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NNSW INTEGRATED CARE MADE POSSIBLE BY STRONG LOCAL PARTNERSHIPS:

NSW GOVERNMENT Health Northern NSW Local Health District

phn NORTH COAST

NSW Ambulance

United in Aboriginal Health NORTHERN NSW

Integrated Aboriginal Chronic Care (IACC)

Presented by Emma Walke
Academic Lead – Aboriginal Health, UCRH, North Coast
University of Sydney
Ack. Rebecca Davey
Clinical Nurse Consultant Chronic Care, Aboriginal Health, NNSWLHD

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Northern NSW
Local Health District

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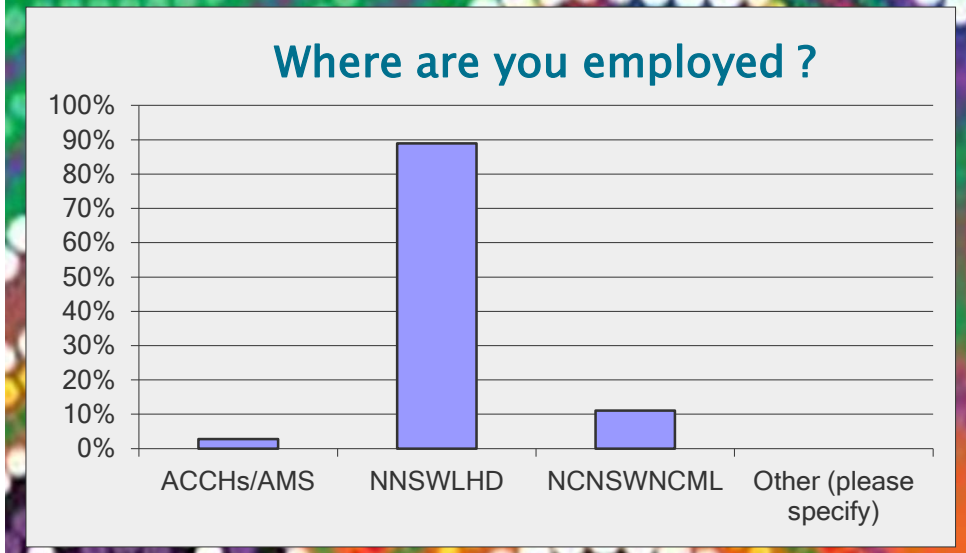
Who are the partners in this process?

NSW GOVERNMENT Health
Northern NSW
Local Health District

United in Aboriginal Health
NORTHERN NSW

We knew we could do better individually and collectively

So what did we do?



What type of chronic care services do you offer?

Answer Options	Response Percent	Response Count
Care-Coordination	50.0%	18
Case Management	33.3%	12
Episodic - GP Clinic setting Acute	2.8%	1
Episodic - GP Clinic setting Chronic	19.4%	7
Clinical Monitoring	50.0%	18
Other (please specify)	41.7%	15
answered question		36
skipped question		0

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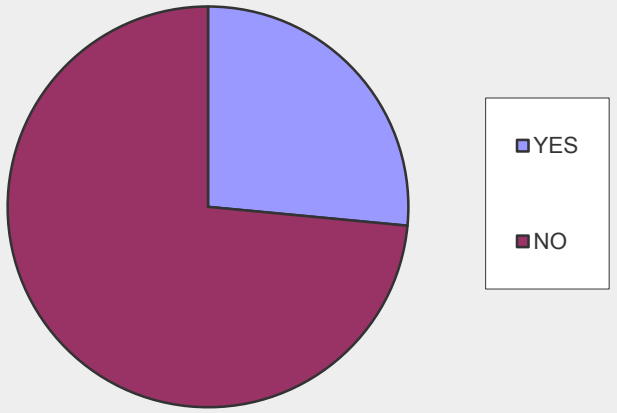
Case-load

Do you have a maximum client number ?



