

## EVALUATION REPORT

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

Prepared by Effective Change Pty Ltd

for the Department of Health and Human Services September 2016

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**Disclaimer**

The opinions, comments and/or analysis expressed in this document are those of the authors and do not necessarily represent the views of the Department of Health and Human Services.

Report commissioned by the Department of Health and Human Services



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#### Contents

[Executive summary 5](#_TOC_250011)

[Introduction 11](#_TOC_250010)

[Overview of the projects 14](#_TOC_250009)

[Methodology 15](#_TOC_250008)

[Continuum of care coordination approaches 19](#_TOC_250007)

[Promising approaches 24](#_TOC_250006)

[Key findings 32](#_TOC_250005)

[Replication 43](#_TOC_250004)

[Contributions to the evidence base 49](#_TOC_250003)

[Conclusions and opportunities for the future 51](#_TOC_250002)

[References 54](#_TOC_250001)

[Attachments - The projects in detail 56](#_TOC_250000)

# Executive summary

This evaluation was commissioned by the Department of Health and Human Services (DHHS) to examine approaches to care coordination and case management in Aboriginal health that show promise and potential for replication in other communities through investigating seven projects funded under the Victorian government’s Koolin Balit investment.

The projects The seven projects involved in the evaluation broadly fit under an umbrella of examples of care coordination and/or case management:

**DHHS Division Project Lead agency/location**

**North** Aboriginal Client Journey project Transition Officers in Shepparton, Seymour, Wangaratta

and Wodonga

**West** Chronic Disease Prevention and Management Program

Ballarat and District Aboriginal Cooperative (BADAC), Ballarat

**South** Integrated Koori Services Monash Health, Dandenong

**North** Aboriginal Health Care Coordinator in the Health Independence Program

St Vincent’s Hospital Melbourne & North Richmond Community Health Centre, Fitzroy

**West** Close the Gap Gunditjmara Aboriginal Cooperative, Warrnambool

**West** Fresh Tracks Project Wathaurong Aboriginal Cooperative, Geelong

**North** Early Years Services Mallee District Aboriginal Services (MDAS), Mildura

A two-page summary of each project is included at Attachment 1.

Methodology The evaluation employed a case study approach, which involved approximately four visits to each of the seven sites, consultations with 166 stakeholders including 40 clients and multiple contacts with program staff over a period of twelve months, allowing strong relationships to develop and a deep understanding of the work of the projects. Ethical approval for the project was received from the DHHS Human Research Ethics Committee.

Common and distinct features of the case management projects

The initial task for the evaluation was to understand the focus of the projects, and the distinctions between the work. It was evident from the early stages that some projects were not technically care coordination or case management projects, based on conventional definitions. The seven projects were not linked under a common program or set of case management guidelines and were focused on different target groups. They varied on multiple characteristics including organisation type (ACCHOs and hospitals), location, local service system, staffing, length of operation and resource levels.

Whilst the projects differed in their contexts and approaches, they shared a number of fundamental elements:

* a program or service developed to provide support at points in the service system where Aboriginal clients are vulnerable to becoming lost to follow-up
* a high proportion of clients with complex medical and/or psychosocial needs, requiring 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.

Continuum of care coordination/case management approaches

The projects were found to be located along a continuum of care coordination, ranging from brief and intermittent interactions, to relationships with clients, which were deep, multi-faceted and extended over several years.

**Transition to care coordination**

* Aboriginal Health Transition Officer, located in hospital
* Brief, one-off face to face or phone intervention with a client after presenting at Emergency Department (ED)
* High client numbers

**Internal service coordination** ­ Chronic disease nurse located in ACCHO

* + Clinical role in health team
  + Develops and monitors Individual Care Plans
  + Regular consultations with clients with focus on chronic disease prevention and management
  + High client numbers

**Care coordination between acute and the community**

**Care coordination and case**

**management in the**

**community**

**Layered service including case work and care**

**coordination**

* Care coordinator employed by hospital, located off-site with community programs
* Focus on Aboriginal patients following admission or ED presentation
* Outreach, care coordination support in the community
* Focus on reducing avoidable ED presentations and connecting client to services
* Work closely with ACCHOs and community agencies
* Low client numbers
* Care team, Care Coordinator employed by ACCHO
* Focus on supporting people with chronic physical or psychosocial needs and/or need help to navigate the service system
* Assertive outreach approach, underpinned by concepts of Aboriginal health and wellbeing
* Client driven – support can be short, medium or long term, brief or intensive
* Case loads of approximately 20 clients
* Team approach in an ACCHO (21 staff)
* Staff include Service Manager, Lead Practitioner, Family Support Case Workers
* The family is the client, and services can commence from maternity through to child entering school
* Services include clinical services, maternity, maternal and child health
* Family support services include a range of capacity-building groups and intensive case management through a consistent Family Support Case Worker
* The work of the Family Services team is strongly informed by theories - Attachment

Theory, trauma-informed care and Newborn Behavioural Observation which are reinforced and strengthened through staff training and reflective practice sessions

#### Key findings

Case management is effective and culturally appropriate

The evaluation has demonstrated that case management (in a generic sense) offers an holistic approach to health care more closely aligned to Aboriginal and Torres Strait Islander peoples’ understanding of health than conventional, biomedical approaches. It is a model of care that can simultaneously deliver evidence-based, best practice care and privilege Aboriginal and Torres Strait Islander peoples’ understanding of health and health care needs.

The significance of the care coordinator role

The care practitioner has a critical role in engaging Aboriginal clients.

In all cases, the evaluation found that the relationship between client and practitioner was approached from a position of respect and encouragement, and fundamentally based on and informed by an Aboriginal perspective of health, acknowledging the importance and role of culture, community, family, country, and spirit. Research undertaken by the Kanyini Vascular Collaboration (KVC) into factors influencing whether Aboriginal and Torres Strait Islander peoples living with chronic disease remain engaged with health services found that:

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 and Torres Strait Islander peoples with chronic diseases.1

The care coordination and case management models provide a health service structure that is fundamentally based on a client-practitioner relationship. The evaluation adds to the knowledge to ‘assist practitioners to better understand…‘how’ and ‘why’ people choose to remain with or disengage from care.’2 The evaluation supports the findings that non-Indigenous clinicians can form strong relationships with clients, but that these relationships require excellent communication skills, and time to develop trust.

Practitioners must have community acceptance, highly developed cultural knowledge and competence, inter-personal and advocacy skills, service system knowledge and networks, and generic clinical and care coordination competence.

The presence of Aboriginal staff members makes a significant difference to the nature of relationships between clients and a mainstream health service.

Aboriginal staff in hospitals make a significant contribution to enhancing the cultural competence and cultural practice of their colleagues, through secondary consultations and role modeling.

The impact of the care coordinator role on clients, colleagues, agencies and local service networks

The evidence suggests that the strong client-practitioner relationships resulted in clients engaging with their healthcare in a way that they otherwise would not. The impact of the care coordinator was generally associated with improvements in the client’s quality of life, health literacy, engagement with and trust of health services, maintenance of clinical care and health improvements. Clients reported that the relationship with a trusted care coordinator reduced feelings of stress, helped maintain motivation and reduced feelings of depression.

In addition to their roles in the involvement of client care, the various care coordinators:

* provided secondary consultations to their colleagues and to external agencies
* contributed to strengthening relationships with local service networks
* contributed to strengthening local agencies’ relationships with ACCHOs.

Supporting and sustaining practitioners

Workplace mechanisms are required to support care practitioners to deal with the personal, cultural and professional challenges of providing care coordination in Aboriginal health, and to minimise the risks of work-induced vicarious trauma.

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. Most staff across the projects had professional qualifications relevant to care coordination / case management (registered nurse, psychologist) or were members of multi-disciplinary, case management teams.

Findings relating to clients’ experience of care coordination

Irrespective of whether the relationship between the client and practitioner was brief or extended over months or years, clients valued the human connection and interpersonal nature of the relationship. They appreciated being acknowledged as a person first, and client second, and being treated respectfully with genuine care about their wellbeing by a practitioner who had a deep understanding of their culture and understood this in relation to care for their health and wellbeing.

Positive encouragement received from a care coordinator contributed to clients

1. Askew, D et al (2016)
2. Marfleet, F., Trueman, S. & Barber, R. (2013). 3rd Edition, *National Standards of Practice for Case Management*, Case Management Society of Australia

& New Zealand. Retrieved 16 August 2016 from <http://www.cmsa.org.au/products/publications/product-name>

changing their perceptions, changing lifestyle behaviours, or to persuading clients to undergo tests, or adhere to treatment regimens. Support of the care coordinator contributed to reducing client stress, particularly in relation to managing a chronic condition or undergoing treatment for a chronic condition, helping clients to maintain motivation and to reducing feelings of depression.

Characteristics of the care relationship valued by clients included:

* + cultural knowledge and understanding which promoted cultural safety
  + trust in privacy and confidentiality of information
  + respect and professionalism
  + reliability and follow-through on actions
  + provision of clear, jargon free medical and health information
  + assistance in navigating service systems and consulting multiple professionals.

Practice-related findings Culturally respectful, informed and integrated practice was found to be essential to establishing and maintaining care relationships with clients across all projects. This was required at all stages, from initial engagement, intake and assessment through to exiting a service.

All projects acknowledged the importance of family relationships as a determinant of the health and wellbeing of clients. Some projects (the Early Years Service, Close the Gap project and Integrated Koori Services) considered the whole family as the client. Projects working with individuals recognised the impact of family relationships and health and wellbeing on the client’s health and wellbeing.

A knowledge of trauma and the effects of trauma was found to be essential to practice across all care coordination models, whether facilitating, coordinating or managing the client’s care.

Successful practice approaches found included providing flexibility for clients to re- engage with the service at any time; assertive follow-up; outreach approaches, enabling the client to chose their preferred environment (convenient, comfort, culturally safe) for consultations and provision of therapeutic services ‘on country’ (Fresh Tracks) and connecting with groups of Elders (Close the Gap).

Organisational findings Trust built with the client through the care facilitator or 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. Examples were found of funding interruptions which disrupted the continuity of projects and resulted in key staff leaving.

Projects constructed around one or two key staff members are inherently fragile and vulnerable to needing to re-build in the event of staff turnover. The MDAS Early Years Service’s focus on training team members was an example of skills transfer and development that strengthens and sustains the model.

Hospital staff reported their health service’s commitment to improving Aboriginal health and improving services for Aboriginal patients. However, examples of culturally insensitive or inappropriate treatment of Aboriginal patients in hospitals and emergency departments in particular was reported from all projects. Care coordination work in hospitals is directly impacted on by clients’ perception of the cultural safety of the environment.

The need for after-hours support for Aboriginal clients in emergency departments was reported across all hospital project sites.

Organisational issues raised by ACCHOs included the challenges facing their

organisations of responding to the health and wellbeing needs in the community.

The sole practitioner care coordination roles at an ACCHO (Chronic Disease Nurse at BADAC, Fresh Tracks Coordinator at Wathaurong) were found to complement and reinforce other health services delivered and contributed to clients remaining engaged with these services.

Service system findings A wide network of relationships and partnerships are required across the 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.

By providing a key point of contact, the care coordinator position often supported improved functioning of the local service system for the benefit of Aboriginal clients. The role acted as the conduit between one organisation and other sectors, and often, served the same role within their organisation.

Care coordinators frequently provided secondary consultations for staff within their organisation and in external agencies. Stakeholders consulted for the evaluation highlighted the value of the secondary consultation process for individual clients, and for informing their work with the community.

Contributions to the evidence base

All projects could improve their data collection, ensuring that baseline, monitoring and outcome data is collected regularly, collated and analysed.

There is scope to introduce collection of data focusing on the case management process, such as the number and frequency of contacts, over time.

The range of care coordination approaches are consistent with, and add to understandings of emerging evidence around:

* the presence of Aboriginal staff providing a transition or liaison role with mainstream health services (the Client Journey Project, Integrated Koori Services, Aboriginal Health Care Coordinator) and in fact go further by focusing on support clients in the space ‘between sectors’
* the success of multi-disciplinary and multi-level outreach-based care coordination work in chronic disease management
* the value and importance of intensive service provision in the early years of life through a wrap-around service model in protecting against long-term poor health and poor educational outcomes.

The evaluation found that the care coordination approaches assisted in:

* preventing Aboriginal clients from leaving emergency departments without being seen or against medical advice and connecting clients to follow-up outpatient and community services
* ensuring that Aboriginal clients with chronic conditions complied with their monitoring and 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 inter-relationship 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.

#### Replication

Approach to replication The models examined represent at minimum one year of service development work, and for others, up to seven years work invested in the development. It is not recommended that any single model be ‘transplanted’, as each has shown the importance of developing a response to the local context – the local community needs, the resources and inter-related services of the host organisation and the local service system.

However, the general approach of providing a relationship-based support for care coordination or case management has great potential for implementation in other communities. The approach is inherently flexible as it can be tailored to the needs of a broad range of target groups and the focus can be clinical, psychosocial or relational. Care coordination or case management can also be delivered through an outreach approach, and this was seen to work particularly well with clients in a number of the projects involved in the evaluation. The approach has been found particularly useful in supporting clients with complex needs, chronic conditions or at risk of chronic disease, and ensures that these clients remain engaged and empowered in dealing with their healthcare journey.

More specific advice for replication of elements of each model are detailed in the seven case studies.

Opportunities for replication The model of an individual case practitioner, located within an ACCHO health team or within a hospital allied health / case management team, lends itself most easily to replication. Successful implementation however, requires the contribution of multiple elements from executive support, recruitment of a candidate with the right combination of skills, attributes and community acceptance, and time for the program to build a profile with clients, colleagues and service providers.

There is scope to strengthen the projects’ focus on data collection of both the process of client engagement and the outcomes achieved for clients, and to develop skills and knowledge in data analysis. There were also consistent suggestions made that the projects could be strengthened by additional resources to expand the scope of work or to provide additional hours of services, in particular after business hours or to provide access to brokerage funds.

There is also scope to provide further support to practitioners to enable them to better deal with the issues of vicarious trauma, to provide professional supervision and cultural mentoring, to support practitioners to connect and share practice knowledge and experience. The part-time nature of most roles however creates challenges for incorporating support and mentoring.

#### Conclusions

It is evident that across the continuum of care coordination types, the projects are delivering services that are consistent with the Koolin Balit objectives of delivering locally developed, culturally informed, empowering, patient-centred care.

Whilst often the intensity of the individual and systemic work is highly challenging, staff providing care coordination in Aboriginal health acknowledged that, at the same time, the work is professionally and personally fulfilling. They have great respect and empathy for their clients, derive great professional fulfillment when they can ‘make a difference’ for clients and experience the relationships as ‘two-way’ relationships, from which they learn and grow.

The seven care coordination projects demonstrate that these culturally-informed, relationship-based models of care are delivering significant benefits for individuals, families and organisations and are also contributing to the 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 in the field of Aboriginal health.

# Introduction

This is the final report on the evaluation of the Aboriginal Health Case Management and Care Coordination Models funded under the Victorian Government’s Koolin Balit strategy.

#### Koolin Balit Strategy

Koolin Balit comprises the Victorian Government’s strategic directions for Aboriginal health from 2012 to 2022. ‘Koolin Balit’ means healthy people in Boonwurrung language. The strategy ‘provides a way forward to make a significant and measurable impact on improving the length and quality of the lives of Aboriginal Victorians in this decade.’

The objectives of Koolin Balit are to:

* + close the gap in life expectancy for Aboriginal people living in Victoria
  + reduce the differences in infant mortality rates, morbidity and low birth weights between the general population and Aboriginal people
  + improve access to services and improve outcomes for Aboriginal people.

The strategy focuses efforts on six key priorities:

1. a healthy start to life
2. a healthy childhood
3. a healthy transition to adulthood
4. caring for older people
5. addressing risk factors
6. managing illness better with effective health services.

Improving the quality of data and evidence, developing strong Aboriginal organisations and culturally responsive services are the three enablers providing the foundation for the key priorities, and supporting their achievement.3 Aboriginal Health & Wellbeing, Department of Health and Human Services (DHHS), commissioned this evaluation. The 12-month project commenced in July 2015 and was undertaken by Effective Change Pty Ltd.

#### Purpose of the evaluation

Through examining seven Aboriginal health projects across Victoria implemented under Koolin Balit, utilising different 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
  + how successful approaches could be replicated in other communities.

When data was available, the evaluation also examined:

* + the extent to which intended target populations were reached in each project
  + impacts on the health and wellbeing outcomes of target populations.

Participating projects The seven projects involved in the evaluation are each focused on different initiatives, for example around pregnancy and early years or chronic disease management.

1. Department of Health, (2013). Koolin Balit – Victorian Government’s strategic directions for Aboriginal health 2012–2022. State of Victoria, Department of Health

Projects also involve different target groups, such as families with complex issues, or people attending hospital emergency departments. Two projects were based in metropolitan Melbourne, and five in regional and rural Victoria.

DHHS

Division

Project Lead agency/location

North Aboriginal Client Journey project Transition Officers in Shepparton

Seymour, Wangaratta and Wodonga

West Chronic Disease Prevention and Management Program

Ballarat and District Aboriginal Cooperative (BADAC), Ballarat

South Integrated Koori Services Monash Health

North Aboriginal Health Care Coordinator in the Health Independence Program

St Vincent’s Hospital Melbourne & North Richmond Community Health Centre

West Close the Gap Gunditjmara Aboriginal Cooperative Warrnambool

West Fresh Tracks Project Wathaurong Aboriginal Cooperative Geelong

North Early Years Services Mallee District Aboriginal Services (MDAS), Mildura

Connection to Koolin Balit Patient-centred care lies at the heart of good Aboriginal health service delivery; it is locally developed, culturally informed and empowers Aboriginal people to make the best choices about their health.

Koolin Balit Summary poster, Department of Health, February 2014

The projects involved in the evaluation have been funded through the regional allocations within the Koolin Balit strategy. Most of the projects were established, commenced or developed under the previous *Closing the Gap in Aboriginal Health Initiative*, which ran from 2008 to 2012.

Koolin Balit Evaluation Plan This evaluation is one of four external evaluations commissioned of Koolin Balit investments, selected on the basis of:

* + the investment
  + replicability or potential for replicability
  + comparability of similar projects, providing insights into replicability
  + critical information needs.

