Integrated Aboriginal Chronic Care (IACC)

Presented by
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On behalf of the United in Aboriginal Health partners
Who are the partners in this process?
We knew we could do better individually and collectively…

So what did we do?
Where are you employed?

What program are you employed in?

What type of chronic care services do you offer?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care-Coordination</td>
<td>50.0%</td>
<td>18</td>
</tr>
<tr>
<td>Case Management</td>
<td>33.3%</td>
<td>12</td>
</tr>
<tr>
<td>Episodic - GP Clinic setting Acute</td>
<td>2.8%</td>
<td>1</td>
</tr>
<tr>
<td>Episodic - GP Clinic setting Chronic</td>
<td>19.4%</td>
<td>7</td>
</tr>
<tr>
<td>Clinical Monitoring</td>
<td>50.0%</td>
<td>18</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>41.7%</td>
<td>15</td>
</tr>
</tbody>
</table>

answered question: 36
skipped question: 0
Case-load - Do you have a maximum client number?

- Yes: 26.5%
- No: 73.5%

- Yes - Always: 11.1%
- Yes - Often: 19.4%
- Yes - Sometimes: 8.3%
- No - Always: 11.1%
- No - Often: 27.8%
- No - Sometimes: 27.8%
- Never: 2.8%
Community Survey

Do you have a chronic Condition/ Illness/ Disease?

- Yes: 60.0%
- No: 35.0%
- Not Sure: 5.0%

Has your doctor given you any information about your chronic disease?

- Not Sure: 10.5%
- No: 55.3%
- Yes: 34.2%
Would you like someone to help you manage your care?

- Yes: 40.6%
- No: 53.1%
- Not Sure: 6.3%

Would you prefer an Aboriginal specific service to manage all your referrals?

- Yes: 84.2%
- No: 13.2%
- Not Sure: 2.6%
## Guiding Principles

<table>
<thead>
<tr>
<th>Patient Flow/Access</th>
<th>Patients will be provided with increased access to chronic care services with improved understanding of what services have to offer</th>
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</thead>
<tbody>
<tr>
<td>Patient Outcomes</td>
<td>Patient outcomes will be improved due to increased referrals to appropriate services and suitable care being accessed which will support the patient in the community setting more adequately and reduce presentations to acute care settings</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Patients will have a better understanding of what services are available and how to access them. Patients will be supported throughout the transfer of care from the acute to the community setting</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Patients safety will be improved through better identification within the system, improved referral processes, initiated follow-up and co-ordination of care</td>
</tr>
<tr>
<td>Staff Experience</td>
<td>Staff will become more aware of services available and confident to access and refer patients to them.</td>
</tr>
<tr>
<td>Waste</td>
<td>Solutions should generate efficiency and reduce duplication and representation of patients to acute settings</td>
</tr>
</tbody>
</table>
INTEGRATED ABORIGINAL CHRONIC CARE (IACC) - MODEL OF CARE

REFERRAL SOURCE
- Hospital
- GP/AMS
- Self
- 48 Hour Follow Up
- Community Health
- CCAP
- CDM
- CCSSS

IACC CO-ORDINATOR
- Simple standard form
- Discharge summary
- GPMP
- Medication List
- Existing Services Consent
- Assess client needs
- Apply Clinical Lead or Case Manager
- Notify GP/AMS &

PROGRAMS
- Care Coordination & Supplementary Services (CCSS)
- Chronic Care for Aboriginal People (CCAP)
- Chronic Disease Management (CDM)
- AMS Chronic Care programs

CASE CONFERENCES
- Between service Providers
- Further comprehensive Assessment
- Services required: which service can provide the care needed?
- How is the patient progressing?
- Evaluation & Quality Improvement

MANAGEMENT PROCESS
- Lead contacts patient
- Home Visits
- Telephone follow up
- Assess client needs/wants/willingness/readiness
- Current service usage
- Case Conferencing
- Update/Communicate to referrer/GP/AMS
- Regular review of ongoing needs (3-6 monthly)
- When stable - discharge back to GP/AMS

United In Aboriginal Health
NORTHERN NSW

Continued communication with healthcare home/GP
Continued communication with healthcare home/GP
Where are we now?

- Implementation phase
- Identification and prioritisation of issues raised
- Commence measurement
- Maintain stakeholder support and embed sustainability
• The IACC coordinator commenced in February 2017, for a pilot period of 12 months
• The partner organisations have agreed on a set of KPI’s to measure success of the initiative at intervals through implementation
• There is also the intent to include PROMS and PREMS in the evaluation of the initiative
IACC - First 4 weeks

• IACC Coordinator commenced receiving referrals on the 15th May 2017
• Has received 43 referrals so far
• All patients have been assessed for need
• Have held 8 case conferences with 28 patients discussed
• Reviewing and refining processes and systems
Take home messages

• Put the client’s needs first and service providers have a common goal to work better together
• Simple solutions to complex problems are often the best way forward
• Work with the people who will be a part of making the change
• Ensure you have Executive/ Management buy in
• Keep checking that what you have designed is still needed and is fit for purpose
1800 93 11 44
Integrated Aboriginal Chronic Care Northern NSW