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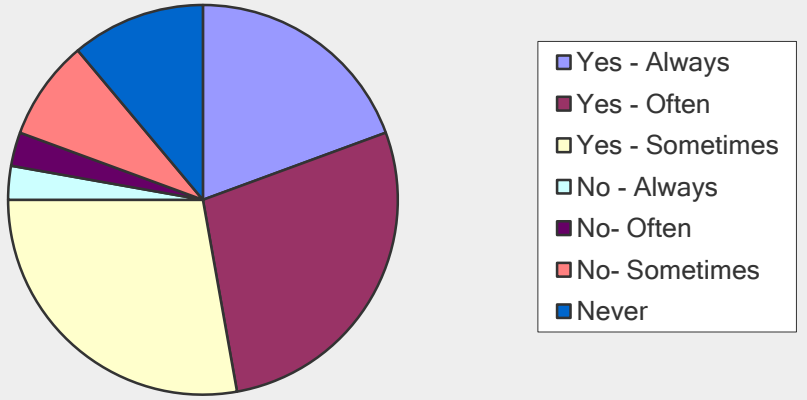
Is there are demand for your services that you are unable to meet? (e.g. too many clients?)



Project Team

Jacque Dalley	Chronic Disease Program – NNSWLHD
Anthony Franks	Aboriginal Chronic Care Officer – NNSWLHD
Leisa Lavelle	Chronic Care & Supplementary Services – NCPHN
Jamie Wimbus	Chronic Care & Supplementary Services – NCPHN
Donna Evans	Chronic Care for Aboriginal People – NNSWLHD
Vicki Eastaway	Chronic Care for Aboriginal People – NNSWLHD
Mandy Carney	Chronic Care for Aboriginal People – NNSWLHD
Kylie Wyndham	CNC Chronic Care – Bulgarr Ngaru Richmond Valley
Marilyn Bailey	Practice Manager – Bullinah AMS
Darren Kershaw	Executive Officer, Bulgarr Ngaru Clarence
Dena Moore	Aboriginal Chronic Care Worker, Ballina NNSWLHD
Robert Monaghan	IACC Project Officer NCPHN/ NNSWLHD
Emma Walke	Academic Lead – Aboriginal Health University Centre For Rural Health
Rebecca Davey	CNC Chronic Care, Aboriginal Health NNSWLHD

Guiding Principles

Patient Flow/ Access :	• Patients will be provided with increased access to chronic care services with improved understanding of what services have to offer
Patient Outcomes :	• 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
Patient Experience :	• 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
Patient Safety :	• Patients safety will be improved through better identification within the system, improved referral processes, initiated follow-up and co-ordination of care
Staff Experience :	• Staff will become more aware of services available and confident to access and refer patients to them.
Waste :	• Solutions should generate efficiency and reduce duplication and re-presentation of patients to acute settings