Site selection In planning the evaluation of the Koolin Balit investment, the DHHS noted that seven different case management and care coordination projects were being implemented by local communities across Victoria. The investment decisions were made through a process of devolved governance in which local communities identified priorities, and in some cases had a role in allocating funding, with the primary mechanism for this being the eight Regional Aboriginal Health Committees co-chaired by a local Aboriginal community leader and the Regional Director of Health and Aged Care. It is therefore the case that, to varying degrees, the programs have been developed and funded with support, and sometimes even under control of their local Aboriginal communities.4

The Department saw that an evaluation of these models presented a useful opportunity for comparison and possible replication both between the existing models and potentially to other communities.5

1. Department of Health and Human Services, (March 2015) *Evaluation Plan for the Koolin Balit Investment*. Retrieved 16 August from https://www2.health.vic.gov.au/about/publications/policiesandguidelines/evaluation-plan-for-koolin-balit-investment
2. ibid

#### Care coordination and case management

Both care coordination and case management are forms of practice applied when a client requires multidisciplinary support, often from a range of service providers and often across sectors. The role of the care coordinator or case manager is to support the client through that journey, to ensure that the client receives continuity of care and, when needs are complex, to actively manage care. The care coordinator or case manager provides support to the client over time, and across the transition points spanning the health and other service systems.

Care coordination and case management is offered in a range of intersecting sectors and settings, including primary and acute health, homelessness, family violence and family services sectors.

Care coordination A general definition for care coordination is ‘the deliberate organisation of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of healthcare services’.6

Case management The Case Management Society of Australia & New Zealand defines case management as ‘a process, encompassing a culmination of consecutive collaborative phases, that assist clients to access available and relevant resources necessary for the Client¹ to attain their identified goals. Key phases within the case management process include: Client identification (screening), assessment, stratifying risk, planning, implementation (care coordination), monitoring, transitioning and evaluation.’7

#### Project management

The evaluation was managed by the Senior Project Officer – Evaluation of the Aboriginal Health & Wellbeing Branch of DHHS. The project received guidance from Reference Group comprising the Regional Aboriginal Health Partnerships Officers from regions where the projects were located and representatives from the Aboriginal Health Evidence and Evaluation Working Group. The Reference met to review the project plan and the interim report.

#### Reporting

Project case studies The evaluation has produced a suite of seven individual, deep case studies evaluating each of the projects. Interim case studies were submitted for the project’s interim report.

Overarching report The interim evaluation report was delivered in February 2016 with a report on progress, overviews of each of the projects and early observations of themes emerging at the time. This final overview report addresses the key evaluation questions and is structured in the following sections:

* + Overview of the projects
  + Methodology
  + Contextual issues
  + Promising approaches
  + Key findings
  + Replication
  + Contributions to the evidence base
  + Conclusions and opportunities for the future

1. Department of Health, (2015). *Care Coordination*. Retrieved 16th August from www2.health.vic.gov.au/hospitals-and-health-services/patient- care/rehabilitation-complex-care/health-independence-program/care-coordination
2. Marfleet, F., Trueman, S. & Barber, R. (2013). 3rd Edition, *National Standards of Practice for Case Management*, Case Management Society of Australia

& New Zealand. Retrieved 16th August from <http://www.cmsa.org.au/products/publications/product-name>

# Overview of the projects

The *Evaluation of Aboriginal Health Case Management and Care Coordination Models in Victoria* is examining seven different case management/care coordination models implemented under the Koolin Balit strategy across Victoria.

The table below provides a summary of the projects participating in the evaluation. More detailed information about each of the projects is provided at Attachment 1.

Project Lead agency/location

Aboriginal Client Journey Project - Transition Officers in Shepparton, Seymour, Wangaratta and Wodonga

Chronic Disease Prevention and Management Program BADAC

Integrated Koori Services Monash Health

Aboriginal Health Care Coordinator in the Health Independence Program SVHM & NRCH

Close the Gap Gunditjmara Aboriginal Cooperative

Fresh Tracks Project Wathaurong Aboriginal Cooperative

Early Years Services Mallee District Aboriginal Services (MDAS), Mildura

Through this region-wide project Aboriginal Health Transition Officers (AHTO) are employed at three hospital emergency departments (ED) and one at an Urgent Care Centre, covering the four sub-regional PCPs. The AHTOs undertake 48-hour follow-up care for Aboriginal people who have presented at an ED or Urgent Care Centre and transition clients, who require assistance, to care coordination in the community.

This program funds the engagement of a Chronic Disease Nurse within BADAC’s Health Program to support to clients with a chronic disease better manage their conditions or for those at risk of developing a chronic disease, take preventative actions. Working closely with other members of the Health team, the Chronic Disease Nurse undertakes health assessments, develops individualised care plans, provides health promotion education, monitors social and emotional wellbeing needs and refers clients to BADAC services and external services.

This project provides care coordination to Aboriginal people through Monash Health. It aims to better integrate Aboriginal clients presenting to Monash Health Emergency Departments, or those who have had an admission to a Monash Hospital, to community services. It coordinates care through an assertive outreach program and develops individualised care pathways for clients.

This project provides care coordination to Aboriginal people through the St Vincent’s Health Independence Program. Clients of the program may be referred internally through the hospital, or can be referred by any partnership organisations, including North Richmond Community Health, other community health services, including the Victorian Aboriginal Health Service (VAHS).

This project provides care coordination to Aboriginal people. Clients of the program are referred by a number of local organisations and services, and a growing number are now also self-referred. They focus on family violence, and related issues of mental health and drug and alcohol abuse. The project also works to make the client’s health journey easier and more accessible, by providing cultural awareness and sensitivity training to local health services.

This Social and Emotional Wellbeing (SEWB) project provides care coordination to assist clients in the management of their health and navigation of the health service system, using an assertive outreach model. Clients have complex psychosocial and/or medical needs. Care planning is undertaken with the client, and support provided through single or multiple contacts and/or complex care coordination is provided.

This project provides case management and care coordination to Aboriginal families with a child under school age. A dedicated, supportive worker focuses on the mother, and provides referrals to specialist services as well as helping to interpret and explain those services to the mother. They also act to make sure there is shared knowledge across the specialist service providers, and a consistent understanding of the clients needs.

# Methodology

#### Ethical approaches

The evaluation was underpinned by the principles of ethical conduct in Aboriginal and Torres Strait Islander health research and in keeping with the values outlined in *Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander People about Health Research Ethics*:

|  |  |  |  |
| --- | --- | --- | --- |
| ­ | Spirit and integrity | ­ | Equality |
| ­ | Reciprocity | ­ | Survival and protection |
| ­ | Respect | ­ | Responsibility |

The project received ethical approval from the DHHS Human Research Ethics Committee in March 2016.

#### Theoretical basis

The projects involved in the evaluation are all funded under the Koolin Balit investment, and each is working with a target group either using a case management or care coordination model. In broad terms, each project aims to ‘enable the whole health system to become more responsive to the needs, preferences, and experiences of Aboriginal people.’ However, they do not all sit under a single program funding initiative. The projects are working with different client groups, with different needs and use locally developed approaches. There are no overarching program guidelines prescribed by DHHS that specify an approach to case management or care coordination. The various projects however, draw on case management principles and guidance from a range of different sources. The projects were known to share some common elements, and are known to have differences, but as the extent of commonalities and differences, or the impact of the different approaches was not known, the case study methodology enabled these characteristics to be described, explored and explained.

As R.K. Yin, the pre-eminent social scientist states ‘…case studies are the preferred strategy when “how” or “why” questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context. Such explanatory case studies also can be complemented by two other types – exploratory and descriptive case studies.’8

In this evaluation the phenomenon of interest and the unit of analysis is the care coordination and case management model (also referred to as ‘the project’).9 The case study questions are about the model as opposed to the staff implementing the model, or the organisation(s) in which the model is being implemented and so forth. However it is important to note that in isolating the model as the unit of analysis the factors that influence the model have not been ignored or excluded from the analysis, rather have been analysed to add *insight* to the model. For example, if staff capacity is raised as a factor that influences the fidelity of implementation or adherence to the design of the model in the delivery process, this finding would be presented as a factor that influences the implementation effectiveness of the model.

Given that the model is the unit of analysis, and seven models are included, a *multiple case studies holistic design* has been used*.10* This design is characterised by several cases, and the holistic element treats the unit of analysis (the model) as having multiple embedded units that influence it (ie. organisational culture, staff capacity, resourcing).

1. Yin, R.K. *Case Study Research: Design and Methods*, Third Edition 2003 Sage Publications
2. Baxter, P. & Jack, S. (2008). Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report,*

13(4), 544-559; Yin, R. (1999). Enhancing the Quality of Case Studies in Health Services Research. *Health Services Research*, 34(5)

1. Ibid

#### The case studies

Evaluation questions The overarching evaluation questions were to examine:

1. What approaches to care coordination and case management have been the most successful?
2. What impacts on health and wellbeing outcomes has each project achieved?
3. Who did each project reach? And to what extent did the projects reach their intended target populations?
4. How can successful approaches be replicated in other communities?

The methodology required initially establishing and describing the projects. Through deeper investigation the evaluation sought to explain and explore the design and implementation of the care coordination and case management models across the seven projects serving different communities across Victoria. Supplementary evaluation questions were therefore designed to guide the evaluation addressing:

* + Context for the project
  + Rationale for the project
  + The role of the community in the project’s development
  + The case management or care coordination model
  + History of the case management or care coordination model
  + The project’s reach
  + Project/model implementation experience
  + Health and wellbeing outcomes for participants
  + Project learnings
  + Specificity to place
  + Potential for replication
  + Connections/contributions to the wider evidence base.

Qualitative and quantitative data sources

To address the overarching evaluation questions, and sub-questions, information was collected from:

* program reports and data
* the program funder
* agency staff
* partner agencies, and
* clients.

|  |  |  |
| --- | --- | --- |
|  | | Information was collected from stakeholders through semi-structured interviews, with |
| the exception of a small number of external stakeholders for the Client Journey Project |
| (8) and the Chronic Disease Prevention and Management project (4) who were surveyed |
| as was the only method suitable to the stakeholders. Most interviews were conducted |
| face to face, and some with external stakeholders were conducted by telephone. |
| ‘Agency staff’ in most cases included the staff directly involved in the case study |
| project, their managers, colleagues and the CEO. The direct project staff were |
| consulted multiple times over the evaluation period. Most partner agencies were |
| consulted once. Clients participated in a single interview. |
| Data Collection |  | A minimum of four site visits were undertaken for each project, comprising meetings |
|  |  | with key personnel and leaders, consultations with those involved in management and |
|  |  | coordination and staff and clients. The purpose of each visit is described below. |
|  | **Visit 1** | Introductions, meet with the CEO (of ACCHOs) acknowledging meeting on traditional lands, seeking permission to conduct the research provide project overview, meetings with key project personnel who have governance responsibilities, introductions to community leaders, plan visit schedule, observe local setting, understand the community context. |

**Visit 2** Consultations with managers and coordinators, interviews with staff and external stakeholders.

**Visit 3** Further consultations with managers, project staff and clients.

**Visit 4** Further consultations, addressing information gaps, present and discuss final draft report.

There was much value in conducting multiple site visits both from a methodological and practical standpoint. Firstly, the process supported the engagement process between the evaluators and the project staff. Stakeholders were given multiple opportunities to identify and provide data. The richness of the data increased over time, as the project was better understood. Program staff were also able to participate in the development of the case study, which was important for maintaining validity. Multiple visits also enabled the evaluators to capture progress and development of the projects, which increased the accuracy of the description and explanation of each of the seven models.

In total, **33 site visits** were undertaken for the project. This includes visits undertaken to the four sites participating in the Client Journey Project in Albury-Wodonga, Wangaratta, Shepparton and Seymour but counted only as a single project visit.

The table below summarises the number of individual internal, external and client stakeholders consulted. Internal stakeholders, in particular the direct project staff, were interviewed and consulted on multiple occasions. In total, the evaluators consulted **168** unique stakeholders, including **40** clients across six of the seven projects.

|  |  |  |  |
| --- | --- | --- | --- |
| Project | Internal stakeholders | External stakeholders | Clients |
| Aboriginal Client Journey project | 21 | 10 | 13 |
| Chronic Disease Prevention & Management | 9 | 6 | 7 |
| Integrated Koori Services | 11 | 3 | 0 |
| Aboriginal Health Care Coordinator | 5 | 5 | 5 |
| SW Consortium Family Case Management | 6 | 17 | 5 |
| Fresh Tracks Project | 11 | 5 | 5 |
| Early Years project | 7 | 12 | 5 |
| **Total** | **70** | **58** | **40** |

|  |  |  |
| --- | --- | --- |
| Data analysis |  | The analysis of the data occurred in two key phases, with each phase building on the previous phase, as more data was collected and site visits undertaken. |
|  | **Phase 1** | Descriptive content analysis, including documentary review of program reports and data, site observations. Interim case studies, addressing the background and context for the project, were |
|  |  | prepared in draft and approved by the case studies agencies. This provided the opportunity to |
|  |  | clarify interpretation and accuracy of information. |
|  |  | An overarching interim report was provided to the DHHS to report on progress and to discuss |
|  |  | emerging findings and issues. |
|  | **Phase 2** | The second phase of the analysis focused on completing the description and explanation of each model, supported by new data collected. Interviews and consultations with program staff, leaders |
|  | | and clients were thematically analysed using the general inductive approach. With greater |
| knowledge of the projects, relevant literature was reviewed to gain further insights. Data from all |
| sources was triangulated. |
| Final case studies were developed for each project documenting the results and answering the |
| case study questions. These were submitted to the agencies for final approval. |
| The case study approach to the evaluation used multiple sources of evidence in order |
| to triangulate the data, the diverse evaluation team allowed for investigator triangulation |
| and the range of methods enabled method triangulation. The phased approach to |

analysis and development of interim and final case studies has allowed key project stakeholders to provide input into the interpretation of data results. This increased validity because context experts were included in the analysis process. The combination of these features, and the appropriateness of the overarching design of the case study, reduces threats to validity.11

#### Project scope and limitations

The focus of the evaluation was on the operation of the case management or care coordination model. This included the work of the nominated case manager or care coordinator, and if applicable, that of the team where the project was located. Data was collected on how the specific project worked and the perceptions of various stakeholders about the work, including colleagues, external service providers and clients of the specific project. The findings are therefore limited to the specific projects, rather than findings about the host organisation.

Clients were selected through non-random, purposive sampling methods. This method is frequently applied in qualitative research. There were multiple reasons for this. Firstly, as participants in the care coordination and case management typically have a range of complex medical and psychosocial needs, a broad-brush recruitment process was not considered appropriate. Secondly, in the Aboriginal Client Journey project, clients have only limited contact with the Transition Officers. Thirdly, many clients do not live nearby the location of the service and the researchers did not want to impose travel burdens on the clients. The approach taken was to work through the care coordinator, to invite a sample of clients who would be willing to participate in the research, without any negative impacts on health and wellbeing. The majority of client interviews occurred at an ACCHO, some occurred in a hospital and some in a community setting. The DHHS had recruited a debriefer for clients to consult in the event of the interview causing distress and all participants were advised of this during the process of gaining informed consent. No clients required debriefing after the interview.

1. Thomas, D. (2006). A General Inductive Approach for Analysing Qualitative Evaluation Data. *American Journal of Evaluation*, 27(2), 237-246

# Continuum of care coordination approaches

This section firstly describes the common features and variables of the projects. The evaluation’s approach to classifying and understanding the care coordination and case management work across a continuum of care coordination approaches is then explained.

#### Common features shared across the projects

Common features shared across the seven projects included:

* + a program or service newly developed under the Koolin Balit initiative and designed to address a point in the service system at which Aboriginal clients were vulnerable to becoming lost to ‘the system’
  + a specific health care worker or professional, who for a period of time, facilitated,

coordinated or managed care or services for an Aboriginal client (individual or family) of a health service and acted as the client’s key contact for the health service

* + staffing by Aboriginal staff and by culturally competent non-Indigenous staff
  + staff’s explicit understanding and application of Aboriginal concepts of health in the services delivered
  + clients (typically) with complex medical and/or psychosocial needs and requiring

services across a range of health and other community service providers.

#### Variation across the projects

While the projects share common features, they are not linked under a common program or set of care coordination or case management guidelines. They vary across a number of characteristics - the organisation they are based in, where they are located, the local service system, when they commenced, how they are staffed and the project target groups they work with. These variations are outlined below.

Organisational context Four projects are located in ACCHOs which have General Practice clinics and provide a range of health and wellbeing services:

* + BADAC
  + MDAS
  + Gunditjmara
  + Wathaurong

Six health services host three projects (Integrated Koori Services, the Aboriginal Health Care Coordinator role and the Client Journey Project):

* + Monash Health ­ St Vincent’s Hospital Melbourne

The Client Journey Project includes a staff member at:

* + Albury-Wodonga Health Service
  + North East Health Wangaratta
* Goulburn Valley Health
* Seymour Health Urgent Care Centre

These health services vary from Monash Health, Victoria’s largest public health service with more than 14,000 staff, to Seymour Health which is an Urgent Care Centre and has a staff of approximately 300.

Location and local service system

Five projects are located in regional Victoria (North-East Victorian centres of Wodonga, Wangaratta, Shepparton and Seymour; Ballarat; Warrnambool, and Mildura). Two projects are located on the Victorian/NSW border (Albury-Wodonga and Mildura).

Two projects are located in metropolitan Melbourne – with one in inner Melbourne (St Vincent’s Hospital, Fitzroy) and one in outer Melbourne (Monash Health).

The local service systems clearly vary considerably from Fitzroy to Mildura, and from Ballarat to Seymour and so on. The local service system also provides important context for, and influence on, the design of case management models.

Project staffing Projects are staffed in a variety of approaches:

* + team-based approaches (including teams of Aboriginal clinicians, teams of Aboriginal and non-Aboriginal staff)
  + sole staff member or clinician within health/medical/community care teams.

Length of operation Some projects commenced under the Closing the Health Gap and have been operating for up to seven years. The Client Journey Project is one example. Other projects, such as Fresh Tracks, commenced with Koolin Balit funding in 2014 or the Aboriginal Health Care Coordinator, appointed in 2015.

Project target groups The project target groups vary from children (0 – 5 years, pre-school) and families to people with, or at risk of developing chronic conditions. Some projects are focused on family units and others on individuals.

#### Approach to care coordination and case management

More significantly, the approach to care coordination or case management varied along a continuum from brief and shallow interventions through to deep and intensive engagements and a layered approach incorporating casework with a range of complementary strategies.12 Variations on a number of key characteristics relating to care coordination or case management include:

* + client or case load
  + length of time the intervention or support is offered
  + staff to client ratio
  + eligibility and entry
  + clinical or therapeutic focus
  + how the service is delivered to the client
  + underpinning philosophies and theories
  + use of service coordination or case management standards.

The evaluation has therefore classified projects in reference to their care coordination or case management characteristics and grouped ‘like’ projects together. Each care coordination type is colour coded, and this colour coding is used consistently throughout the report. Each of the classifications are explained below.

**Transition to care coordination** The Client Journey Project in North Division involves one identified Aboriginal staff member, employed in a hospital (or urgent care centre) as an Aboriginal Health

Transition Officer (AHTO). Broadly, the focus of the AHTOs is to support Aboriginal people presenting to Emergency Departments (ED), either at the time of presentation if during the AHTO work hours or through a follow-up phone call.

