

Evaluation of Aboriginal Health Case Management and Care Coordination Models in Victoria

Summary of findings



Evaluator: Effective Change

Aim: To examine approaches to care coordination and case management in Aboriginal health that show promise and potential for replication in other communities.

Approach: A case study approach involved four visits to seven study sites, consultations with 166 stakeholders including 40 clients and multiple contacts with program staff over a period of twelve months.



Common and distinct features of the case management projects

The projects differed in their contexts and approaches yet successful models shared a number of fundamental elements:

- Support should be provided at points in the service system where Aboriginal clients are vulnerable to becoming lost to follow-up.
- A high proportion of clients with complex needs require services across a range of health and community services.
- Identification of a consistent healthcare professional to facilitate, coordinate or manage care for Aboriginal clients.
- A personal, supportive care relationship between client and staff member, rather than a relationship between the client and the organisation/institution.
- Aboriginal and/or culturally competent healthcare staff.

Conclusions

Culturally-informed, relationship-based models of care are delivering significant benefits for individuals, families and organisations. The approach also contributes to more culturally-informed functioning of the broader local service system.

The findings are consistent with emerging themes in the literature and add to the growing knowledge about how and why this approach is highly suitable to Aboriginal health, wellbeing and safety.

Improved lifestyle behaviours

↓ stress and ↑ motivation

↑ engagement with healthcare

↑ health literacy

↑ health and wellbeing

Client Outcomes

Client and practitioner relationships

Personal relationships between the client and practitioner can overcome institutional barriers to accessing healthcare. Clients value:

- Cultural knowledge that promotes cultural safety
- Trust in privacy and confidentiality
- Respect and professionalism
- Reliability and follow-up actions
- Clear, jargon free health information
- Assistance in navigating service systems
- Consulting multiple professionals

On top of their client care roles, care coordinators also:

- Provide secondary consultations to colleagues and external agencies
- Contribute to strengthened relationships with local service networks and Aboriginal Community Controlled Health Organisations (ACCHOs).

Case management and care coordination is well matched with **Aboriginal concepts of holistic health.**

The approaches recognise the impacts of historical, **social and cultural determinants** of wellbeing and privileges Aboriginal health care needs.

Knowledge of, and competence in working with the effects of **TRAUMA** are **ESSENTIAL** when managing client care.

Workplace systems

Supporting case managers and care coordinators are critical for:

- Skills and training

- Cultural and professional mentoring
- Connections to professional standards
- Capacity to work flexibly with clients
- Building relationships with services beyond the health sector.

Working within professional frameworks and standards of case management practice is an enabling and supportive factor for care coordinators in Aboriginal health and supports the professionalism of the work.

Organisational findings

- Trust built with the client through the care coordinator can transfer to trust in the health service
- Organisations require secure funding and sufficient time to embed care coordination services, and in particular to retain key staff
- Projects constructed around one or two key staff members are inherently fragile
- The need for after-hours support for Aboriginal clients in emergency departments was reported across all hospital project sites.

Service system findings

A wide network of relationships and partnerships are required across the local ACCHO, acute, primary care and community sectors. Relationships are also required outside the health sector with, for example, housing, justice, legal services, child protection, family services, Centrelink and the National Disability Insurance Scheme.



The evaluation report is available on the [health.vic](http://health.vic.gov.au) website. In your search engine, type 'Koolin Balit evaluations'

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Purpose of the evaluation

Through examining seven Aboriginal health case management and care coordination models, the purpose of the evaluation was to investigate:

Approaches to care coordination and case management that have been successful or show promise

The evaluation found that care coordination approaches assisted in:

- Preventing Aboriginal clients from leaving emergency departments without being seen or against medical advice
- Connecting clients to follow-up outpatient and community services
- Ensuring that Aboriginal clients with chronic conditions complied with their health assessments
- Ensuring that Aboriginal clients with complex needs, at the intersection between acute and community services, were not lost to the system
- Ensuring that Aboriginal clients with complex issues were assisted in the management of their medical and psychosocial needs by practitioners with a clinical understanding of the interrelationship of these issues
- Ensuring that Aboriginal families stay connected to services during a child's early years and are well positioned to derive the protective benefits of this support across the child's life course.

How successful approaches could be replicated in other communities

Opportunities for replication

The approaches to case management and care coordination highlight the importance of developing responses that are specific to local context – local community needs, available resources and connections of host organisations to the local service system. In this sense, various activities and approaches may be replicated, but as a model, it is not readily transferable to all communities.

“ Rather than the sole emphasis being on clinical endpoints, a focus on understanding patients' frame of reference is also critical. Building relationships, which enhance and sustain the two-way interface of patient-provider engagement appears to be at the heart of the potential for change and making improvements in health outcomes for Aboriginal peoples with chronic diseases.

(The Evaluators)

“ I came of my own accord for my grand daughter. She wasn't talking or toilet trained at age 4. I didn't know how to get her into pre-school and she wasn't up to date with her needles. Centrelink wasn't paying me. I just can't go there on my own. We were lost, had no home and we weren't getting out. I was isolated. They arranged childcare, as I had no support, and enrolled her into Kinder. I have joined playgroups and am doing a course at MDAS. It teaches me how to look after my grand daughter and how to deal with my drug and alcohol problems. They treat me like family. It is like a home.

Early Years Services client

(The care coordinator) comes with me to appointments. She organised respite for me after the mastectomy. There's no (family) there for me. She's come with me for bi-ops, x-rays. If I need food vouchers, she'll get one. If I need anything, I can ask her. I've had issues with the chemotherapy people. I get angry. With (her) around I feel much calmer, more relaxed. Without her I wouldn't be where I am today. She's pushed me. I'd be still at home thinking about whether to have the operation. She's pushed me, made me do things - go to appointments.

Client, currently undergoing treatment