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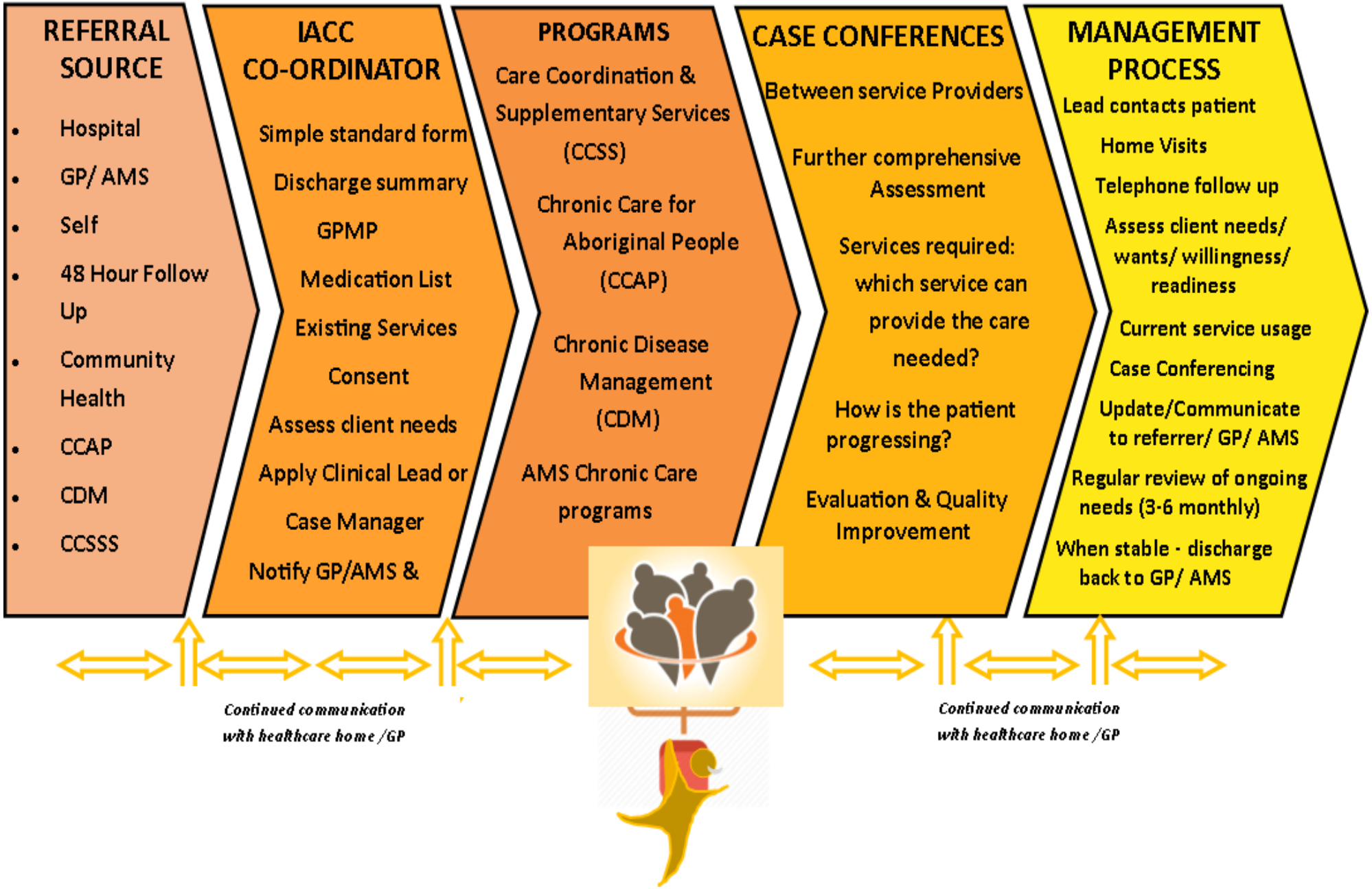
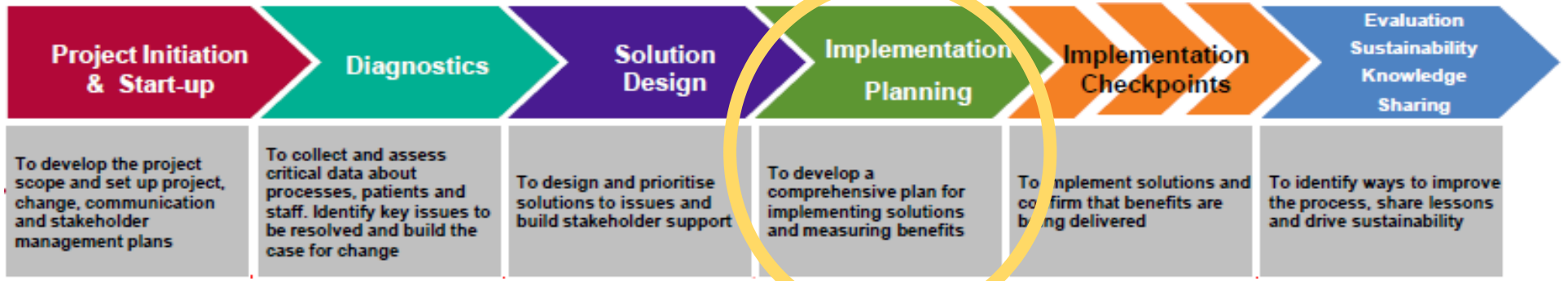
INTEGRATED ABORIGINAL CHRONIC CARE (IACC) - MODEL OF CARE - JULY 2016



Where are we now?