In terms of care coordination characteristics:

* + the intervention typically is a brief, one-off follow-up call
  + the goal is to contact people within 48 hours of leaving ED
  + the number of potentially eligible patients (ie. Aboriginal clients presenting at ED) is high
  + contact can only be made with a proportion of potentially eligible people due to resource constraints

1. There are parallels with the Kaiser Permanente Triangle, which describes levels of care for people with chronic conditions. This model has three levels – Level 1 – self managed, Level 2 – High Risk and Level 3 – High Care. The intensity of support required increases from Level 1 at the base of the triangle, to Level 3 at the apex.
   * priority is given to people who have left ED against medical advice or who have left without being seen, and after that by factors such as previous presentations, seriousness of presenting issue, vulnerability of the client, child/family issue and so on
   * when clients require assistance, the role of the AHTO is to provide a range of

supports, such as clarifying medications, explaining assistance available, following up ED staff in relation to referrals, making calls to health services and so on

* + the AHTO role does not include on-going care responsibilities for clients.

When clients require care coordination in the community and require assistance from the AHTO, the focus of their role is on **facilitating the client’s transition to that care coordination**, whether it is provided by an ACHHO, community health or other service.

**Internal service coordination** The Chronic Disease Nurse, employed at BADAC’S Baarlinjan Medical Clinic under the Chronic Disease Prevention and Management Project, assists patients of the clinic with

a chronic condition or at risk of developing a chronic condition. Patients who have undergone a GP Aboriginal Health Assessment Plan or GP Management Plan for Chronic Disease are referred to the Chronic Disease Nurse.

The Chronic Disease Nurse:

* + consults clients on a regular basis to monitor and review progress on their Individual Care Plan goals
  + conducts health checks and clinical tests, provides and explains test results to clients
  + manages patient recalls and reminders
  + receives referrals from GPs and other clinicians at the practice, and refers clients to practitioners and programs within the clinic
  + may refer clients to external health and allied health services, and accepts referrals

from these services

* + annually conducts over 300 health assessments, develops around 70 new individual care plans, and reviews around 100 care plans
  + consults clients at the medical clinic.

Contact with the patient is primarily clinical and focused on chronic disease prevention and management support. Consultations range between 30-60 minutes. Regular contact is maintained with patients, including by telephone. The focus of the role is on engaging the client, encouraging self-management and coordinating their care with a focus on the internal services. This level of care has been classified as **internal service coordination**.

**Care coordination between acute &**

**community**

The Integrated Koori Services Project at Monash Health and the Aboriginal Health Care Coordinator role at St Vincent’s Hospital provide **care coordination for Aboriginal people moving between the acute and community settings**. Each project is based in an acute health service, but physically located off-site from the hospital with community/health services. The role of key staff is to coordinate care in the community for Aboriginal people:

* People who have been admitted to hospital or who have presented to ED may be referred. Aboriginal Health Liaison Officers, discharge planners or ED staff generally make the referrals.
* Clients are referred because they require support in the community.
* The Aboriginal Health Care Coordinator at St Vincent’s also receives referrals from community organisations for people at risk of hospital admission or with chronic diseases.
* In addition to providing support to people in the community, these projects both aim to reduce avoidable presentations to ED or admissions to hospital.
* Both roles work closely with local ACCHOs and community/health services.
  + A registered community nurse who works in partnership with an Aboriginal Health Access Worker working within a community allied health team staffs the Integrated Koori Services. The St Vincent’s Care Coordinator is a registered mental health nurse, is Aboriginal and works as a sole practitioner within a care team.
  + The key Care Coordinators maintain a case load of around 10 clients.
  + Care coordination activities are driven by client needs, and the level of support they are receiving (or not). The engagement can be short or medium to long term.
  + Both projects work on an outreach basis, and consult with clients off-site at a health service, at their home or other community locations, such as a café or a park
  + Staff conduct secondary consultations with other providers involved in the client’s care.

**Care coordination and case management in the community**

The Close the Gap project based at Gundijtmara and Fresh Tracks at Wathaurong provide **case coordination and case management** services to people who require support due to chronic physical or mental health needs, and/or needs for assistance to navigate service systems. These projects are both community based and use an outreach approach, ie. the case manager or care coordinator will meet with the client in the setting of their choosing, such as their home or a community location.

In terms of care coordination and case management characteristics:

* client or case loads are generally less than 20 clients at any one time
* the Close the Gap project can support a family unit as a client
* the length of time the intervention or support is offered may be one-off and short, medium or long term - up to two years for people with high health needs and vulnerability
* Fresh Tracks is staffed by a sole practitioner, whereas the Close the Gap project has a small team of three-four staff, with case workers allocated to support specific clients
* the projects are structured around working with clients to achieve goals. There is capacity for clients to move out, and return to the program if they require support at a future time.
* the Fresh Tracks Coordinator is a psychologist and can provide therapeutic support to clients as well as care coordination
* the projects require relationships with other community based services, and at times

may be undertaking joint care coordination of clients (eg. between Department of Justice and the ACCHO). Both provide (and seek) secondary consultations to (from) other services.

* the Close the Gap project is going through a redevelopment phase (likely to result in a name change) and implementation of new assessment tools and processes
* both projects are firmly based on Aboriginal and Torres Strait Islander concepts of

health, are strongly aligned to the Social Emotional Wellbeing Framework and integrate an understanding of the determinants of health for Aboriginal people into case management practice (in particular the impacts of connections to family and kinship, culture, community and to spirituality and ancestors in determining the client’s health and wellbeing and in determining the pathways to follow to improve health and wellbeing.

**Layered service including case work and care coordination**

The Early Years Services at MDAS focuses on support for pre-school children and support for parents. Case work and case support is one of the services provided, and the approach is consistent with the general principles of care coordination and case management described above.

Characteristics that distinguish the approach of the Early Years Services from other categories include:

* + that it is a multi-layered service, which includes casework as one component. The Early Years Services include Family Support Services, Maternity Services, Maternal

& Child Health, Family Capacity Building Groups

* + the service focus is medium to long-term – a child and their parent could be engaged with Family Services for up to six years, as the target group includes children from birth to school entry
  + the Koolin Balit-funding supports the Family Support Case Workers and the Lead Practitioner, a psychologist with expertise in working with vulnerable populations and in trauma recovery and applied behavioural analysis across the life span.
  + there is a strong wrap-around focus for clients, which includes one to one case work, maternal and child health services, playgroups for children and parents, parents’ groups and home-based support
  + there are strong referral pathways and secondary consultations with internal and external services, including other maternal and child health services, paediatric health services
  + there is a strong theoretical foundation to the work of the service with a focus on attachment theory which is integrated in practice and focuses on encouraging strong bonds between baby/child and parent(s)
  + skills and theory-based training for all staff teams to ensure consistent and reinforcing practice for clients.

# Promising approaches

…the overarching message is a simple one. Setting targets and monitoring outcomes should not be the primary focus of efforts. More attention and resources need to be devoted to policy evaluation. Knowing more about what works and why is the key to designing policies that achieve positive outcomes for Aboriginal and Torres Strait Islander Australians.

Productivity Commission, National Indigenous Reform Agreement, Performance Assessment

2013-14. p.17

The following approaches from the care coordination and case management projects were selected on the basis that they received positive feedback from clients, program staff, internal and external stakeholders, and compare well to approaches identified in the literature.

**Transition to care coordination** *The Client Journey Project* examined in this evaluation provides a ‘transition to care coordination’ model of care in four regional hospitals, functioning between hospital emergency departments and community-based services.

**Service system focus and reason for the**

**approach**

This support is provided at a complex point in the health system, where patients have one-off contact with multiple staff (reception, triage nurse, various ED clinicians). Rates of discharge against medical advice or without being seen are known to be higher for Aboriginal people than for the general population. The implications of this are significant for the care of the individual. High rates of discharge against medical advice is also taken as a proxy indicator for perceived lack of cultural safety in a health service.13 Research suggests multiple reasons for disengagement at this point in the service system, including waiting for care, which reinforced feelings of marginalisation, feelings of being ignored or invisible and that the health system was indifferent to needs.14 The approach is based on the NSW Health ‘48-hour follow-up care’ model.15

Whilst Aboriginal Health Liaison Officers are employed in Victorian public hospitals and focus on supporting Aboriginal in-patients, very few hospitals employ Aboriginal health staff or resources, which focus specifically on supporting patients during or after an ED presentation.16 The distinctive and promising aspects of this work has included a focus on systemic change, so whilst the project includes a specific position focusing on supporting Aboriginal patients from ED to community care – the Aboriginal Health Transition Officer (AHTO) - the broader context for this work includes region-wide governance structures, with representation from all health services, preparatory work and trials of appropriate models, training for hospital staff around improving processes to identify Aboriginal patients (‘Asking the question’), community awareness campaigns and development of resources for staff and community members.

**Staffing model and**

**support**

The AHTO position is a non-clinical, part-time role based in regional hospitals and one Urgent Care Centre. The staff member is Aboriginal. In three of the four hospitals, the position is located in the allied health/care planning team responsible for discharge planning and community-based care coordination. This provides the AHTO with good linkages within the hospital to allied health care coordinators and assists in assuring that their work provides continuity of care for the clients. Location within this team or department provides collegiate support for the AHTO and access to professional

1. Shaw, C. (2016). *An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients.*

Deeble Institute Issues Brief

1. Askew, D. et al., (2014). *The fork in the road: Exploring factors which influence whether Aboriginal and Torres Strait Islander peoples living with chronic disease remain engaged with health services* KQS Monograph Series: No. 2
2. NSW Department of Health, (2010). *Clinical Services Redesign Program: Chronic Care for Aboriginal People Model of Care.* Retrieved 16th August from https://[www.aci.health.nsw.gov.au/resources/chronic-care/chronic\_care\_for\_aboriginal\_people/ccap/ccap/CCAP-moc.pdf](http://www.aci.health.nsw.gov.au/resources/chronic-care/chronic_care_for_aboriginal_people/ccap/ccap/CCAP-moc.pdf)
3. Those identified include: Western Health, Sunshine Hospital and Werribee Mercy (ref: Karen Millward Consulting Services (Sept 2015) *HealthWest Aboriginal Health Hospital to Community Pathways Project)* and Mildura Base Hospital, West Gippsland Hospital, Echuca Regional Health, Northern Health and the Royal Women’s Hospital (ref: Department of Health, (2010). *Improving the patient experience for Aboriginal people in the emergency department.* Hospital and Health Service Performance Division Victorian Government, Department of Health, Melbourne

supervision. It also provides the Allied Health team with access to the AHTO for secondary cultural consultations and opportunistic cultural education. The AHTOs also liaise with the hospital Aboriginal Liaison Officer(s).

The presence of Aboriginal and Torres Strait Islander staff is known to ‘make a significant difference to the nature of the relationships created within a healthcare service’.17 This was reinforced through the evaluation, and feedback from clients clearly demonstrated that the staff member makes a significant difference to their experience of ED and the hospital, and provides a strong message that the health service cares about their wellbeing and the quality of their experience. The role also acts as a conduit to the community, builds the community’s confidence and trust in the health service and assists non-Indigenous healthcare workers to work more effectively with the community, including eliciting information from clients or providing observations that would otherwise go unnoticed, including signs of family violence.

**Promising practices** The main focus of the AHTO role is to follow-up Aboriginal patients after leaving ED. This follow-up care is known to assist patients comply with their follow-up treatment and to assist in reducing preventable hospital re-admissions. Priority is given to people who have left against medical advice or before being seen. Most of the follow-up work is undertaken by telephone. Assistance is provided with referrals, supports such as transport, referrals to ACCHOs and information about financial support. The follow-up also provides a quality check on whether medical advice has been understood, whether the client requires assistance to follow through and whether the client felt that the treatment they received at ED was respectful.

If an Aboriginal person presents at ED during the AHTO work hours, the AHTO will visit them in ED to say hello, to acknowledge family members, to provide advice on waiting times and GP options if the issue is non-urgent and to calm distressed patients and encourage them to wait for medical attention rather than leave in frustration. As the high rate of Aboriginal people disengaging or leaving before being seen in ED is known to be linked to feelings of being ‘unacknowledged and invisible’,18 this simple practice of visiting Aboriginal patients in ED changes the negative perceptions to those of feeling cared for, acknowledged and visible.

‘It was the first time anyone has ever rung to follow up on me. Really thorough. Really helpful.’

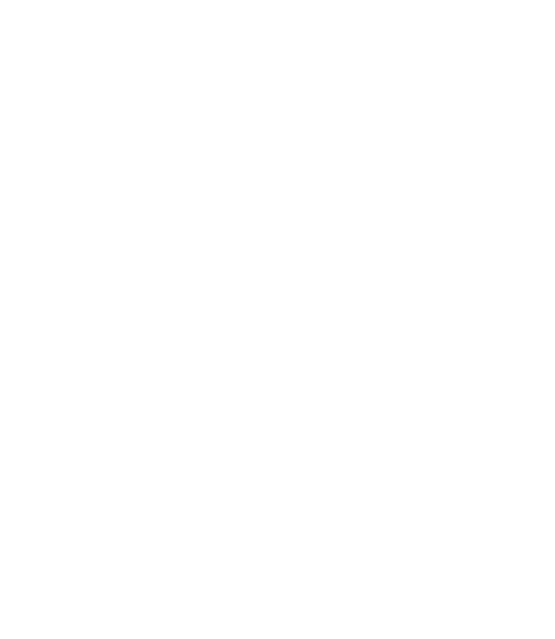
Client who had suffered a

serious workplace injury and spent months in (a different) hospital. Still has ongoing issues with damage and

medication.

As the focus of the AHTO role is on acute and community needs and services, through their direct engagement with the client they can also:

* provide opportunistic health promotion, such as encouraging a client to undertake a health check at the local ACCHO



* provide information and referrals to address social or cultural isolation
* facilitate a client’s journey to another hospital, eg. the Royal Children’s Hospital by liaising with the relevant AHLO and organising a welcome visit.

In addition to support for the client, the AHTO roles enhance the practice of ED staff by:

* providing secondary cultural consultations to ED and medical staff
* advocating for the client to medical staff, especially, eg. if a patient is in shock, distressed, overwhelmed or shy and symptoms could be minimised and assisting in more accurate clinical consultations.

1. Askew et al (2014) op cit
2. Askew, D., Brady, J., Brown, A., Cass, A., Davy, C. et al (n.d.) *To your door: Factors that influence Aboriginal and Torres Strait Islander peoples seeking care*. Kanyini Qualitative Study Monograph Series: No. 1; Askew, D… et al. (n.d). *Complex needs and limited resources: Influences on the provision of primary healthcare to Aboriginal and Torres Strait Islander peoples living with chronic disease.* KQS Monograph Series: No. 4

**Internal service coordination** *The Chronic Disease Prevention and Management Program is managed by a Chronic Disease Nurse who is part of the ACCHO’s health team located in the medical clinic.*

**Service system focus**

**and reason for the approach**

This role is based in an ACCHO primary health care setting and focuses on providing internal service coordination for clients with, or at risk of developing, a chronic disease. The Chronic Disease Nurse has a dual role in providing clinical care for people with chronic conditions, and providing health promotion support to address lifestyle risk factors responsible for chronic diseases. The role acknowledges the disproportionately high rate of chronic disease in the community. It also acknowledges the importance of providing primary care and health promotion in a community controlled health organisation.

Through adding this position to the health team, the nurse is able to spend longer one to one time with a client (up to an hour) than is possible for a GP. In addition to clinical services, the nurse can provide health promotion and education, motivate and encourage the client, identify parallel issues, make referrals, and manage client reminders and recalls.

**In-depth consultations**

**and relationship-building**

The Chronic Disease Nurse is able to conduct consultations of up to one hour when developing a management plan for a new client. Reviews and follow-up consultations are generally shorter. The longer appointment times allow the Chronic Disease Nurse to engage and listen in-depth to the patient, and allows for providing in-depth information health management information to the client. The establishment of a trusting relationship with the client provides space for discussion of social and emotional well-being issues.

**Adaptive and culturally respectful processes**

Through the engagement process and relationship building, strategies are developed that best suit each individual client. The process of respectful listening is emphasised, knowing that if a client does not have the opportunity to tell their story, they may lose respect and disengage from the process. The nurse listens closely to the client’s story and has the insight to ask the critical questions, often in response to clues provided within the story, but not directly elaborated on by the client.

**Opportunistic health**

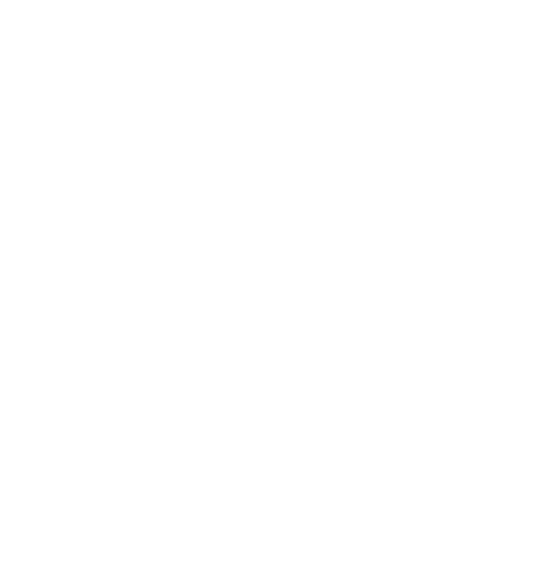
**promotion**

Each consultation presents the opportunity to present and reinforce positive health promoting information. Whilst a client may require asthma management, if the opportunity is presented, topics such as nutrition and healthy eating will be discussed.

**Positive approach** Clients frequently have multiple health issues and maintaining motivation can be challenging. The Chronic Disease Nurse’s approach is to break down the steps for each client, and ensure that they are working on small but achievable health goals, in order to have a continued sense of achievement and empowerment.

**Wrap-around services**

**from BADAC**



l’d be able to find services without BADAC, but I would probably make excuses not to go to outside appointments. If I didn't have the support of this place I probably wouldn't go.

Client, BADAC

With the opportunity to collect detailed information from individual clients, a range of social and emotional wellbeing issues may emerge in a consultation. The Chronic Disease Nurse can ensure that clients are linked into other services at the clinic, such as drug and alcohol counseling or support for family violence. If a client discloses an issue of immediate concern, for example, suicidal ideation, the nurse can secure an appointment with one of the clinic’s GPs, and accompany the client on the consultation for a warm handover. The Chronic Disease Nurse is engaged in regular monitoring and recall of patients. Patients are encouraged to attend the clinic regularly, and there has been a steady growth in the number of annual health assessments occurring at the clinic.

The Chronic Disease Nurse works with the other staff in the health team to design and introduce healthy lifestyle programs. Clients are linked to healthy lifestyle programs (focused on exercise, nutrition, group support) whenever the opportunity presents.

