



# Closing the Gap through Care Coordination

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# what you will hear...

- Background and policy context
- Who are the Aboriginal Health team in primary care?
- Care Coordination models adopted in NSW
- Early challenges, successes
- Cross program approach
- Where to from here...



# Aboriginal and Torres Strait Islanders - the facts...



- Experience burden of disease 2.5 times that of non-indigenous Australians
- Chronic diseases and their risk factors are responsible for two-thirds of the life expectancy gap
- Under use primary health care service
- 60% choose mainstream GPs for services
- More likely to access hospital services for conditions treatable in primary care



# Government Indigenous Policy

On 29 November 2008 the Council of Australian Governments (COAG) agreed to an historic \$1.6 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes to address the first of the COAG Closing the Gap targets – **to close the life expectancy gap within a generation**



# Closing the Gap - five priority areas



- Tackling smoking
- Primary health care services that can deliver
- Fixing the gaps and improving the patient journey
- Providing a healthy transition to adulthood; and
- Making Indigenous health everyone's business.

Funding approximately \$1.6 billion over 4 years:

- Commonwealth: \$805.5 million
- States and Territories: \$771 million



# Closing the Gap: Improving Indigenous Access to Mainstream Primary Care Program



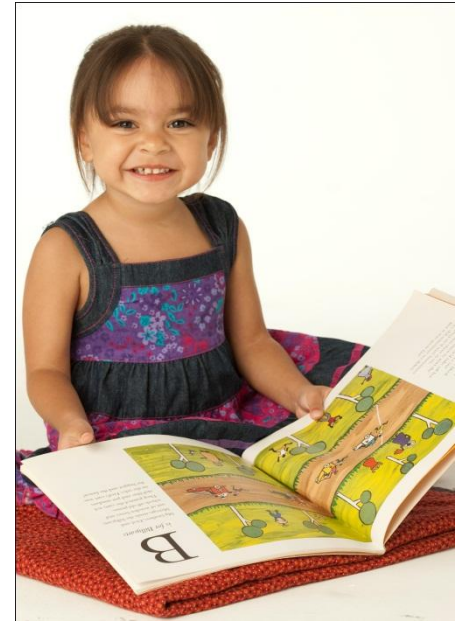
- Aims to close the gap in life expectancy and health outcomes by improving access to cultural sensitive primary care services
- Divisions are being contracted by DoHA for Indigenous Health Project Officers and Indigenous Outreach Workers
- GP NSW contracted to fund Care Coordination



# Indigenous Health Project Officers (IHPO)



- Lead role in Division for Aboriginal Health
- 80 FTE Project Officers nationally
- 29 NSW Divisions are funded to June 2012 (0.6 to 1 FTE)



# Indigenous Health Project Officers (IHPO)

- Non – clinical role
- Support changes in general practice
  - Increase access
  - Cultural awareness
  - Identification
  - Foster relationships between mainstream General Practice and AMS



# Aboriginal and Torres Strait Islander Outreach Workers

- 23 Divisions have at least 1 Outreach Worker
- 8 AMSs in NSW have received Outreach Worker funding with additional investments coming in 2011-12



# Aboriginal and Torres Strait Islander Outreach Workers



- Active patient support
- Guide people on their journey through the health care system
- Strong links to the community
- May not be formally qualified
- Feedback on barriers to access



# PIP Indigenous Health Incentive Payment to General Practice



Payment available to encourage general practices to provide better health care for Indigenous patients, including best practice management of chronic disease.

