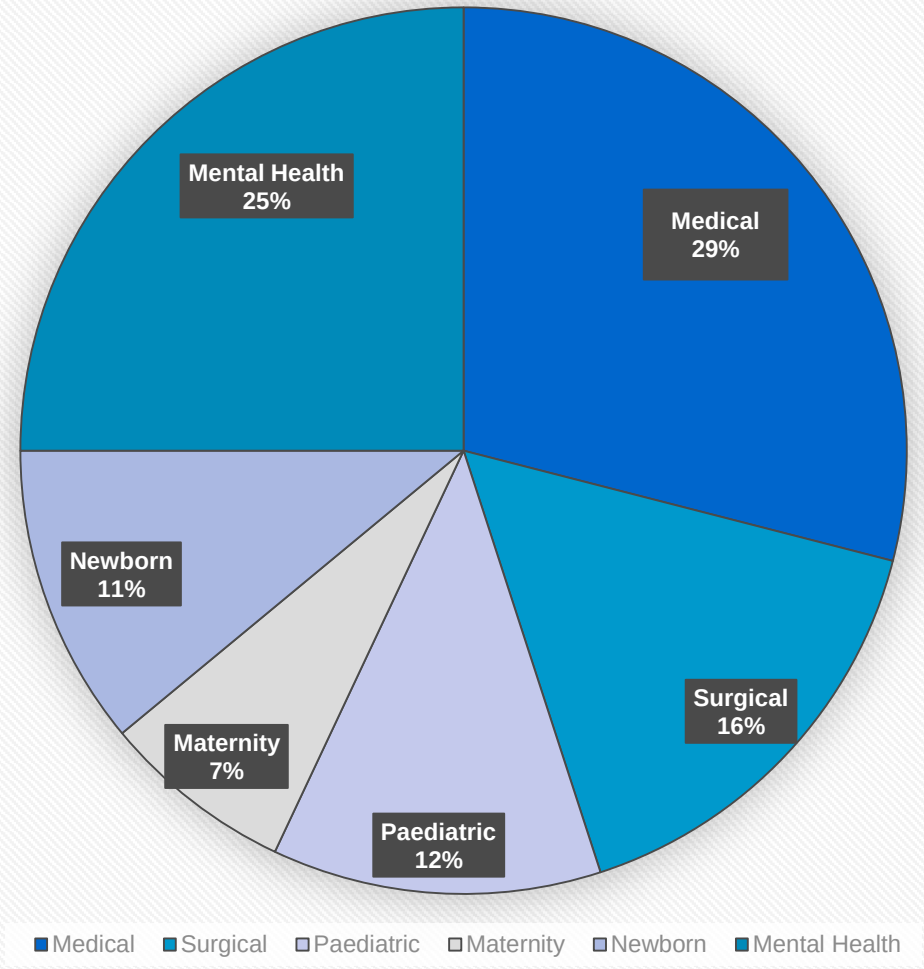
Admission type



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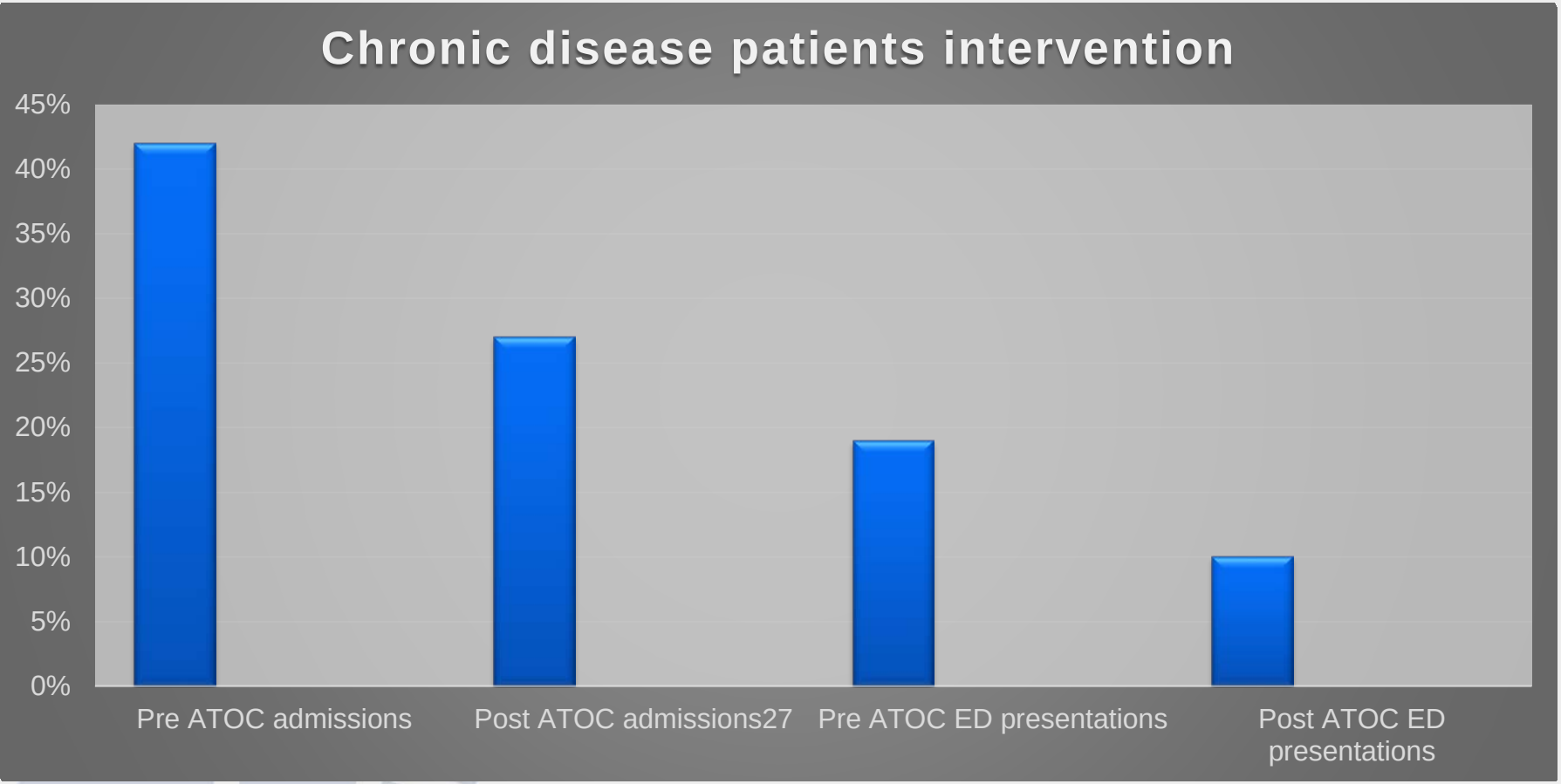
Reduced Readmissions



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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

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While on a good thing……

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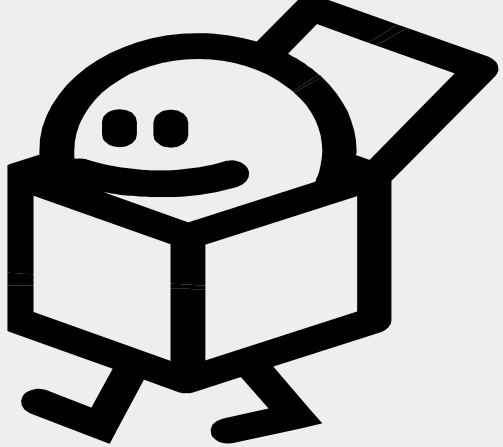
Thinking outside the box