**Care coordination between acute and**

**community**

Projects: *Integrated Koori Services, Monash Health*

*Aboriginal Health Care Coordinator, St Vincent’s Hospital and NRCH*

**Service system focus**

**and reason for the approach**

The examples of care coordination spanning acute and community services were both based in major metropolitan hospitals. The coordinator role shares similarities with the AHTOs in that they are located at a point in the health system where Aboriginal clients may be lost to follow up or are at risk of disengaging with their health care. Important distinctions are that:

* + this role is based in the hospital’s community-based services’ arm
  + clients may be directed to the coordinator following an ED presentation or an admission, through the health services’ community programs (eg. Hospital Admission Risk Program (HARP)) or from the community agencies
  + this role takes on the direct care coordination for the client (subject to meeting certain criteria) and can work with the client over a period of weeks or months
  + for some clients, the support may focus on ensuring that the client is connected with

the appropriate care coordinator in the community (who may be in another city, town or state.

Both projects have established relationships with their local ACCHOs and Aboriginal health services (eg. the Aboriginal Community Elders Services for St Vincent’s). Coordinators maintain regular contact with ACCHOs, and attend events, such as NAIDOC or Reconciliation Week events. In addition to the partnerships with key local agencies, the roles are promoted to potential internal and external referrers. Within the hospital this includes ED, social work, discharge planners and specialist programs such as HARP, Sub-Acute Ambulatory Care Services (SACS) and Post-Acute Care (PAC).

**Staffing model and**

**support**

The two projects have reached different approaches to balancing clinical and community skill requirements. The Integrated Koori Services project is staffed by an experienced registered nurse, who works in close partnership with an Aboriginal Access and Support Worker. The Access and Support Worker provides the gateway and connection to the Aboriginal community, and can help build client trust in the coordinator. This position is located in the Monash Community and Allied team.

The Aboriginal Health Care Coordinator at St Vincent’s Hospital is an Aboriginal mental health registered nurse who combines the community skills and relationships, with experienced clinical skills, which are particularly relevant for the needs of the target group. This position is located with the Health Independence Program team, which includes the HARP team, so there is close proximity to these staff.

**Supporting people in the ‘space’ between hospital**

**and community-based**

**services**

The care coordinator positions address the fragile intersection between the acute and community sectors. Support is prioritised for Aboriginal people who have multiple and chronic health needs, possibly mental health issues and/or limited social supports and are highly vulnerable. Both positions also provide support for clients from regional Victoria who need to attend a major metropolitan hospital for their treatment.

Lack of engagement with a health service and with medical practitioners is known to be a critical cause for Aboriginal patients disengaging with their health care.19 Through the connection to a care coordinator, a personal care relationship is established for the patient. With manageable client caseloads, the coordinators are able to maintain regular contact with patients, encourage compliance with treatments and services, and intervene and provide support at points, which may otherwise escalate to crises or hospital admissions.

1. Kelly, J., Dwyer, J., Pekarsky, B., Mackeen, T., Willis, E., … et al. (2015). *Managing Two Worlds Together. Stage 3: Improving Aboriginal Patient Journeys-Study Report*. The Lowitja Institute: Melbourne

**Working in the community**

The Coordinators provide a range of supports to the client, and work on an outreach basis, visiting the client in their home, or meeting in public spaces. They will assist clients to manage a range of outpatient and other health-related appointments. The coordinators’ community-focused roles also provides scope to address more than just the medical needs of the person, acknowledging the health-related impacts of other needs. For example, they could be involved in advocating for the client with housing services, Centrelink, education providers, drug and alcohol services or family violence services.

Further, the coordinators take a holistic view, and are able to consider, for example, the needs of the whole family or other family members, recognising the inter-relationships between the health and wellbeing of all family members.

By taking an outreach approach, the client is not burdened with needing to comply with yet another appointment, or the stress of getting him or herself to a health facility. Rather, the process can be empowering for clients who can choose the time and place of the consultation (with the proviso that the appointment meets health and safety policy requirements).

**Focusing and enhancing the roles of hospital Aboriginal health team**

**members**

Prior to establishing the coordinator roles, AHLO staff would be expected to contribute to discharge planning and support for Aboriginal patients, particularly in relation to liaising with ACCHOs or community needs of the patient. The addition of the care coordinator roles provides the hospitals with complementary resources, with one role supporting in-patients, and another supporting patients in the community. It is important to note that stakeholders from both projects reported the importance of developing and negotiating the role distinctions, definitions and referral pathways.

‘(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 going through treatment for breast cancer

**Care coordination and case management**

**in the community**

Projects: *Close the Gap, Gunditjmara Aboriginal Cooperative Fresh Tracks, Wathaurong Aboriginal Cooperative*

**Service system focus and reason for the**

**approach**

The community-based care coordination and case management examples examined are located in ACCHOs. Close the Gap is staffed by a small team of case workers and a coordinator, and Fresh Tracks is delivered by a sole coordinator, who is a qualified psychologist with prior experience in care coordination in HARP.

Both ACCHOs provide medical, health and wellbeing services through on-site clinics (GP, allied health, dental, AOD counselling, housing support, visiting consultant services, eg. psychiatrists). Referrals for the programs are accepted from internal ACCHO services, and from a range of external agencies (eg. health services, housing, justice, education).

Both programs focus on clients with psychosocial needs. Fresh Tracks also assists people with chronic conditions and complex health needs who require assistance navigating the service system. Close the Gap also supports families as well as individuals, but is moving its focus to people over 18 years.

The programs’ broad target groups of people with psychosocial and complex care needs, combined with their links to internal and external referral sources allow both programs to support people whose needs do not neatly fit into a single service requirement – for example for alcohol and drug counseling - and who are at risk of ‘falling through the cracks’.

**Application of the Social and Emotional Wellbeing**

**Framework**

The programs are explicitly founded on the Aboriginal health Social and Emotional Wellbeing (SEWB) framework20 and work with clients to explore connections (and disruptions) to culture, country, family, kinship, ancestors and spirituality, mind, emotions and body. The programs recognise the inter-relationship between physical and mental health wellbeing, and the health impacts of disruptions to these cultural frameworks. The SEWB-informed practice, for example, enables the client’s relationship with their family members to be an important component of support, and within both programs, there is scope to support family members or family relationships, as a means for supporting the health and wellbeing of the client. Further, often the reason for neglect of physical health is related to a mental health issue – for example, anxiety, panic disorder, depression. Within Aboriginal health, the underlying causes for these issues are often complex and related to experience of trauma, transmission of intergenerational trauma, dispossession and discrimination, amongst others. SEWB support provided by an ACCHO can enable the client to address the symptoms, to explore and understand more of their own personal experience from a psychological and cultural perspective and to be guided through processes to identify strengths within themselves, their families, communities and culture, and supported to make changes in their life.

**Assessment process** Both programs emphasise the importance of a culturally-attuned assessment process, which involves close listening to the client’s story and time for the story to unfold, with a sensitivity to the potential of the client having a history of trauma. Often, the presenting issue is not the issue which emerges over time, with trust and confidence in the practitioner.

**Outreach approach** The programs use outreach approaches, which enables the client to direct the setting for engagement. Attending a clinical setting can be challenging for clients with complex psychosocial or medical issues for multiple reasons. The programs therefore ensure that this challenge is removed and that, despite complex issues, the clients maintain access to services.

**Assertive outreach** Fresh Tracks in particular is based on an assertive outreach approach. This approach, often applied in mental health services, housing and alcohol and other drugs. The ‘assertive’ aspect of this model refers to the efforts of the practitioner to prevent the client ‘falling through the cracks.’ If a client does not keep an appointment, the practitioner will (assertively) follow-up. This requires professional skills and judgement to achieve the balance between not neglecting the client, nor over-riding the client’s wishes.21

**Provision of therapeutic services ‘on country’**

The Fresh Tracks program has access to Wurdi Youang, a local Indigenous Protected Area and a recognised cultural heritage site, believed to be an initiation and ceremonial site. Providing clients with therapeutic services on this site was cited by clients and stakeholders, as one of the most important and innovative features of the Fresh Tracks program. The integration of culturally identified protective factors within the delivery of support – connection to land, culture, spirituality, ancestry and family, and community – is significant. These factors have been found to ‘*moderate the impact of stressful circumstances on social and emotional wellbeing at an individual, family and community*

1. Gee G, Dudgeon P, Schultz C, Hart A, Kelly K (2014) Aboriginal and Torres Strait Islander social and emotional wellbeing. In: Dudgeon P, Milroy H, Walker R, eds. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. 2nd ed. Canberra: Department of The Prime Minister and Cabinet, p.57
2. Lakeman, R. (2002, 18-29 May). *Towards Assertive Community Care.* Paper presented at The North Queensland Sub-branch of the Australian and New Zealand College of Mental Health Nurses Winter Symposium, Yeppon.

*level...(and) can serve as a unique reservoir of strength and recovery when Indigenous people are faced with adversity*.’22

**Joint care coordination**

**and secondary consultations**

Joint care coordination is undertaken with other community agencies, such as homelessness or health care services, which is particularly important for clients with complex needs, who may need to access a range of services. The care coordinator can facilitate this process for the client, ensure that the other agency is aware of the client needs and can provide secondary consultations for external agencies.

Fresh Tracks has invested significant effort in promoting the program to external agencies, to ensure that the program receives appropriate referrals and that the agencies can provide effective joint care coordination.

**Professional supervision provided by Indigenous**

**Psychologist**

The non-Indigenous Fresh Tracks psychologist accesses professional supervison from an Indigenous Psychologist, to ensure that cultural protocols and contexts can be debriefed and understood in a therapeutic sense. This is a particularly promising approach for non-Indigenous clinicians working in Aboriginal health.

I can talk to my worker and she listens. I don’t take advice. Dad rings her when I am angry and she tries to talk me down. My worker gets me into camps. We go for a drive to talk.

I have changed heaps. I now go to school all the time, I don’t muck around as much. I am not an angry kid any more. I used to explode!

When I got my diagnosis, [the Coordinator] sat me down and put it my terms, made it real, no jargon. It took me a year to realise how serious it was. He’s been there pushing me to get the help and care for my kids and me…. I actually care about my health and my mental health now.

Clients of community-based care coordination programs

**Layered service including case work**

**and care coordination**

The layered service examined is the *MDAS Family Services* model, which includes case work and care coordination as part of a broader model of care, including individual and group services for parents and children, from prenatal to school entry.

**The Early Years Model** The MDAS approach to Early Years comprises a number of related services. They include:

* + Maternity Services
  + Maternal & Child Health
  + Family Support Services
  + Family Capacity Building Groups

The grouping of these services together under the one umbrella of Early Years is unique. Its uniqueness relates in part to the location of these services on the same premises and within the same agency. This co-location allows for a high level of coordination across services at worker and management level. For example, it provides very easy pathways for referrals. Clients can literally be walked from service door to service door. It also enables workers from different services to formally and informally share their experiences with each other.

There is a further layer of integration at Early Years, which is provided through the Family Support Services worker. The role of this worker is to actively provide the linkage for clients across services and, as the caseworker, to interpret these services to the client. Where required, the caseworker also interprets the needs of the client to the

1. Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. (2009). *Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People.* Discussion Paper No. 10, Darwin: Cooperative Research Centre for Aboriginal Health.

different services. These features when taken together – the co-location of complementary services and the integrating role of the family support services worker – make the Early Years Services model at MDAS unique.

The multi-dimensional integration of Early Years Services breaks down the silo approaches of traditional service delivery and provides instead a genuine holistic approach to service delivery. It has drawn praise from both clients and stakeholders. This model is considered a highly promising approach that warrants further investigation and is likely to warrant replication.

There are also specific elements of the MDAS model that constitute promising approaches.

**Theory base** The evolution of the Early Years model over the past four years has been based on input from the Queen Elizabeth Centre, Royal Children’s Hospital and Royal Women’s Hospital. These agencies have helped Early Years Services develop a strong connection to theory including attachment theory, trauma informed care and Newborn Behavioral Observation. The direct relationship between these bodies of theory and the practice of Early Years staff has given the multi layered Early Years model an evidence base from which it provides a range of related services. It is has given clients, staff and stakeholders a high level of confidence in these services.

**The Lead Practitioner role - supporting theory**

**into practice**

The Early Years Services are supported by a Lead Practitioner, who is a qualified psychologist with over 15 years of behavioural and therapeutic work with vulnerable populations, working specifically with trauma recovery and applied behavioural analysis across the life span. The Lead Practitioner supports trauma-informed and attachment- focused practice across the Early Years Services, including through training and practice advice to staff.

**Theory into practice - Intensive training, reflective practice and**

**modelling**

The theory base for Early Years has been translated into training programs and procedural guidelines for all staff. The Lead Practitioner provides intensive training, facilitates reflective practice supervision and modeling for staff. This element of the Early Years model is praised by staff and appears to be highly effective.

**Use of groups** The extensive use of Family Capacity Building Groups is a key feature of the Early Years model. The groups include therapeutic groups (Circle of Security and Collaborative Therapy) as well as playgroups. All groups are designed to teach clients by using expert leaders, peer leaders and peer support. Based on client interviews and interviews with staff it is evident that the extent and manner in which groups are used to complement family support services is a major contributor to the outcomes achieved by Early Years.

‘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

# Key findings

This section of the report presents the key findings from the evaluation of seven Aboriginal health case management and care coordination models in Victoria. These relate to staffing of the various model and the role of the practitioner, clients’ experiences of case management and practice-related findings. The impacts of the case manager or case coordinator role within organisations and on the local service system are also discussed. Finally, there are findings in relation to data collection.

This section commences with a discussion on findings relating to the distinctive elements of care coordination in Aboriginal health and why care coordination fits as a promising approach within this context.

#### Care coordination / case management findings

The distinctive elements of care coordination and case management in Aboriginal health

Clients requiring coordinated care by definition have higher care needs, and need support to coordinate their access to a range of services and health professionals. These needs are elevated for someone who requires an even greater level of individual support, or case management. Some elements that distinguish the care coordinator role in Aboriginal health from that of the broader health care system include:

* the need to understand the concepts in Aboriginal health and role of connections to culture, community, family, Country, kinship and spirituality in determining health and wellbeing
* the need to understand the enduring impacts of trauma and inter-generational trauma in the community and on individuals
* the need for all elements of health practice to be informed by these concepts
* working with subsets of the client target group who have highly complex needs that span multiple medical and psychosocial domains, frequently with co-presentation of trauma and impacts of trauma
* levels of psychological distress in the community that are double the rate of the non- Aboriginal population23
* the coalescence of a combination of past and present discriminative practices which

deter Aboriginal and Torres Strait Islander peoples from engaging with care24

* evidence that mistrust of mainstream services is a primary reason for delaying or not seeking care.25

Care coordination as a promising approach in Aboriginal health

In a broad sense, care coordination can be seen as a promising approach in Aboriginal health. Whilst care coordination is not new, there is a growing appreciation that the approach fits well with the medical, psychosocial and cultural needs of Aboriginal clients, and this mitigates against many of the causes for Aboriginal clients’ disengagement with health services.

The health disparity The disparities in health and life expectancy of Aboriginal and Torres Strait Islander peoples compared to non-Indigenous Australians are well documented.26 While Victorian data is not available on life expectancy, what is known is that:

* + Leading causes of death among Indigenous persons include circulatory diseases, neoplasms (cancer), injury, poisoning and external causes, diabetes and respiratory diseases. There remains a gap in mortality rates in each of the leading causes between Indigenous and non-Indigenous Australians according to the National Mortality Database (NMD), 2008-2012.

1. Department of Health and Human Services (n.d.) Koolin Balit infographic
2. Askew, D. et al (2016) Investigating the feasibility, acceptability and appropriateness of outreach case management in an urban Aboriginal and Torres Strait Islander primary health care service: a mixed methods exploratory study. *BMC Health Services Research*, 16(178)
3. ibid
4. ibid
   * Hospitalisations for Indigenous Australians continue to be higher than for non- Indigenous based on data from the National Hospital Morbidity Database (NHMD) in 2011-13. Reasons for hospitalisation are associated with dialysis for diabetes and end-stage renal disease followed by injury, poisoning and external causes, childbirth and pregnancy and respiratory and digestive system diseases.
   * Diabetes is more prevalent among the Indigenous population than the non- Indigenous. Mortality rates due to diabetes were 6 times higher among Indigenous Australians compared with non-Indigenous based on data from the NMD.
   * In 2012-13, 44% of Indigenous Australians aged 18 and over in non-remote areas of

Victoria had a disability or long-term health condition.

* + Low birthweight is twice as common among babies of Indigenous mothers as among babies of non-Indigenous mothers residing in Victoria, however the gap is has decreased from 2000 to 2011.27

Reasons for clients disengaging with health services

Sustained engagement with health services by Aboriginal and Torres Strait Islander people is often far less than what would be expected, given the burden that chronic disease imposes on the community. The Kanyini Qualitative Study (KQS), designed to explore barriers to and enablers of quality chronic disease care, found that:

* Experiences of racism, discrimination and distrust often resulted in patients disengaging from healthcare services altogether.
* Disengagement was also influenced by cultural differences, lack of culturally appropriate care, different constructs of health and illness, dislocation from family and country, cultural obligations, miscommunications and feelings of disempowerment.
* Having to wait for care discouraged engagement when it was perceived by participants as indicators of system indifference to their needs, wants and expectations.
* Adhering to chronic disease regimens and treatments was challenging and overwhelming.
* Patients were often dealing with competing demands of family and community,

and/or under financial duress.28

Aboriginal concepts of health

The Koolin Balit investment and its associated evaluation plan is underpinned by Aboriginal and Torres Strait Islander concepts of health and wellbeing which are broader, and less individualistic than non-Indigenous concepts. They recognise cultural differences and acknowledge the impacts of historical and social determinants on wellbeing, including the importance of employment, housing and education. Health is ‘not just the physical well being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.’29

Care that privileges Aboriginal concepts of health and health care needs

Consistent with Aboriginal and Torres Strait Islander holistic and collective understanding of health, an individual’s health status is inextricably linked to the health status of their whole community. Thus, reductionist compartmentalised and individualised biomedical approaches to addressing health disparities often have significant limitations.30

1. Australian Health Ministers’ Advisory Council, (2015). Aboriginal and Torres Strait Islander Health Performance Framework: 2014 Report. AHMAC: Canberra
2. Askew, D. et al., (2014). op cit
3. Department of Health, (2015). *Care Coordination*. Retrieved 16th August from www2.health.vic.gov.au/hospitals-and-health-services/patient- care/rehabilitation-complex-care/health-independence-program/care-coordination
4. Askew, D… et al., (2016). op cit

A recent study calls for ‘models of care that simultaneously deliver evidence based, best practice care and privilege Aboriginal and Torres Strait Islander peoples’ understanding of health and health care needs.’31

Outreach case management, which facilitates multidisciplinary care for individuals in their home or other settings away from traditional health care facilities, is proposed as a promising approach, which can ‘exploit the strengths of biomedical science in a culturally appropriate manner.’ As case management offers ‘a holistic approach to health care which recognises the interconnectedness of psychosocial factors and physical and mental health, (this) conceptualisation and operationalisation of health care appears more closely aligned to Aboriginal and Torres Strait Islander peoples’ understanding of health than many other conventional approaches.’32

Supporting this is the KQS finding that ‘healthcare practitioners’ investment in the *process* of engagement impacted on *outcomes* of engagement (for Aboriginal and Torres Strait Islander patients)’.33 Practitioners’ communication skills, as well as their ability to establish trusting relationships and maintain connections with patients over time were associated with sustained engagement. Further enablers of the process of engagement included the healthcare practitioners’ flexibility and perseverance in maintaining a connection, and approach to care encounters as opportunities to help support behaviour change. Critically, engagement is enabled when the care relationship is culturally informed and respectful, and demonstrates an understanding of the holistic Aboriginal and Torres Strait Islander concepts of health, including the role of family, kinship, culture, cultural obligations, community, country and spirituality in contributing to healthcare.