Divisions and IHPO promote the uptake gateway to Care Coordination program



# Care Coordination and Supplementary Services Program



## Care Coordination:

- Patients must be referred by their GP or Indigenous Health Service
- Practice must be PIP IHI registered
- Targets patients with chronic disease
- Improve access to specialists, allied health and other services
- Activities will be in accordance with the GP Management Plan (care plan)



# Supplementary Services

- Flexible pool of funds locally managed by Division
- To overcome barriers to access – transport, cost of specialist and allied health services
- Funds limited – priority is to address risk factors such as waiting periods for a service longer than clinically appropriate



# Care Coordinators

- NSW 12 Divisions (1 FTE)
- 11 more to be funded 2011/12
- Clinically qualified, some identified
- Work closely with the Division's Aboriginal health team and the Aboriginal Medical Services
- Services are designed with local partners (AMS, Local Health District)



## Clinical Care Coordination

- Engagement, self management, diabetes education, etc

## Brokerage/ Team approach

- Aboriginal health worker and Outreach Worker do hands on work with patients
- Care Coordinator deals with complex issues and provides clinical supervision

## Service Navigation

- Information, appointments arranged



# April to June 2011 ...

- Data for 7 of 12 sites
- 44 patients referred – 12 by GPs
- 49 episodes of care delivered
- Even number men and women
- Biggest group overall men over 70yrs
- 35 services arranged with Allied Health Professionals
- 2 services arranged with Specialists



# An example ...

- 59 Year old woman
- Referral through Aboriginal Health Worker
- Reduced function in one arm since birth
- Employed for 30 years in the disability laundry
- Owns her own home
- Lives with her sister who is moving for work
- Property is in bad state of repair – no funds for repairs



# The practical solutions ...

- Home assessment with the Aboriginal Health Worker
- GP Completed care plan
- Referral to an Occupational Therapist for home modifications
- Brokered services from a builder - Employment Plus (assisted trade scheme) – cost of materials only
- Follow up visit will be made



# If help was not provided ...

- Potential for falls
- Loss of independence
- Forced to sell her home
- Loss of pride and achievement
- Increase risk of exacerbation of other chronic conditions
- Potential for more hospital treatments



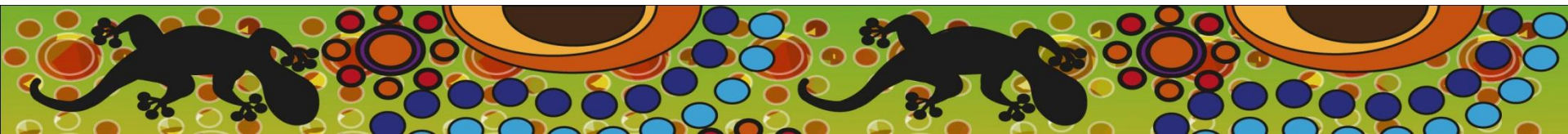
# The tension of opposites....

- Qualifications vs skills base
- Community members vs service deliverers... 24 hour on call to the community
- Patient need vs eligibility ... patients referred through other sources than the GP
- MBS claiming rules vs flexible funding arrangements
- Clear team communication vs regulations for record keeping in different agencies



# GP NSW supporting role...

- Develop network of care coordinators
- Promote cross program approach
  - Linkages with Mental Health, Drug and Alcohol and other programs
- Cross agency approach
  - Linkages with programs outside Divisions network



# GP NSW supporting role...



- Education and training
- Clinical supervision and mentoring
- Development of tools and guidelines
- Sharing resources developed by Divisions through GP NSW website
- National linkages – lessons and tools to be shared



# Cross program approach...

- Get to know your Aboriginal health teams: IHPOs, OWs and CCs
- Mental health service providers supporting Care Coordinators via ATAPS / FCPs?
- Creating clinical support teams
- Develop “seemless” referral pathways/ triage between Mental Health (FCP) and Chronic Disease Care Coordinators



# Key messages....

- Lessons for emerging FCP roles in mental health – both programs working with hard to reach groups with similar problems
- Focus on building your FCP and CCSS Care Coordination Teams
- DoHA looking to those Divisions/ MLs that are integrating these programs



# Where to from here.....

- Gather de-identified patient data via our on-line reporting tool - MMEx
- Gather stories and experiences via on-line diary *A day in the life of ...*
- Participate in CTG evaluation
- Support next 11 sites in implementation
- Share lessons and tools from other care coordination programs



Thank you...



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