

Rural Health and Research Congress #RHRC2019

INTEGRATED ABORIGINAL CHRONIC CARE (IACC)

‘Together We Did’

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YARNS OVER COFFEE

between NCPHN and NNSWLHD
found a lack of:

- Accountability
- Transparency
- Communication
- Consistency
- Seamless patient centred care
- Collaboration of service programs
- Cultural Leadership
- Regular service/ program updates
- Regular Community Cultural Business Forum

"Aunty Ethel's got no money for her heart specialist appointment but not registered with the ITC program!"

"Patients are restricted to the service scope of their provider."

"Uncle Jimmy's not with an AMS and he didn't get transport or vouchers!"

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IACC Partnership:

- Northern NSW Local Health District
- North Coast Primary Health Network
- Local Aboriginal Medical Services
- Rekindling the Spirit
- University Centre for Rural Health



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IACC Team:

NNSWLHD:

- IACC Coordinator
- Aboriginal Health Workers
- Chronic Care for Aboriginal People
- AHLO- Aboriginal Hospital Liaison Officer
- Healthy Lifestyles
- Chronic Disease Management Service
- Aboriginal Mental Health Coordinator
- Integrated care
- Community Transport

NCPHN (+IHPO):

- Aboriginal Health Unit

Rekindling The Spirit:

- Integrated Care

Aboriginal Medical Services:

- Bulgarr Ngaru - Casino
- Bulgarr Ngaru - Maclean
- Bulgarr Ngaru - Grafton
- Bugalwena - Tweed Heads
- Bullinah - Ballina
- Jullums - Lismore

UCRH:

- Academic Lead - Aboriginal Health

Total - 79 staff



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IACC Team Matrix

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Scenario- Patient A

- Attends Mainstream GP
- Recent discharge from hospital (new diabetes diagnosis)
- Needs glucometer etc and diabetes education
- Aboriginal Health Worker to attend specialist appointments
- Clinical case management
- Program coordination
- Transport and fuel vouchers for after hours return
- Clinical home visits
- Want to lose weight in improve diabetes

Transparency, accountability, patient centred care, collaboration of service programs, Community cultural business, fortnightly program and organisational updates, and a collective intelligence.



	CCAP	CDM	AHW	ITC AMS	ITC General	IHPO	Patient Requesting / Needs
Equipment				✓	✓	✓	✓
Clinical Review	✓	✓	✓				✓
Clinic / Health Support & Advocacy			✓		✓		✓
Case Management	✓						✓
Care Co-ordination (ITC- Aboriginal & Torres Strait Islander Health)					✓		✓
Transport (including funding & fuel vouchers)	✓		✓		✓		✓
Home Visits (as required)	✓		✓		✓		✓
Healthy Lifestyle (Hospital Base/ Home Base/ Community Group/ E.P. 1.1)			✓				✓

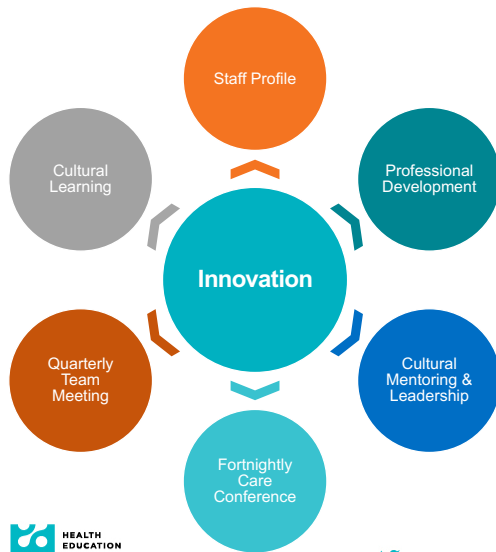
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Innovation & Originality

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IACC Outcomes

- Since 2017 IACC has received 700+ referrals
- 253 referrals where complex cases (example – PFP, multiple faceted and priority response)
- 260 referrals where “quick-wins” (examples GPMP appointments, transport, advocacy and support)
- 156 Care conferences inclusive of all IACC team networks broken into 5 captions, and 7 face to face IACC training and team meetings

Referral Complete	Complex referral	Quick Wins	Care Conferences	IACC Team Meeting	Received Referral
513	253	260	156	7	24 Total 537



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IACC Sustainability & Transferability

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- Patient Experience Symposium, Sydney Convention Centre- ‘Aboriginal Care experience’
★★★★★
- Rural Health Congress Tamworth ‘Working Together’
- NSW Quality Awards and ACI highly commended Innovation award (2019)
- Rural Health Congress (October 2019) Lismore ‘Connecting Communities’



Transferability

- IACC team expanded from 20 to 79 staff
- Collaborating with other services including:
 - NDIS
 - Aboriginal Community Transport/Hart
 - Aboriginal Mental Health
 - QLD Aboriginal Medical Services.

Sustainability

- IACC is now a permanent program with NNSWLHD Integrated Care funding
- A Clinical Nurse Consultant has recently been recruited to ensure that a clinical lens can be added to the case management
- IACC is predominately Aboriginal & Torres Strait Islander grass roots/frontline staff

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**“Working everyday in the
GAPS we need to close
in Aboriginal Health”**





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