Care coordination and case management fundamentally reorients the relationship between the client and a health service *from* a relationship with an institution *to* a relationship with a known, and identifiable, healthcare professional. The care coordinator can assist and support the client in their engagement with clinicians within the health service and with external services. The model of care is person-centred, and the support for engagement is not solely with one service, but across the service system, which is of particular importance for people with chronic diseases as people living with multi-morbidities and complex social care needs frequently experience fragmented care. For Aboriginal and Torres Strait Islander peoples, the deleterious effects of this fragmentation are compounded by the institutional racism they so frequently experience in the health care system.34

#### Staff related findings

The role of the care coordinator in Aboriginal health

The role of the case manager or care coordinator in Aboriginal health is critical in engaging with the client and sustaining a relationship with the client, building trust on a one to one basis, and often facilitating trust-building with multiple service providers and health practitioners. The development of these relationships must start with knowledge of the community, the health issues in the community and definitions and understandings of health.

The Aboriginal health case worker requires not only the cultural competencies and interpersonal skills to engage with the client, and often family members and the community, they also require the skills and knowledge to access and negotiate a broad range of services and service systems. Client needs can span the acute and community health sectors, alcohol and other drugs, housing, family violence, family services, justice, and so on. The case worker or care coordinator requires a fundamental understanding of these services and service systems to provide initial assistance to

1. Ibid
2. Askew, D. et al (2016). op cit 33 Askew, D. et al (2014). op cit 34 Askew, D. et al (2016). op cit

clients. Those providing more intense levels of assistance require the skills to successfully navigate, refer, consult and co-coordinate across these sectors. An interaction with these sectors is often not a straightforward or simple referral. Often the care coordinator will need to advocate strongly for the client, when the issues are complex and multi-faceted, and additional services or supports are required.

The need for appropriate mechanisms for staff support

Themes raised in relation to the nature of care coordination and case management work include the personal and professional challenges of supporting people with complex needs, magnified when the needs are particularly intense, the relationship is intense and/or clients need to be supported over long periods of time. As the majority of job roles are part-time, most staff raised the issue of simply not having enough time to meet all the demands of the role.

The issue of vicarious trauma is raised in the literature and was raised by stakeholders. Staff can be required to support clients through highly challenging events, and can be exposed to highly challenging situations. The work was often described by staff as ‘*tough, very tough’*. The impacts can be more pronounced for Aboriginal staff. As community members, they are more deeply affected by trauma affecting the community and at times, they can be dealing with tough situations that are affecting people they know, friends or their family members.

Given the demands of the roles, it is essential that staff are provided with professional support appropriate to their needs. Support to staff involved in the evaluation was provided in various ways - through the supports of the team and a supportive manager, through reflective practices with their team or supervisor or through accessing professional supervision. Peer support was strong for those working in team-based structures, and the MDAS Family Services team has a strong focus on team training. But some staff work in isolated roles, are professionally isolated or are culturally isolated. Staff require support that spans their professional focus, their own mental health and wellbeing and capacity to cope, and their need for cultural support. The needs in terms of cultural support vary in relation to the staff member, the organisation employing them and their position within the organisation. Having the opportunity, or the choice, for cultural support, debriefing and mentoring is important for Aboriginal staff in hospitals. Staff in identified Aboriginal positions in hospitals may comprise less than 1% of the organisation’s workforce. The opportunity to seek cultural support, either within the organisation or outside the organisation, is an important choice to be made available. Similarly non-Indigenous staff may wish to access cultural mentoring to support them in their roles. This was found in one project, with the staff member accessing professional supervision through the Indigenous Psychologists Association. Whilst not all staff raised the need for professional supervision, having a supportive workplace, which would enable leave to be taken, for example, following a critical incident, was appreciated.

Connections to professional frameworks and standards of case management practice

Connections to frameworks and standards of case management practice were found to be supportive and assist in supporting the staff member’s resilience and capacity to sustain themselves in their roles. These roles included registered nurses with specialties in chronic disease, mental health and midwifery (Chronic Disease Prevention and Management Program, Integrated Koori Services, Aboriginal Health Care Coordinator, Early Years Service) and psychologists, with particular expertise in case management, work with vulnerable populations, trauma recovery and applied behavioural analysis (Fresh Tracks, Early Years Service). The AHTOs, the Integrated Koori Services Care Coordinator and the Aboriginal Health Care Coordinator are closely linked to case management teams and support through the location of their positions within their respective hospitals. Across the projects with team structures, there was strong support for informal mentoring, and professional and cultural skills transfer.

The role and impact of the Aboriginal health practitioner within a hospital setting

The role of the Aboriginal staff member employed in a hospital has benefits and challenges. The research is clear that the presence of an Aboriginal staff member makes ‘*a significant difference to the nature of the relationships created within a healthcare service’.*35 The experiences of the AHTO project reinforce this. Clients reported that just having someone they can ‘relate to culturally’ makes a huge difference to their experience in hospital. One woman who had been in hospital many times previously, before the AHTO, found that ‘*Now she's here it makes a big difference. It can be very confronting, waiting to go into theatre. She visits me in hospital when I’m there. It’s lonely, and it’s scary. She cheers me up, has a laugh - gets your mind off things.’* Staff report that Aboriginal clients ‘*open up more to an Aboriginal staff member.’*

The AHTOs and the Aboriginal Care Coordinator not only support the client to engage with the hospital, they provide a link between the community and the hospital.

Whilst the AHTO staff are all part-time, and provide a brief intervention for clients, a number of examples were provided demonstrating the impact the position can have on practice. For example, following an informal staff training session presented by an AHTO and a Community Outreach Worker to ED staff which focused on ‘having a yarn and sharing personal life stories’, one of the nurses participating remarked that ‘*Now I understand why I shouldn’t say ‘I’ll just take your baby (over here for a procedure)’.* Colleagues of the AHTOs and the Aboriginal Care Coordinator in allied health departments and ED noted the importance of the secondary cultural consultations they were able to provide.

A number of examples were provided that demonstrated the significance of the AHTO role, for example, in identifying family violence issues and linking the client to support. In another example, when an AHTO could not make contact with a client she was concerned about, she contacted the local ACCHO to undertake a welfare check, which they did. The client was found to be very unwell and his mobile phone was disconnected. It was found that the client had been taking his medication incorrectly, and with medical intervention, he was monitored, instructed on his medication and provided with a new mobile phone.

Whilst all staff working within hospitals were positive, they acknowledged that the scope of the role is large, and they have to meet expectations from the community, as well as within the organisation. They constantly wear an advocacy hat, monitoring whether practices are friendly or alienating. Most job roles expect that through the position there is a contribution to system and culture change, however, expectations need to be attuned to the total representation of Aboriginal staff in the workforce, their place in the organisational hierarchy and the part-time nature of most positions.

#### Client experiences of case management and care coordination

Client feedback gathered through the evaluation supports research findings that:

For many community participants, the relationship between the patient and their healthcare provider was critical to determining whether they sought care. Strong relationships with healthcare staff were considered to be a fundamental factor in a community member’s decision to engage with a healthcare service.36

Whilst the structure and orientation of the projects influenced the nature of the relationship between practitioners and clients (eg. long-term or brief, with an individual or a team, and whether it was clinical, therapeutic or focused on facilitating the transition to care), across all projects clients valued:

1. Askew et al (n.d.) *To your door* p.8
2. Askew, D. et al. (2016). op cit
   * being acknowledged as a person first and client second
   * genuine caring and friendly interactions
   * polite and respectful interactions
   * the help and offers of assistance received
   * having someone explain their options to them
   * having the opportunity to clarify and check on medical information.

The 40 clients across the various projects who contributed feedback were asked to rate the helpfulness of the key staff member. All staff were rated between 8-10, with an average of around 9.6. A number of clients wanted to rate the service ‘11’. Whilst not statistically significant and likely subject to response bias, the results serve as a proxy indicator to demonstrate the perceived helpfulness of the care coordination or case management, and the value placed on this.

The critical characteristics of extended care-relationships were clearly expounded by clients to included trust, confidentiality, reliability, professionalism and persistence.

Trust building Direct therapeutic benefits have been shown to result from the building of a trusting relationship between patients and providers.37

Trust (or lack of trust) is repeatedly raised in the literature as a critical factor in the engagement (or not) between a client and health service, particularly in Aboriginal health. From the clients’ perspective, trust was built if the staff member told them what they could (and could not) do for them, and if this was reliably followed through. The expression *‘Say what you do, and do what you say’* was heard multiple times, from clients and from staff. Even if the client was rung to be told that no progress had yet occurred, this was appreciated as it was understood the staff member was making efforts on their behalf. The more times the staff member demonstrated to the client that they would follow through on their commitments, the more the sense of trust built. Staff also agreed that demonstrating their reliability to clients was key to building their trust, and acknowledged that trust needed to be earned.

Trust was also related to a combination of other factors - maintaining privacy and confidentiality was fundamental. Perceiving that the staff member genuinely cared for them, often by going above and beyond, which could range from getting them a cup of tea in the ED to taking their call or coming to visit them on their day off. Often too, staff reported the importance of ‘sharing something of themselves’ with the client, in order to establish the relationship and to build trust.

The persistence of the care coordinator & impacts on client motivation

Clients from all projects provided examples of the staff member’s persistence in motivating them to take action on their health and wellbeing. They often related that without the intervention of the care coordinator, they wouldn’t have taken action themselves ‘until they had to’. This is consistent with reports in other studies of community participants describing ‘how they often waited until signs of illness were evident before they sought care.’38 Sometimes this was described, affectionately, as nagging by the care coordinator, but the clients who provided these stories all appreciated the support and recognised the difference made to their health. AHTOs reported that when making follow up calls to people who have left ED, they don’t just ask whether the person has their prescription, they will *‘ask the next question – When will you get it filled? Do you need any help with that?’*

Clients reported a number of ways that staff ‘didn’t give up on them’ and how their persistence motivated them:

Her help made a big difference. I wouldn't have known half the stuff. I probably would have put up with the pain or got painkillers.

1. Askew, D. et al (2014) op cit
2. Askew, D. et al. (n.d.) op cit

My worker has encouraged me to do other things than just play games at home. She wants me to socialise and is trying to build my confidence. We talk a lot and it helps sort out my mind.

About 4 years ago I was only coming in for checks every couple of months. Without the nurse, I would have had to rely on the GP, I wouldn’t have sought treatment till I needed immediate help. I only got the spot checked because [the Chronic Disease Nurse] nagged me. I probably would have had skin cancer without her.

Positive & encouraging approach

Clients in regular contact with practitioners appreciated being encouraged to actively participate in their health care management, and helping them to stay positive or remain positive, often in the face of other demands and issues. With the establishment of a positive and trusting relationship, clients stated that they were happy to receive reminders and advice and to actively participate in their health management. They appreciated that clinicians would leave the door open for them to return. From the ‘right’ practitioner who was trusted to have, their best interests at heart, clients appreciated a practitioner ‘laying it on the line.’ One client, for example, who had been homeless, reported that the care coordinator took him out for a cup of tea and told him ‘You’re better than this’. With trust and support, the client has moved to supported accommodation, entered into rehabilitation and has eventually moved from Melbourne, but maintains phone contact with the care coordinator. Another client who had a serious diagnosis reported that he really did not want to act on it, but the care coordinator ‘sat him down and explained what it meant in his terms’. Without treatment, the implications would have been life threatening, but with support the young man sought treatment. He is now a healthy young parent, and reports being highly motivated to maintain his good health.

Listening to the client & allowing time for stories to be told

Clients and staff emphasised the importance of listening to the client’s story and allowing time for this. Clients felt acknowledged through this process. Care coordinators reported how important the listening process was – as a sign of respect initially, but also in order to listen ‘between the spaces’ to identify other, deeper issues, relevant to the person’s health and wellbeing. Often the presenting issue was only one part of a larger mosaic of issues, with issues of family or personal trauma emerging over time as trust in the practitioner developed.

Culturally informed care relationships

Feedback from staff and clients highlighted that when care relationships are culturally- informed and not only understand, but address the barriers Aboriginal people have experienced in accessing services either directly or vicariously, clients are more likely to engage or re-engage with health services and medical treatments.

‘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 and Torres Strait Islander peoples with chronic disease.’39

#### Practice-related findings

Culturally integrated practice The unifying theme for all projects, irrespective of the length of client engagement, was the critical nature of culturally informed and respectful case practice. As well as practitioners having a strong knowledge of Aboriginal health and appropriate health practices, most talked about particular ways in which clients were engaged. The practice of deep and respectful listening was particularly important to assessing client needs and engaging with the client. It was also an area of practice, the literature confirms, which can lead to the client’s long-term disengagement from services, if handled inappropriately. The AHTOs reported often passing information gathered from patients to ED staff, with ED staff wondering ‘*How did you find that out?*’ and AHTOs

1. Askew, D. et al. (2016) op cit

responding that they simply ‘talked to the person’ – but meant that they had really engaged with the person/family and shown genuine care and interest, rather than simply a formal, clinical interaction. The Early Years Service and the Close the Gap project consider the family as the ‘client’, but all projects reported including and supporting family needs along with those of an individual client if and when appropriate (ie. driven by the client’s wishes to involve their family).

The projects using outreach approaches (Fresh Tracks, Integrated Koori Services, Close the Gap and the Aboriginal Health Care Coordinator) also discussed the importance of meeting with the client in a setting that provides them with comfort and security. Building this engagement with the client creates a level of trust in the service, which over time, can be transferred to other health services.

An important practice component of the Fresh Tracks work is engaging with clients at Wathaurong’s Indigenous Protected Area called Wurdi Youang. This site is about 15 minutes away from the Wathaurong site, and is an area of particular cultural significance. The coordinator can consult clients, individually or in groups, on the site, and issues around connections to Country and culture are directly and naturally integrated in the counseling and support.

Clients of the Close the Gap project can meet with an Elders group each fortnight, which provides a simple way to maintain and strengthen family, community and cultural connections. While the AHTOs only have brief contact with the client, examples were provided of referring people who had lost community connections to community organisations and community Elders.

The work of the MDAS Family Services involves a range of individual, family and group support options, aimed to involve and engage families and their children from birth to school entry age. This long-term support aims to move with parents and children through the critical early years of development, and bonding. Individuals and families can receive case support during this time, some of which may be received on-site, or through a caseworker attending at the home.

Trauma-informed practice Projects with longer-term engagements with clients particularly raised the importance of knowledge and skills in trauma-informed practice. The MDAS Family Services project focus on this area of practice and all team members receive training in trauma-informed care. Clients with complex needs engaging with Fresh Tracks often presented with experience of trauma or post-traumatic stress disorder. As a psychologist, the Coordinator is professionally qualified to provide the appropriate care, and referrals for these clients. The Aboriginal Health Care Coordinator at St Vincent’s Hospital is mental health nurse, and able to support clients with mental health needs, and connect them to appropriate services. Irrespective of the length of engagement with the client, an understanding of the levels of trauma in the community is essential for any practitioner working in Aboriginal health. Not all staff received training in this area of practice, but could connect clients to practitioners with the organisation or service network, and also drew on their community experience. Provision of this training would be an enhancement for staff involved in the various care coordination roles.

Care coordination which privileges Aboriginal concepts of health

The projects evaluated worked with specific client groups (eg. people with chronic conditions) and/or focused on points of engagement with the health system where Aboriginal clients are vulnerable to being lost to follow up (eg. ED presentations, post- admission) and/or focused on critical life stages (eg. conception, birth, early years). These client groups, service system entry points and life stages are points where existing models of care alone have not demonstrated significant change in addressing health disparities. The evaluation found that common to the various care coordination models, practice was characterised by an approach that privileged Aboriginal concepts of health, was culturally-informed, was holistic, recognised the interconnection of psychosocial factors and physical and mental health and was relational.

#### Organisational findings

Findings relating to hospitals The focus of the evaluation was on care coordination approaches, rather than organisational practices, however organisational matters that were raised in relation to this work within hospitals and should be noted include:

* + that trust built with the client through the care facilitator or coordinator can transfer to trust in the health service
  + the importance of hospitals ensuring the cultural safety of Aboriginal clients
  + the challenge of changing hospital cultures, given the size of the organisations and the turnover of staff, and expectations on one or two Aboriginal staff contributing to this
  + acknowledgement of leadership support, policy and practice improvements and supportive staff in hospitals, however, a lack of consistent practice was reported throughout hospitals, with examples of ill informed or inappropriate practice still evident.

With the AHTO role in particular, the need was raised for this type of support in ED to be provided after-hours – at night, and particularly on weekends, when a higher proportion of Aboriginal people present. There were also recommendations for the engagement of male and female staff in care facilitation or coordination roles in hospitals, in order to better meet the cultural needs of male and female clients.

Fragility of project structures and funding

A number of projects were based on one or two key roles. The Fresh Tracks project is an example. While the individual staff were often the project’s strength, structures built on one role are fragile and disruptions, such as staff turnover, can have profound impacts. The Close the Gap project and the Integrated Koori Services project experienced changes and interruptions to funding, which impacted on the project’s continuity. Staff in the Aboriginal Health Transition Officers, the Aboriginal Health Care Coordinator and the Integrated Koori Services project work within teams, however, because the client work and community relationships are significantly based on the work of key individuals, any staff turnover would also have a significant impact.

The Early Years Service is staffed by a large team, and the focus on training and skills transfer provides some insurance against staff turnover, however turnover in senior roles would likely impact on the work.

Findings relating to ACCHOs ACCHOs reported issues such as:

* + lack of time and resources to fully engage with all clients in the case management project, and/or to engage to the depth that some clients require
  + sole staff members or small staff teams supporting clients with a wide range of

issues

* + concerns about funding, or changes to funding, or dealing with multiple funders
  + concerns about time and effort required to report on funding expenditure.