- 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

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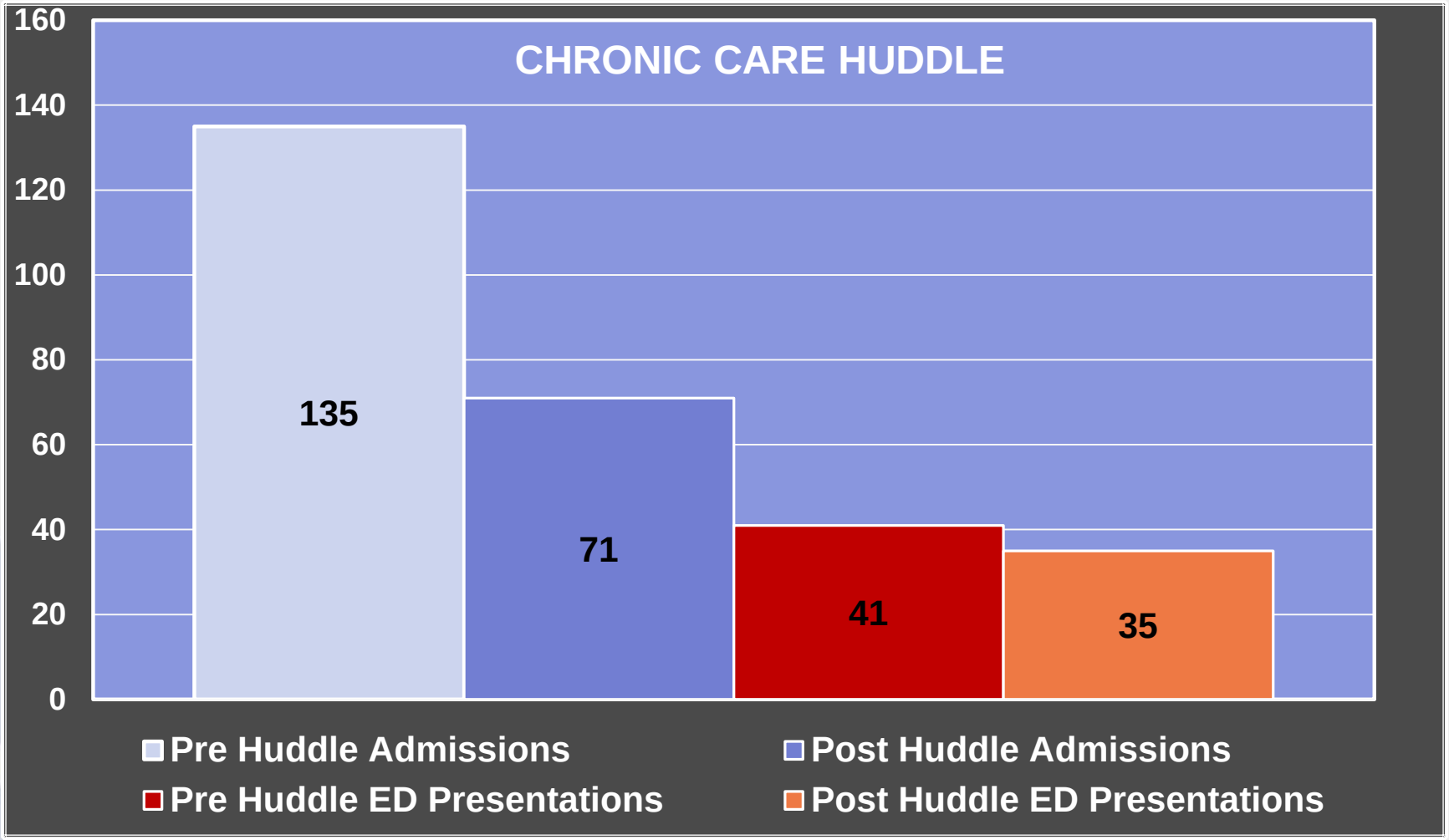

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Challenges

- 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.

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Food for Thought

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Acknowledgements

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- Vicki Bonfield
- Joyce DeGuzman

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