- Implementation Planning
- IACC coordinator has been recruited to
- Identification and prioritisation of issues raised
- Build Stakeholder support

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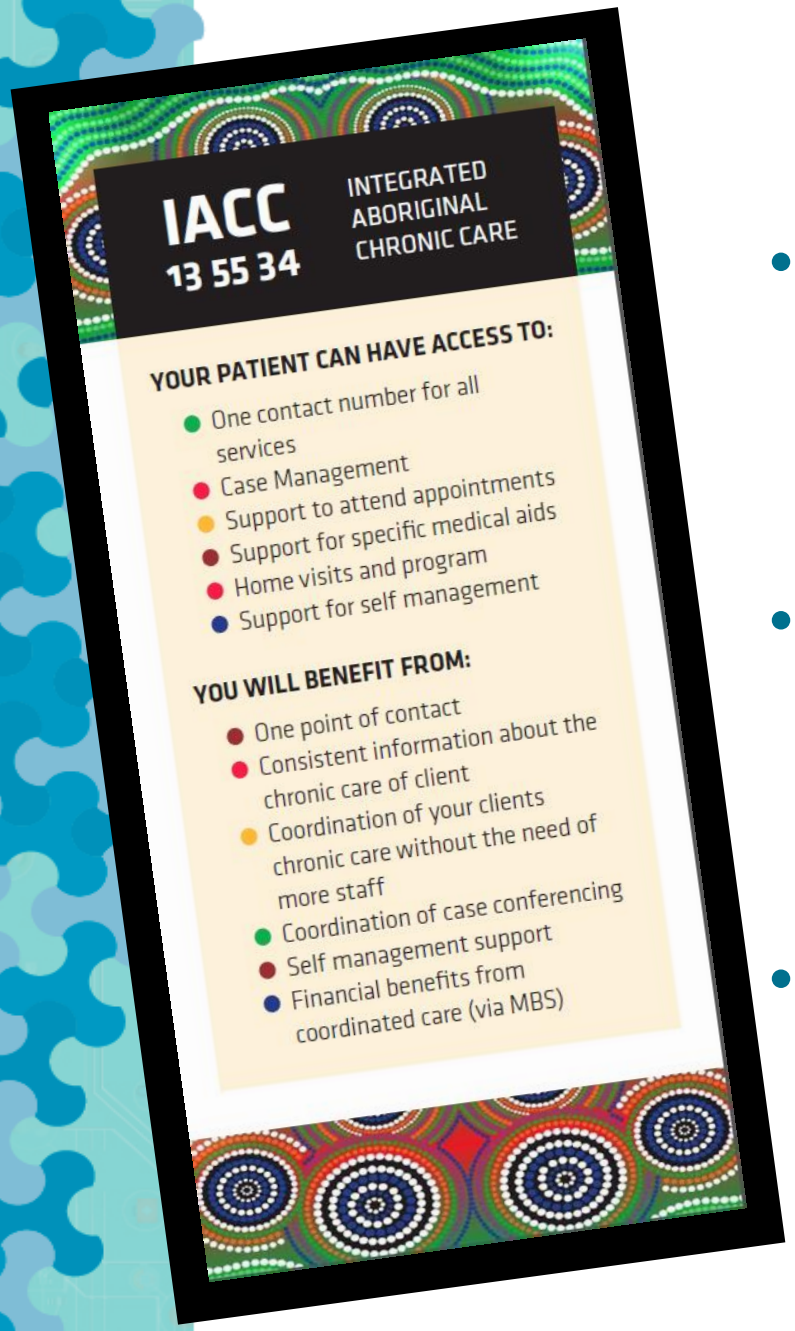

- The IACC Coordinator commenced in February 2017, for a trial period of 12 months initially.
- The partner organisations have agreed on a set of KPIs to measure success of the initiative at the 12-month mark.
- There is also the intent to include PROMS and PREMS in the evaluation of the initiative.

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Take Home Messages

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- 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 need will be a part of making the change
- Ensure you have Executive/management buy in
- Keep checking that what you have designed is needed and is fit for purpose

Thank You

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