Multiple positive benefits were found through the care coordinator role located within an ACCHO. In addition to the specific support provided to the client, the care coordinator frequently played an important role in keeping the client engaged with other services and programs provided by the ACCHO. For example, clients who may be waiting for housing services or drug and alcohol counseling, could be kept engaged and monitored through their engagement with the care coordinator. As the ACCHOs involved in the evaluation provided a range of health and wellbeing services, the care coordinator role was able to coordinate these internal services for the client, and the client was able to receive wrap-around and holistic services.

#### Service system findings

Partnerships & networks The nature and extent of networks and partnerships was found to be influenced by the type of agency undertaking the case management, geographic location of the agency, the nature of the local service system, and the nature of services required by the client.

The projects located in hospitals required relationships with their local Aboriginal health service providers and community-controlled organisations. For example, St Vincent’s has established relationships with a range of relevant ACCHOs such as the Victorian Aboriginal Health Service (VAHS) and the Aboriginal Community Elders Services (ACES). However, as major metropolitan hospitals both St Vincent’s and Monash Health may need to respond to clients who have come from any region across Victoria. The regional health services have well-established relationships with local (or closest) ACCHOs but also require networks with specialist, often metropolitan-based, services.

The relationships ACCHOs are required to establish are also similarly determined by the make up of the local service network. Wathaurong Aboriginal Co-operative has entered into a memorandum of understanding (MOU) with Barwon Health, and SVHM and VAHS have an existing MOU.

Relationships required beyond the health sector

Neither cultural competence nor primary health expertise alone is sufficient to meet the needs of all clients in Aboriginal health. Referral relationships are required between Aboriginal and non-Aboriginal staff, and ACCHOs and mainstream organisations in order to deliver the best quality of services to clients. All projects reported the need for a wide network of relationships outside the health sector with, for example, housing, education, family violence, justice, legal services, child protection, family services, Centrelink and the National Disability Insurance Scheme. Sometimes, but not always, these relationships existed between organisations. However, a care coordinator supporting clients with needs across these organisations and sectors, required the skills to establish these contacts and referral relationships. As sectors outside of health may also be case managing a client, for example, family violence, housing or justice, the care coordinator also requires the capacity to jointly manage a client’s care with case managers from these sectors.

The contribution of the care coordinator role to the functioning of the service system

The care coordinator is often a key contact for external staff also providing care or services for the client. The evaluation found many examples of the care coordinator introducing and connecting external and internal staff, thus strengthening informal networks, professional relationships and functioning of the local service system for the benefit of Aboriginal clients.

A further important component of the care coordinator’s connections with external agencies is providing secondary consultations around the work with individual Aboriginal clients and sometimes with community members more generally, thus contributing to more culturally-informed delivery of services across the service system.

In some cases, the evaluation found that external service providers were not confident that they knew or understood the work of the ACCHO or of the care coordinator. This may have been related to staff turnover issues (at either organisation).

Connections with other institutions

Some ACCHOs have developed strong relationships with external organisations to assist their work. The MDAS Family Services team has long-standing relationships with the Queen Elizabeth Centre, the Royal Children’s Hospital and the Royal Women’s Hospital. This strengthens the theoretical and evidence-base of the Family Services work, with focuses on work around attachment theory, trauma-informed care and Newborn Behavioural Observation. Fresh Tracks has also connected with Melbourne University in evaluating the work conducted on Country, in particular men’s behavior change programs.

#### Evidence and data findings

Data Maintaining client data was an issue for a number of projects, though all had some basic monitoring data. The evaluation found that data collection could be improved for most projects and that currently projects either lacked the time or the knowledge to collate and analyse the data. Where possible, the evaluation has assisted with data analysis and has been able to identify significant and positive findings for projects, demonstrating the impact of their work.

Collection of client data could be further improved, in relation to client demographics, intensity of service, client satisfaction and client outcomes. Qualitative as well as quantitative data is useful for capturing some of the complexity of the care coordination work, and also the sometimes profound affects of care that has been well facilitated, coordinated or managed.

Process indicators and measurements

A disconnect was sometimes found between the data collected, the information and indicators that were meaningful to the project, the data that the agency collected on internal client databases, and time and resources available to input data.

There are few process indicators set or data collected to demonstrate the work of the care coordinator or case manager in establishing relationships with clients, families, internal and external referrers, local and regional networks and health and other service systems. The relational aspects of the care coordination and case management are also highly significant in contributing to the success of this work in Aboriginal health, but are often reported as part of the work that is overlooked. This could include, at simplest, the number and frequency of client contacts, over time.

More focus is required to refine the progress reporting of all projects, and ensure that effort is invested in collecting data that is meaningful, useful to both the service provider and the DHHS, and contributes to creating useful databases, that can, over time, show the impacts of the project work. It would be useful for DHHS and the projects to work together on reviewing the data collection and reporting processes, especially with the evaluation report available to highlight the impacts of the projects, and to co-design updated reporting templates.

# Replication

The evaluation was required to consider and report on how successful approaches to case management and care coordination could be replicated in other communities. This section provides an overview of how the seven case management and care coordination projects were implemented and their potential for replication.

The general issues are discussed first, noting the importance of context and community involvement in terms of replicating any of the case management and care coordination models. Further, working from the experience of the projects, some guidance is provided on steps to consider as part of the project development cycle.

#### General principles

Avoid a template approach

& design to suit client needs

& local context

The experience of all projects, reinforced in the literature40, is that a ‘template’ approach is not advised – a project ‘model’ cannot simply be lifted and applied in another setting. There are multiple reasons for this. Firstly, the projects need to be designed around the needs of the target group. Further, care coordination and case management necessarily involves the development of close working relationships between the health professionals engaged in the client’s care. The design of new projects utilising a care coordination or case management approach therefore needs to respond to the context of the services provided by the host organisation and those provided in the local service system, and the needs of the client target group.

Community involvement The projects examined in the evaluation included one group located in ACCHOs (BADAC, Gunditjmara, Wathaurong and MDAS) and another group located in hospitals (Albury-Wodonga Health, Goulburn Valley Health, Northeast Health Wangaratta, Seymour Health, Monash Health and St Vincent’s Hospital, Melbourne).

The group of ACCHO-based projects are clearly community driven and owned approaches to priorities determined by the community. Of the hospital-based group of projects, one project (the Client Journey Project) evolved from a regional planning process undertaken jointly between the DHHS, regional representatives of the Aboriginal community and local ACCHOs, and regional representatives of health and community services. The two other hospital-based projects emerged as a result of each of the hospitals identifying internally the need to focus on better supporting Aboriginal clients at the acute/community health interface. These projects are not community- driven, but both acknowledge the need to involve and work with the local community, through close relationships with local ACCHOs.

#### Project development cycle

Whilst recommending against a template approach, broad lessons can be identified from the evaluation across the project development cycle of preparation and planning, implementation and sustaining the work of the project.

Preparation and planning The preparation and planning required to implement a new care coordination or case management should include the establishment of a ‘fit for purpose’ management process – a small, contained project could be driven by a sole manager, but projects with a wider or more complex focus may require the establishment of a committee or working group. It is important that there is accountability to progress the work, which otherwise become subsumed in the day-to-day pressures of health service delivery.

1. Wunan Foundation, (2015). *Empowered Communities: Empowered Peoples Design Report*. The Wunan Foundation: Sydney; Morley, S. (2015). *What works in effective Indigenous community-managed programs and organisations.* CFCA Paper No. 32. Australian Institute of Family Studies: Melbourne

Management support is essential to develop a new service or project. While the CEO/relevant senior managers may not be required to undertake the service development work, it is critical that they establish the ‘authorising environment’ for the work to proceed. They therefore need to be kept informed with developments.

Clear decisions are required about the focus of the project, the client group(s) and why/how care coordination or case management is the preferred approach. For example, because of one or more of the following conditions apply:

* + management of the health condition(s) requires the involvement of multiple services and disciplines
  + the complexity of managing the condition(s) has the potential to overwhelm the

client

* + psychosocial issues may compromise an individual’s capacity to access or coordinate treatment
  + the intervention and support of a caring and skilled professional can have a major impact on an individual’s health journey
  + coordination of care can increase the likelihood of a client maintaining specialist

treatment and medical regimen

* + transforming an individual’s health journey through care coordination or case management can have positive flow-on effects for family members
  + an intervention, however brief, can positively transform an Aboriginal person’s experience of a health service and/or can sustain an Aboriginal person’s involvement in self-management of their health.

The seven projects involved in the evaluation provide support at known pressure points at which Aboriginal people can disengage from health services (eg. due to complexity of the health condition, the addition of psychosocial issues, presentations at ED). A number of the projects had a broad focus (such as chronic disease and/or psychosocial issues), which allowed sufficient flexibility to include support for factors such as homelessness and alcohol and drug issues.

A life-stages approach is an alternative option for targeting support. The MDAS project focused directly on ‘Early Years’, as a key life stage and the pre-birth to pregnancy and parenting has been endorsed by the community as a key life stage. The community has also identified the points of transition from one life stage to the next, as times when special attention and integrated support is required, including transitioning from adolescence to adulthood, from school to work, in and out of institutional care and end of life.41

The experience of the seven projects is that the development of a new approach necessarily takes time, and may involve trial and error. It is important that a new project commences with assurance that it can evolve to fit needs, and even that small failures can be tolerated.

Relationships with external services are critical to the functioning of care coordination approaches, and therefore during project development there should be direct consultation with external agencies (and should cover the ACCHO sector, primary and acute health services as a minimum). Opportunities for partnerships, or participating on steering groups could be canvassed at this time if appropriate.

After the initial preparatory work, it is important to commence formally articulating the project or service. While this initial work may change as the project gains real-world experience, the project design should articulate elements such as: the aims of the project or service, the target group, eligibility criteria, key staff contacts and referral processes.

1. Department of Health (n.d.) *Aboriginal Health Wellbeing and Safety Strategic Plan: Thematic analysis of community consultation findings.* State of Victoria, Department of Health

Implementation The care coordinator is critical to the success of the role. If entering into a recruitment process, then knowledge of and capacity to work with Aboriginal concepts of health are essential. The position may also be an identified Aboriginal position. Other essential requirements include the personal and professional qualities relevant to case management and care coordination and knowledge of service networks relevant to clients. Clinical skills may also be a requirement.

Mainstream organisations should consult with local ACCHOs to promote a job vacancy and negotiate for a community representative to participate on the selection panel.

Remuneration for the job role should also be established at this point. Despite budget constraints, the remuneration level should be appropriate to the level of complexity required for the job role. Whilst financial challenges cannot be ignored, it is also important to recognise the complexity and personal challenges of care coordination and case management roles. If staff are recruited without the necessary professional and personal experience, the risks of staff burnout or turnover are increased, which may be more costly to the project than appropriately established rates of pay.

The demands of the position should be acknowledged through appropriate support processes. Staff require support through regular supervision, peer and team support, possibly through external professional supervision or through processes such as reflective practice sessions. The need for cultural mentoring, supervision or debriefing should be also addressed. The importance of this is heightened for Aboriginal staff working in mainstream organisations.

When the care coordination or case management project is ready to commence, it is important to promote the service both internally and externally. This should be done through direct contact (phone call or visit), and with written information about the project. If self-referrals from clients are to be accepted, then client friendly material should be developed and distributed at appropriate places.

Data should be collected from the commencement of the project. A minimum data set for a project providing services over medium to long-term time frames should include details of the client (age, gender, address), presenting issues, commencement with the project, client contacts and client exit. Client records may need to be kept in a separate system, but these should include progress towards achievement of goals. The project needs capacity to collate data to show outcomes of the total project cohort, aligned with the project’s goals.

Sustaining the case management project

Attention is not always focused on how to sustain the work of case management or care coordination projects. Addressing staff needs and providing the support and encouragement to sustain them in work, which can be intensive, and emotionally draining is critical to the success of the project. If a team is involved, it is important to celebrate the achievements of the project overall and individual successes.

When the project/service is well established, the focus should turn to monitoring and reviewing progress. The project goals and intended outcomes should provide the guide to this process. Data should be analysed to identify whether the target group is being reached, and whether the service to clients is achieving the desired outcomes. Referral partners (internal or external) should be consulted to check whether processes are working well from their perspective, and also to identify the changes and impacts they are seeing for clients. If there is a staff team, they should be consulted for their perspectives. It is important to build in time for this reflective process, so that staff have a clear sense of what the work is achieving and also to identify any changes or improvements which could be made to the project.

It is also essential that there is capacity to refine and recalibrate the project if any problems are identified.

At an appropriate point, if and when promising approaches are emerging, the work could be promoted and shared in public presentations. Sometimes it is useful if this starts with presentations to internal staff groups, and then the information is taken out to external forums. This is important if the project is working in new ways or with new groups of people, and has information to share about promising approaches.

#### Implementation experience

The following overview of the implementation experiences of the various projects illustrates the depth of work involved in planning and implementing a project. The potential for replication is also outlined.

**Transition to care coordination**

The work relating to the Aboriginal Health Transition Officers in the North division dates back over a period of seven years, starting in 2009. The work has been governed by a region-wide steering committee, comprising representatives of regional ACCHOs, Aboriginal community organisations, community and public health services, the DHHS and others such as Primary Care Partnerships.

The work is only one element of a broader Client Journey Project, overseen by a working group of the steering committee. The project was preceded by preparatory research and trialling, undertaken over four years (2010-14), which included:

* research and investigation of appropriate models
* trialling of approaches
* developing resources for health services
* delivering cultural awareness training
* developing educational resources for hospital staff
* developing community resources
* delivering a community awareness campaign
* developing an implementation and evaluation plan.

During implementation, the project was supported by two Partnership Managers, each covering half of the geographic region. The AHTOs and the Partnership Managers met as a group every six months or so:

* to ensure consistency of approaches
* to identify issues which needed to be raised at the Working Group forum
* for cultural support.

Each health service continues to promote the role to the community through the hospital’s website, flyers and posters in the ED, AHTO uniform and through maintaining regular connections and relationships with local ACHHOs.

**Potential for replication**

The AHTO role can be replicated in other hospitals or adapted to work at other complex points in hospital systems such as outpatient clinics or attached to discharge planning. The role could also be adapted to support clients and families before a hospital admission, for example, preparing clients for what they can expect with an admission and procedure. However, the experience of the Client Journey Project, and the depth of planning and coordination should be noted. Implementation of an AHTO-type role requires explicit management support, and requires involvement and coordination across hospital departments, as well as coordination with local ACHHOs and community health services.

The essential elements include the recruitment of an Aboriginal staff member, strong executive and management support, strong linkages with AHLOs and with the allied health/community programs of the hospital and provision of appropriate cultural support for staff. The evaluation experience also indicated the need to provide support in the ED for Aboriginal clients outside of business hours, especially over weekends and at night.

**Internal service coordination**

The key implementation issues for this project included:

* promoting the role to all clinic staff, including visiting consultants and all health and wellbeing program staff
* integrating the role within the clinic’s existing team of specialist and generalist

nurses and Aboriginal health workers

* identifying additional opportunities afforded to the organisation through the role, such as providing mentoring and education for health workers, or the opportunity to take on special projects
* promoting the role to external service providers, ie. those making or receiving referrals, and establishing good working relationships, including providing the staff member the opportunity to visit service providers (or invite them to visit the ACCHO) to discuss the role, effective referral practices, pathways for clients, any other issues.

**Potential for replication**

This role could be implemented at an ACCHO with a medical clinic and could be adapted to other work with specific clinical issues and/or target groups, particularly those for whom regular contact with a supportive health professional could make a substantial difference to client motivation and compliance. Stakeholders recommended that this position works best in a larger medical clinic, where the role can both ease pressure on GPs, consultants and allied health, and complement and strengthen the work of other clinic health professionals.

**Care coordination between acute and community**

The key implementation issues for the care coordination projects operating between the acute and community sectors identified through the evaluation include:

* + allowing time for the implementation process
  + community involvement in the recruitment process, eg. through representative of the local ACCHO(s) in the recruitment process
  + recruiting a staff member(s) with appropriate community recognition and clinical skills
  + defining and negotiating how the role works with the hospital’s Aboriginal Health

Liaison Officers in order to provide the best service for clients and make the best use of specific hospital Aboriginal health resources

* + the need for senior management support and involvement to drive the process
  + defining and negotiating pathways from the hospital ED and discharge services to the care coordinator with and through appropriate managers
  + promoting the role and referral pathways to hospital staff, and providing training if

necessary (taking into account the rate of staff turnover, absences)

* + defining the extent of the care coordinator’s role with individual clients
  + incorporating an outreach approach, so that the care coordinator can meet with clients in an appropriate community setting
  + promoting the role and the staff member to local ACCHOs, community health services through direct visits in order to establish good relationships
  + promoting the role to the community and potential clients through introductory flyer if self-referrals are suitable

**Potential for replication**

Stakeholders believed that the model could be implemented in other hospitals, with attention paid to steps outlined above. Stakeholders supported locating this role with the hospital’s community programs providing care coordination services, such as the Health Independence Program, HARP or an allied health team. In addition to the logic of placing this position with these programs, it also allows for skills transfers and secondary consultations between the care coordinators in the community team.

**Care coordination and case management in the community**

The key implementation issues identified through the evaluation include:

* recruitment of suitably culturally competent and qualified staff
* community acceptance of the practitioner
* community ownership of the model
* the right networks, connections and working relationships across community and mainstream organisations
* negotiated internal and external referral pathways, and promotion of the referral

pathways

* case management and care coordination standards
* assertive outreach approach
* establishing program standards and performance indicators
* appropriate client database
* collection of baseline data
* establishing monitoring and review processes and refining the program design over time.

**Potential for replication**

Stakeholders strongly believed the model could be adapted and implemented in other ACCHOs and believed appropriate staff recruitment was critical to success. Caveats on this were the need for community ownership and adaptation, rather than transplanting a model from one community to another, and allowing time for the model to evolve.

**Layered service including case work and care coordination**

The MDAS Family Services model has developed over four years. It has grown from an earlier iteration of a service which provided support to women during pregnancy and to children and parents during the early years of childhood. This has evolved into a multi- layered service with a team of 21 staff, and a Lead Practitioner led by the Early Years Manager. The implementation experience has been guided by a strong focus on:

* the inter-relationship between internal maternity, maternal and child health and family support services
* connections with external expertise (Queen Elizabeth Centre, Royal Children’s

Hospital and Royal Women’s Hospital) and development of strong theory base for practice across the team

* establishing referral relationships and pathways with external agencies, including hospitals, GPs, council provided maternal and child health services, children’s services and Child First
* developing team skills, guided by the Lead Practitioner through a range of strategies including:
* development and delivery of a series of practice training modules
* development of resources including practice guidelines
* reflective supervision sessions
* modelling practice
* developing client intake and assessment processes
* allocating clients with a consistent, supportive Family Support worker to work with the family while they remain with Family Services
* the use of family capacity-building groups, including therapeutic groups and playgroups using peer leadership and peer support.

