ABORIGINAL CHRONIC CARE RN

ORANGE COMMUNITY HEALTH

Background/Aim

The Aboriginal Chronic Care Registered Nurse ACCRN position is an Aboriginal identified position created in 2016. It operates within the Chronic and Complex Care team at Orange Community Health Service. This role has a specific focus on cardiopulmonary rehabilitation and Diabetes Education. However with the passage of time the scope of this position continues to evolve.

It has highlighted a need to have Aboriginal nurses skilled in chronic disease management working with the Aboriginal and Torres Strait Islander (ATSI) community. It has also highlighted the benefit of having a role to support ATSI patients and families with chronic diseases.

The position has provided support to the Aboriginal Liaison Officer and Aboriginal Health Education officer in managing patients and families who are affected by chronic disease. The position is driving the ATSI 48 hour follow-up program and building our ATSI specific Aunty Judy Healthy Lifestyle program. The aim is to improve avoidable admissions and re-admissions by implementing upstream interventions and delivering preventative care in the community. This position is supporting the Chronic and Complex Care team in building partnerships with local organisations including the Orange Aboriginal Medical service.

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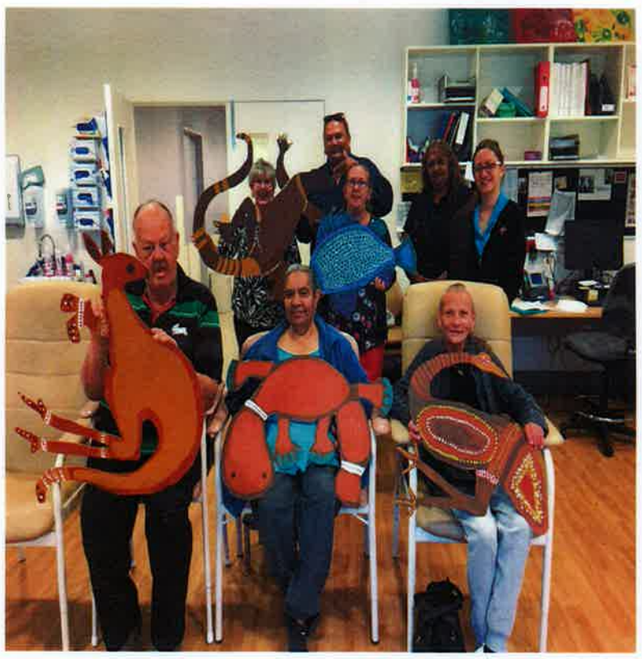
Planning/Implementation

Historically the uptake of ATSI people into cardiopulmonary rehabilitation programs in Orange has been poor. Across the WNSWLHD the prevalence of chronic disease is higher in this population relative to non-ATSI population. In order to address this, the Manager for Primary and Community Health developed a brief to change a vacant identified Aboriginal Health Worker position to our ACCRN position.

Outcomes & Sustainability

Following on from the ACCRN commencing in May 2016, there has been consistency in running the Aunty Judy Healthy Lifestyle Program. Enrolments in this program have increased from 8 to 33. Attendance and retention of clients has increased from <3 a week to 20 a week. This program is now offered 2 days a week to improve access for elders who have other community and family commitments. The Aboriginal Health Workers and Connecting Care Coordinator have welcomed the position in sharing case management of complex ATSI cases. It is anticipated that review of patient satisfaction data will show an improvement relative to before the position commenced.



Key Take Home Message

Improved strategic direction in building our Aboriginal health workforce is enabling services to better target the chronic disease management of our ATSI people. The ACCRN is a key resource in helping the Aboriginal Health workers while also allowing other non-Aboriginal staff to be more sensitive to the needs of ATSI community. This enables better community engagement and outcomes.

Conclusions

To date the improvements in community engagement following creation of the ACCRN position is largely anecdotal. However improvements in access to specific programs for the ATSI community are measureable. There is sustained participation by a growing group of ATSI people with chronic disease in healthy lifestyle programs which indicates we are moving in the right direction. Having a skilled RN and supporting this position in developing expertise in engaging their community in chronic disease self-management is helping to bridge the gap in mainstream service provision. It is also highlighting the contribution the ATSI people can make in the work force. This needs to be promoted on many levels and across many services.