**Potential for replication**

Stakeholders believed that there was potential for replication of this model, however noting that the model itself is multi-layered, and sophisticated and has been built over four years. It also needs to fit within an ACCHO of an appropriate size and scale, providing or with capacity to provide a range of maternity, maternal and child health and family services. The model has been strongly supported by the Lead Practitioner role in terms of training, staff support and resource development. Strong partnerships are also required with external services across maternal health through to services to pre-school children.

# Contributions to the evidence base

Recent work in health services research and in particular research into refining services and service models for Aboriginal and Torres Strait Islander people has clarified and consolidated the balance between maintaining flexibility and understanding of different cultural models of health, and ensuring that services can make concrete changes to ensure cultural appropriateness and access.

This section provides an overview of particularly relevant seminal research to the care coordination and case management models evaluated in this project. It is intended that this section highlight the alignment between current practice and what could be referred to as ‘best practice’ research, while understanding that this definition is not static.

#### Aboriginal staff and care coordination in secondary, mainstream services, emergency departments

**Projects: Client Journey Project, Aboriginal Care Coordinator, Integrated Koori Services**

The presence of Aboriginal staff that fulfill a transition or liaison role within mainstream health services in Australia is supported by findings from both national and international research.

A review of 31 Australian42 publications investigating the care and experiences of Aboriginal and Torres Strait Islanders in Emergency Departments indicated that despite the fact that Aboriginal peoples on average are about twice as likely to visit an ED compared with non-Aboriginal Australians they are more likely that any other patient to choose to leave without first being assessed by a health professional. Authors of the review concluding that; ‘closer collaboration between ED staff and Indigenous hospital liaison staff, combined with regular monitoring of routinely-collected ED data, have the potential to improve Indigenous ED care and so contribute to improvements in Indigenous health.”(68). However review authors prefaced conclusions with concerns about the quality and consistency of data collection and monitoring, highlighting considerable variability in admission rates although there was general agreement that rates were highest in remote areas. Critically, review authors identified that there were some barriers that were more important than others, for instance cultural barriers (linguistic barriers, different constructs of ‘health) far outweighed financial barriers to accessing services.

“The most obvious strategy to improve and protect Indigenous patients’ access to the ED is through the availability of Aboriginal hospital liaison officers, who help support Indigenous patients and their families to overcome these social and cultural obstacles to their hospital care.” (73)

The Client Journey Project, the Aboriginal Health Care Coordinator and the Integrated Koori Services models of care facilitation and coordination illustrate the value of the position not only supporting the cultural appropriateness of mainstream services which Thomas & Anderson endorse, they go further to ensuring the transition from acute to community-based health services is seamless.

A multidisciplinary and multi- level approach to chronic care management in primary care

**Projects: Chronic Disease Prevention and Management, Aboriginal Care Coordinator, Fresh Tracks, Close the Gap**

A holistic, multidisciplinary and multi-level approach to care coordination has been employed in several care coordination and case management models evaluated. BADAC, SVHM and NRCH and Fresh Tracks all exhibit a clear alignment to this

1. Thomas, D. & Anderson, I. (2006). Use of emergency departments by Aboriginal and Torres Strait Islander people. *Emergency Medicine Australasia*, *18*, 68-76

approach to care coordination. Indeed the more brief models of care coordination including AHTOs also support this model. There has been much support for such a model to be employed in Aboriginal health, and the Social and Emotional Wellbeing Framework, was developed to inform service refinement.43

A particularly seminal piece of research demonstrating the value and indicative efficacy of holistic and multidisciplinary care coordination/management was the developmental evaluation of the Home-based Outreach case Management of chronic disease Exploratory (HOME) study. The study aimed to explore feasibility, acceptability and appropriateness of the model was conducted, and indicated high-levels of satisfaction among clients.44

In addition improvements in the management of diabetes and risk factors for other chronic diseases were evident, with a reduction in blood sugar45 systolic blood pressure and reductions in the rates of moderate to severe depression at six-month follow-up. Clients reported through interviews that because the case managers had worked with them in a culturally appropriate manner, they were able to develop a respectful relationship with them, they felt listened to, cared for and empowered. These findings echo that of the perspectives of clients in many of the evaluated case management and care coordination models including BADAC, Fresh Tracks, the Aboriginal Health Care Coordinator role at SVH and NRCH and Close the Gap at Gunditjmara.

#### Early intervention for improving long-term health

**Project: Early Years Services**

The final area of relevant research for the MDAS model of care coordination and case management is the value of intensive service provision in the early years of life. There is extensive research demonstrating the value and importance of intervention in the early years, and this is grounded in the theoretical perspective of the life course theory. That is that health is a cumulative concept, and that early health status influences long-term health.46 Studies have indicated that breastfeeding, general maternal and child nutrition, as well as interventions to support healthy neural and physical development during the first 1000 days of life are particularly important for long-term health.47 In addition, during the early stages of life, there are different and magnified risk factors for particular conditions, for instance maternal mental health is particularly sensitive (particularly for first-time mothers) in the immediate period following child birth.

The wrap-around service model is a service design that tends to be employed in maternal and child health and paediatric health services, which employs a holistic and multidisciplinary approach to care coordination, and enables flexible service provision based on the needs of children and families during a sensitive period of development.

The MDAS model reflects the principles of the wraparound process.48 This intensive model of service provision has been shown to be protective against long-term poor health, and poor educational outcomes attributable to developmental delay, probability of being in juvenile detention and the probability of having an unsupportive home learning environment.49

1. Centre for Research Excellence: Intervention Research in Chronic Disease, (n.d.). *A 'Wellbeing Framework' for Aboriginal and Torres Strait Islander Peoples Living with Chronic Disease.* Retrieved 23rd June 2016 from <http://www.kvc.org.au/wp-content/uploads/2015/02/Wellbeing-Framework-> printable-20150213-v1.pdf
2. Askew, D…et al. (2016)
3. HbA1c mean difference= -0.5, p= 0.05; systolic blood pressure mean difference = -13.0mmHg, p= < 0.001; moderate to severe depression 62% at baseline, 39% at 6 month follow-up.
4. Elder, G. Jr. (1998). The Life Course as Developmental Theory. *Child Development, 69*(1), 1-12
5. Maternal and Child Nutrition Study Group, (n.d.). Maternal and Child Nutrition: Executive Summary of The Lancet Maternal and Child Nutrition Series.

*The Lancet*. Retrieved 18th August from <http://thousanddays.org/tdays-content/uploads/Lancet-2013-Executive-summary.pdf>

1. Suter, J. & Bruns, E. (2009). Effectiveness of the Wraparound Process for Children with Emotional and Behavioural Disorders: A Meta-Analysis. Clinical

*Child Family Psychology Review, 12,* 336-351

1. Effect sizes ranged from small to moderate (ES= 0.05 – 0.68).

# Conclusions and opportunities for the future

The task for the evaluation was to examine approaches to care coordination and case management that show promise and potential for replication in other communities through investigating seven projects in different locations and different settings. This section of the report provides the conclusions to this investigation.

The evaluation employed a case study approach, which involved approximately four visits to each of the seven sites, consultations with 168 stakeholders including 40 clients and multiple contacts with program staff over a period of twelve months, allowing strong relationships to develop and a deep understanding of the work of the projects. The initial task for the evaluation was to understand the focus of the projects, and the distinctions between the work. It was evident from the early stages that some projects were not technically care coordination or case management projects, based on traditional definitions. Over time however, common underlying approaches emerged, and the projects have been considered along a continuum of care coordination, ranging from brief and intermittent interactions, to relationships with clients, which were deep, multi-faceted and extended over several years.

Most significant, and common to all projects was the focus on the relationship between a client and a practitioner. In all cases, these relationships were approached from a position of respect and encouragement, and fundamentally based on and informed by an Aboriginal perspective of health, acknowledging the importance and role of culture, community, family, country, and spirit. Research undertaken by the Kanyini Vascular Collaboration (KVC) into factors influencing whether Aboriginal and Torres Strait Islander peoples living with chronic disease remain engaged with health services found that:

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 and Torres Strait Islander peoples with chronic diseases.50

Whilst at one end of the spectrum, the AHTO engagement with clients in EDs is brief and one-off, the KVC research found that the presence of Aboriginal and Torres Strait Islander staff members was ‘integral to the creation of a welcoming space’. Further, Aboriginal and Torres Strait Islander staff ‘whether doctors, nurses, healthcare workers or administration officers – made a significant difference to the nature of the relationships that were created within a healthcare service.’51

The care coordination and case management models provide a health service structure that is fundamentally based on a client-practitioner relationship. The evaluation adds to the knowledge to ‘assist practitioners to better understand the nature of (the) interactions in the complex setting of chronic disease care and management…(and) understand what is happening during engagement, as well as ‘how’ and ‘why’ people choose to remain with or disengage from care.’52 The evaluation supports the findings that non-Indigenous healthcare providers can form strong relationships with clients, but that these relationships require excellent communication skills, and time to develop trust. The use of appropriate professional frameworks and standards for care

1. Askew, D et al (2016)
2. Department of Health, (2013). *Koolin Balit – Victorian Government’s strategic directions for Aboriginal health 2012 – 2022.* State of Victoria
3. Marfleet, F., Trueman, S. & Barber, R. (2013). 3rd Edition, *National Standards of Practice for Case Management*, Case Management Society of Australia

& New Zealand. Retrieved 16 August 2016 from <http://www.cmsa.org.au/products/publications/product-name>

coordination and case management supports the professionalism of the work, and serves to professionally support and sustain staff.

Sustaining the client-practitioner relationship is particularly important in the care of people with chronic disease. Ensuring that the relationships with these clients are trusting, motivating and demonstrate flexibility and perseverance were characteristics of all the projects that involved clients with chronic diseases (Chronic Disease Nurse, Fresh Tracks, Integrated Koori Services, Aboriginal Care Coordinator, Close the Gap).

Whilst there were inconsistencies in the client data available across all projects, based on the existing data, combined with the feedback from clients, the evidence suggests that the strong client-practitioner relationships resulted in clients engaging with their healthcare in a way that they otherwise would not. This came through strongly in the qualitative feedback. A common element of client feedback from multiple projects was that without the information, support, encouragement and persistence of the practitioner, they would not have taken the steps they did or obtained the outcomes they achieved. This feedback covered ‘small’ steps – embarking on an activity program for example, through to many examples of significant changes – having health tests and procedures, for example, that in some cases had averted life-threatening consequences. There were clear testimonials from clients, staff and external stakeholders that, at times, the care coordinator was instrumental in the client reaching or maintaining life-transforming or life-preserving healthcare, preventing suicide or incarceration, assisting Aboriginal families to remain intact, or to reunite, or preventing the escalation of child protection issues. Irrespective of the small or profound impacts, the impact of the care coordinator was generally associated with improvements in the client’s quality of life, health literacy, engagement with and trust of health services, maintenance of clinical care and health improvements.

In addition to their roles in the involvement of client care, the various care coordinators also:

* + provided secondary consultations to their colleagues and to external agencies
  + contributed to strengthening relationships with local service networks
  + contributed to strengthening local agencies’ relationships with ACCHOs.

The models examined represent at minimum one year of service development work, and for others, up to seven years of work invested in the development. It is not recommended that any single model be transplanted, as each has shown the importance of developing a response to the local context – the local community needs, the resources and inter-related services of the host organisation and the local service system.

However, the general approach of providing a relationship-based support for care coordination or case management has great potential for implementation in other communities. The approach is inherently flexible as it can be tailored to the needs of a broad range of target groups and the focus can be clinical, psychosocial or relational. Care coordination or case management can also be delivered through an outreach approach, and this was seen to work particularly well with clients in a number of the projects involved in the evaluation. The approach has been found particularly useful in supporting clients with complex needs, chronic conditions or at risk of chronic disease, and ensures that these clients remain engaged and empowered in dealing with their healthcare journey. None of the projects had an exclusively preventative focus (the Early Years Services integrates a significant preventative component), but it could be posited that there is potential to apply the approach with this focus.

There is scope to strengthen the projects’ focus on data collection of both the process of client engagement and the outcomes achieved for clients, and to develop skills and knowledge in data analysis. There were also consistent suggestions made during the evaluation that the projects could be strengthened by additional resources to expand

the scope of work or to provide additional hours of services, in particular in hospitals over weekends and after business hours. There is also scope to provide further support to practitioners to enable them to better deal with the issues of vicarious trauma, to provide professional supervision and cultural mentoring, to support practitioners to connect and share practice knowledge and experience. The part-time nature of most roles however creates some challenges for incorporating support and mentoring.

It is evident that across the continuum of care coordination types, the projects are delivering services that are consistent with the Koolin Balit objectives of delivering locally developed, culturally informed, empowering, patient-centred care.

Whilst often the intensity of the individual and systemic work is highly challenging, staff providing care coordination in Aboriginal health acknowledged that, at the same time, the work is professionally and personally fulfilling. They have great respect and empathy for their clients, derive great professional fulfillment when they can ‘make a difference’ for clients and experience the relationships as ‘two-way’ relationships, from which they learn and grow.

The seven care coordination projects demonstrate that these culturally-informed, relationship-based models of care are delivering significant benefits for individuals, families and organisations and also contribute to the more culturally-informed functioning of the broader community-based service system. The research is consistent with emerging findings in the literature about the efficacy of the approach, and adds to the growing knowledge about how and why this approach is highly suitable in the field of Aboriginal health.

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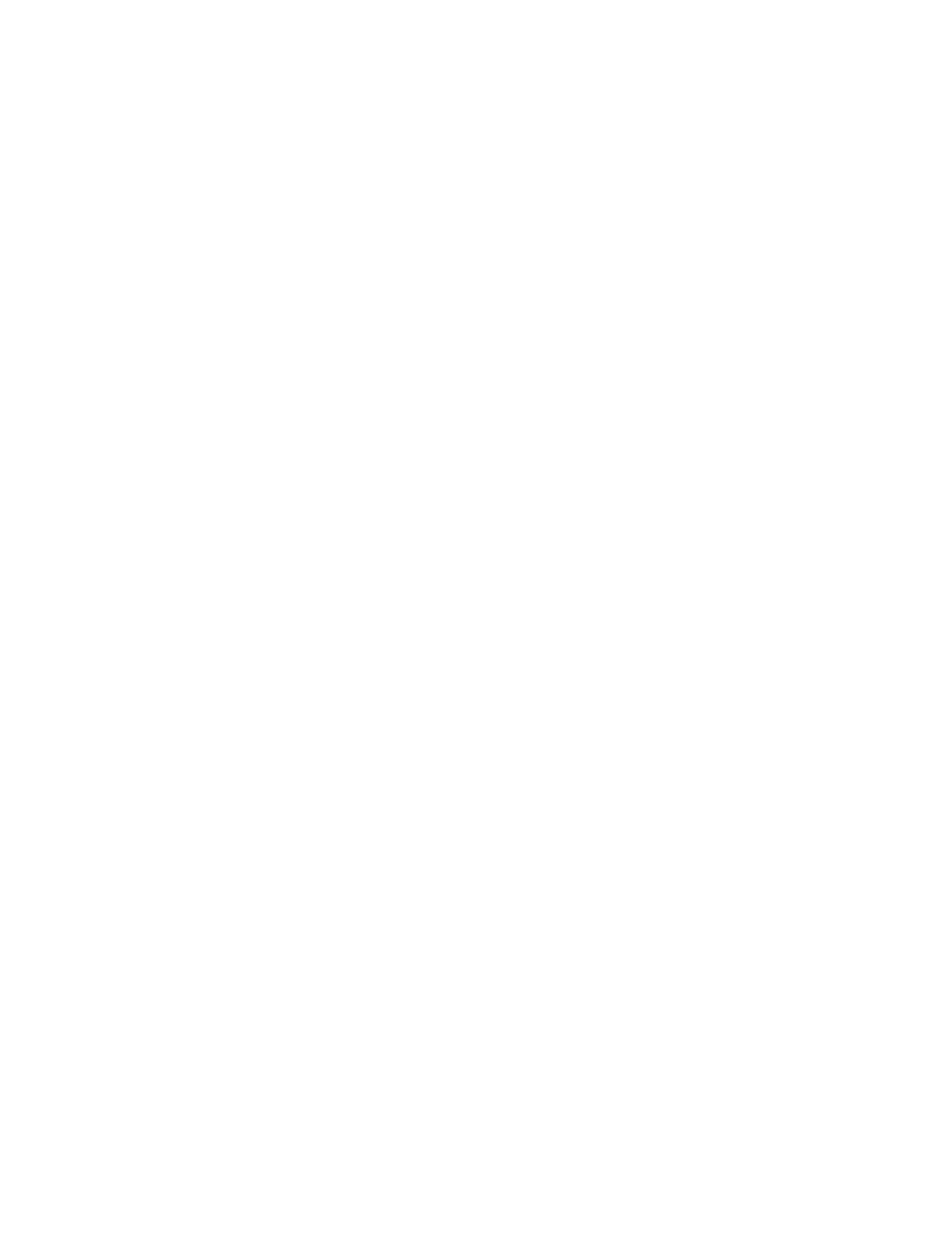
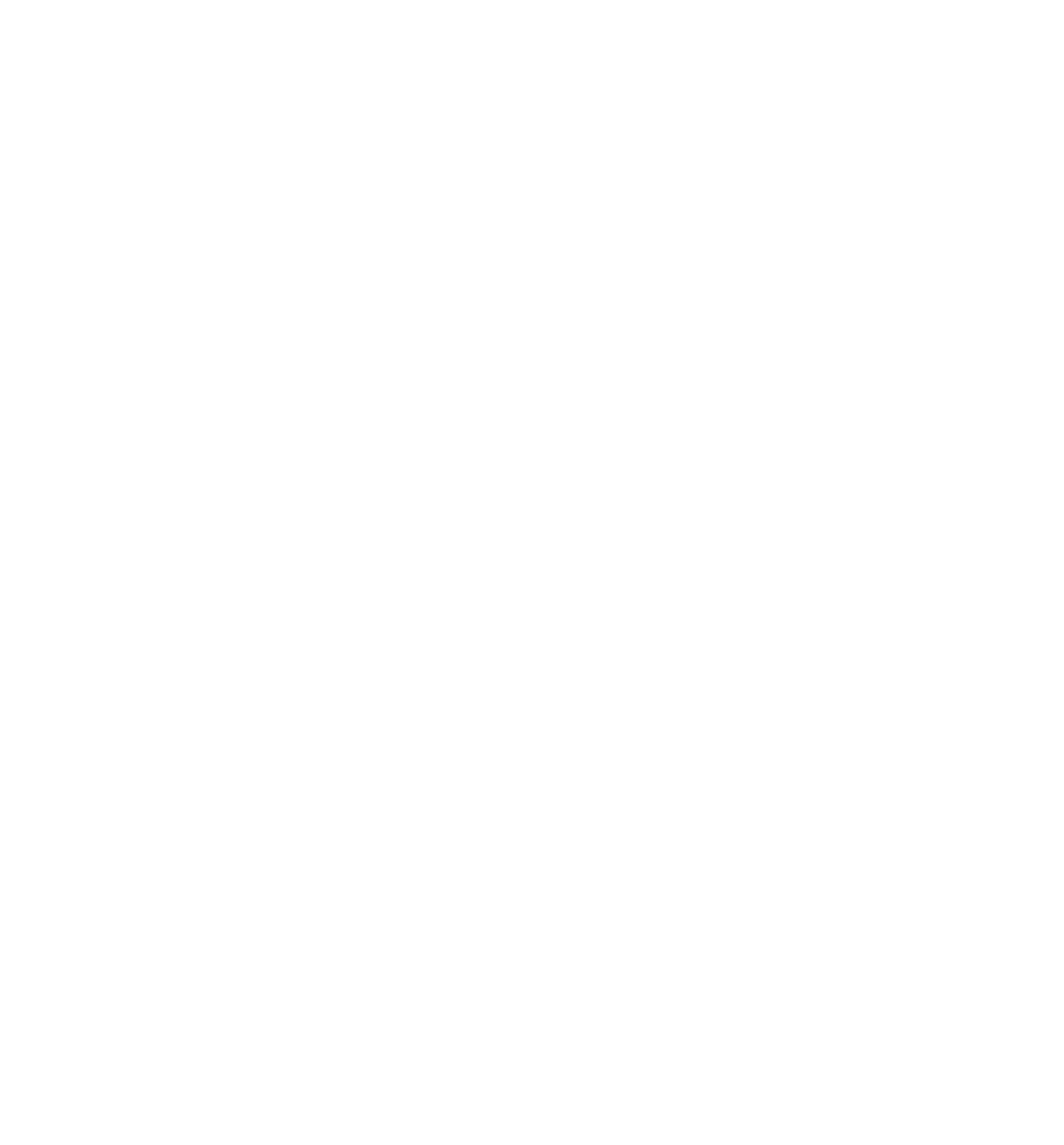
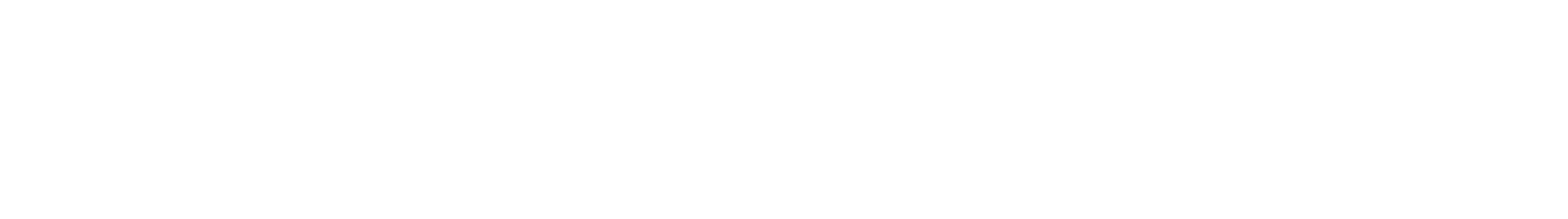
# Attachments - The projects in detail

1. Aboriginal Client Journey Project
2. Chronic Disease Prevention and Management Program
3. Integrated Koori Services
4. Aboriginal Health Care Coordintor in the Health Independence Program
5. Close the Gap
6. Fresh Tracks
7. Early Years Services

Aboriginal Client Journey Project

### Hume Region

### Introduction



#### Through this region-wide project, Aboriginal Health Transition Officers (AHTOs) are employed at Albury- Wodonga Health, Goulburn Valley Health in Shepparton and Northeast Health in Wangaratta, and the Seymour Health Urgent Care Centre.

#### The AHTOs undertake 48-hour follow- up care for Aboriginal people who have presented at an Emergency Department (ED) or Urgent Care Centre, and transition clients who require assistance to care coordination support in the community.

#### Project Background

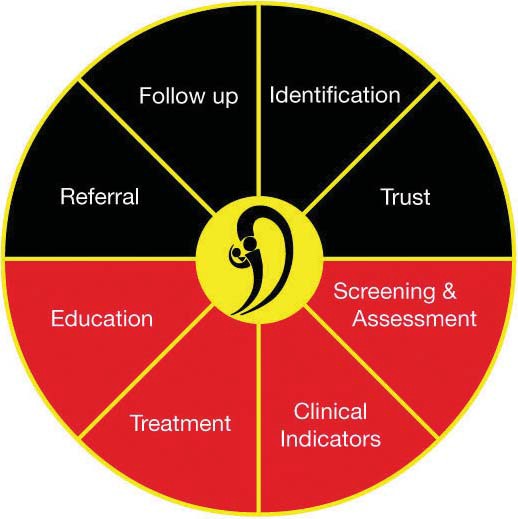
###### The Client Journey Project dates back to 2009 when the Regional Closing the Aboriginal Health Gap Committee recognised that Aboriginal people presenting at hospital emergency departments were more likely than non- Aboriginal people to leave without being seen or against medical advice.

###### On a regional basis it was decided to ‘Improve the client journey’ between hospital and primary care services across the region. This priority resonated with local ACCOs and the DHHS who shared the concern that hospitals were not systematically identifying Aboriginal patients, and that Aboriginal people were leaving emergency departments early or without treatment, and without follow up.

**The Aboriginal Health Transition Officer role** The role of the Aboriginal Health Transition Officers (AHTO) is to follow-up Aboriginal people after they have presented to ED. Rather than coordinating the patient’s care, the AHTO focuses on assisting the person’s journey from the acute sector to the community sector. When needed, the AHTO ensures that the Aboriginal person transitions smoothly to an appropriate care coordination health service in the community.

This model of care is based on the NSW Chronic Care for Aboriginal People (Figure 1) and the participating health services in the Hume region decided to focus on the stages of identification, screening and assessment, referral, and follow- up of Aboriginal patients who present at ED. The AHTO work is one element of a broader systems change approach.

**Figure 1: The Chronic Care for Aboriginal People Model of Care**



AHTOs aim to make a follow-up call within 48 hours after an Aboriginal person has presented to ED. People who have left without being seen by a medical officer or against medical advice are prioritised. As part of the follow-up contact, the AHTO checks on the person’s wellbeing and

whether they need any assistance with medications or follow-up appointments. They may make an appointment for a client, or organise transport for them to attend an appointment or they may refer them to a local Aboriginal Community Controlled Health Organisation (ACCHO).

If a person presents to ED while the AHTO is at work, they will visit them and have a chat and respond to any questions they may have, such as knowing how long they may need to wait.

There are differences across the four communities and health services in Albury- Wodonga, Shepparton, Wangaratta and Seymour, including the size of the local Aboriginal population and frequency of presentations to ED.

The AHTO roles have been adapted to suit each health service, but the essential service provided by all is connecting with Aboriginal patients, reassuring them and assisting them in their follow-up after ED. Most AHTOs are based in allied health departments or teams, responsible for care coordination of patients in the community. The AHTO at Seymour Health is based at the local Gathering Place, which is on the grounds of the Urgent Care Centre.

**Outcomes for clients**

Whilst the contact with clients may be brief and one-off, clients, external stakeholders and staff reported that the work of the AHTO:

* improves the quality of the Aboriginal patient’s experience of ED
* improves the patient’s health literacy and use of the health system
* helps to prevent people unnecessarily falling through the cracks
* encourages Aboriginal people to feel safe to identify their Aboriginality at a hospital.

Aboriginal people who receive good follow up care are more likely to trust the hospital in the future. (Manager, Hospital)

**What did clients say?**

“The AHTO helped me get in contact with my family, emergency contacts – I left my phone at home. Made things a lot easier for me.”

“Glad she was there yesterday, made me feel secure and comfortable. Nice for someone to check on me anyway.”

“We were treated very respectfully, very well… it eases your mind to know there is someone there you can talk to. Then that helps healing and health because when you're stressed it's not good.”

**What did stakeholders say?**

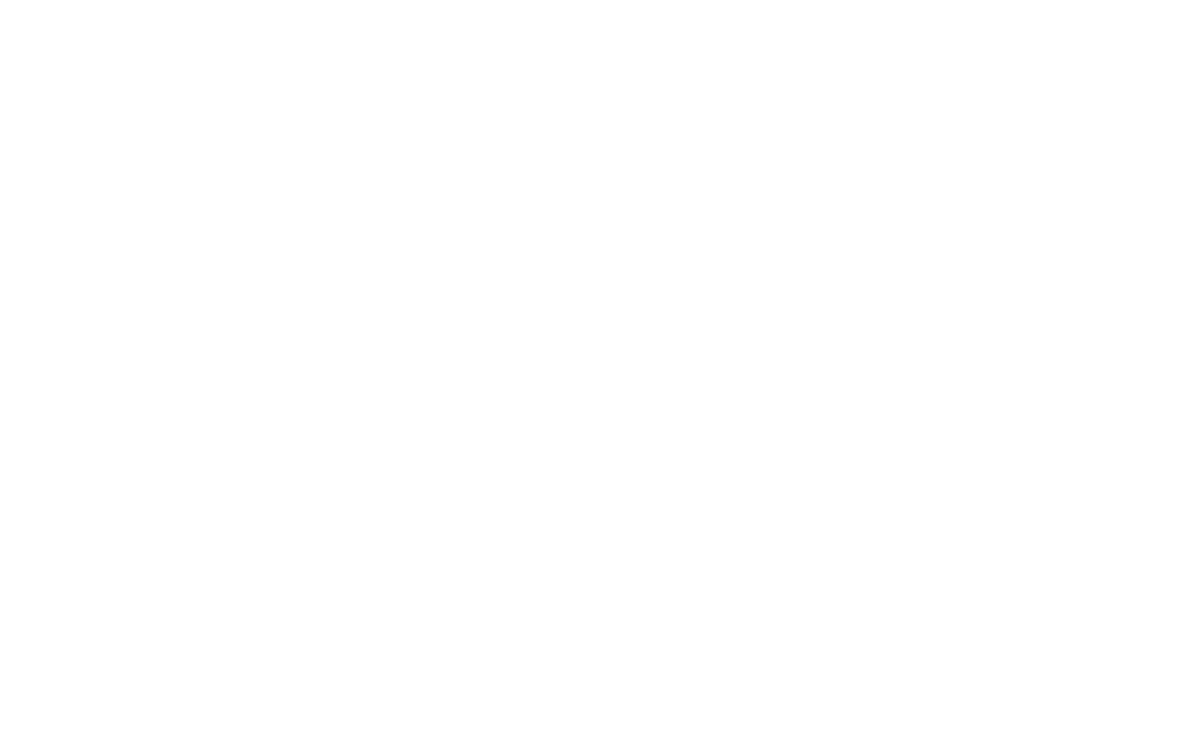
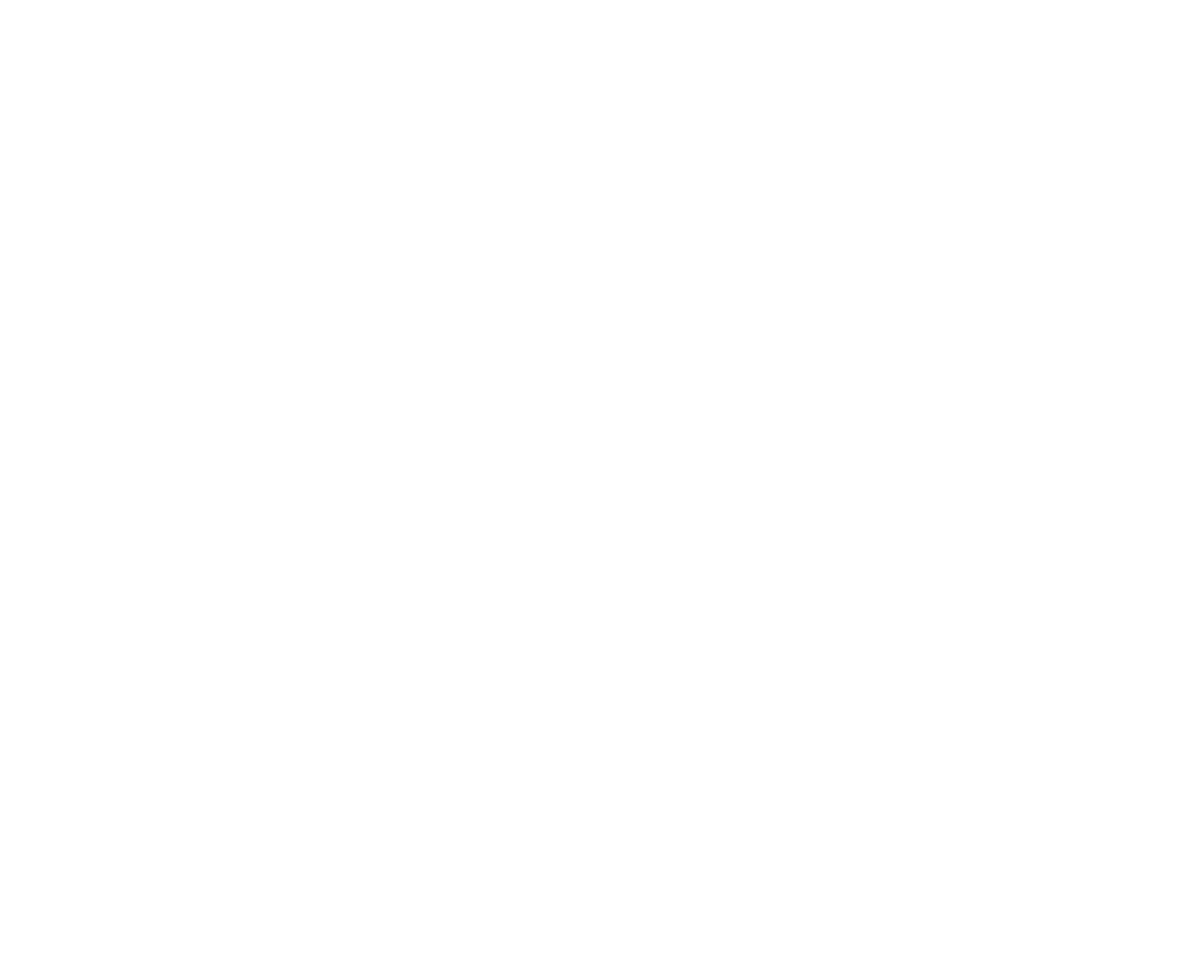
“Because (the AHTO) is here, a lot more black fellas are coming in and staying.” (Health service)”

“We know that more Aboriginal patients are being recognised and staying to receive treatment at ED.” (ACCHO)

“Part of the work and success of the role is to build relationships between the community and the hospital.” (Hospital)

#### Learnings

###### Implementing change within hospitals and across the acute, ACCHO and community sectors required a significant investment of time and resources.



###### The commitment and involvement of the Aboriginal community has been critical to the project’s success.

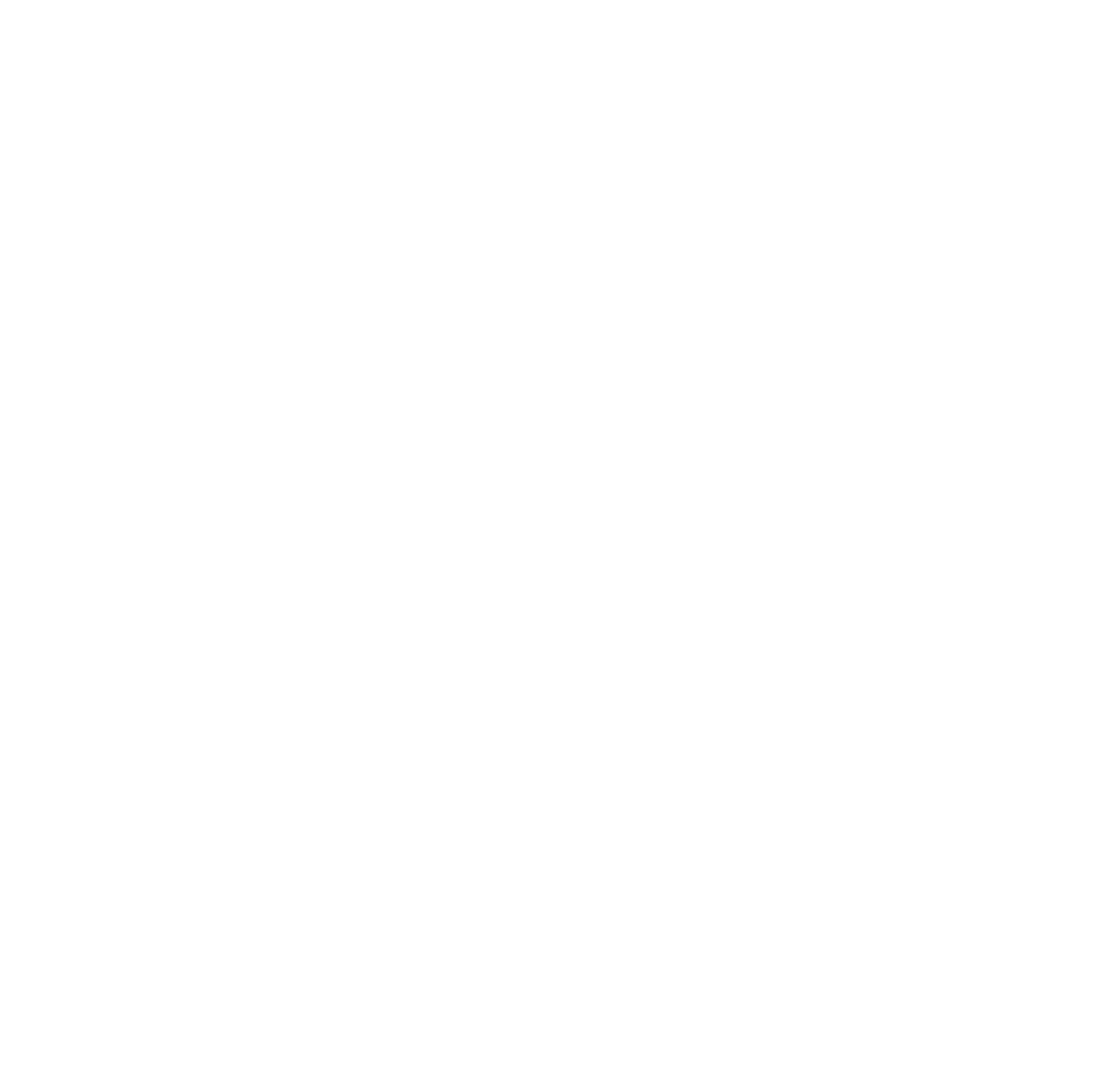
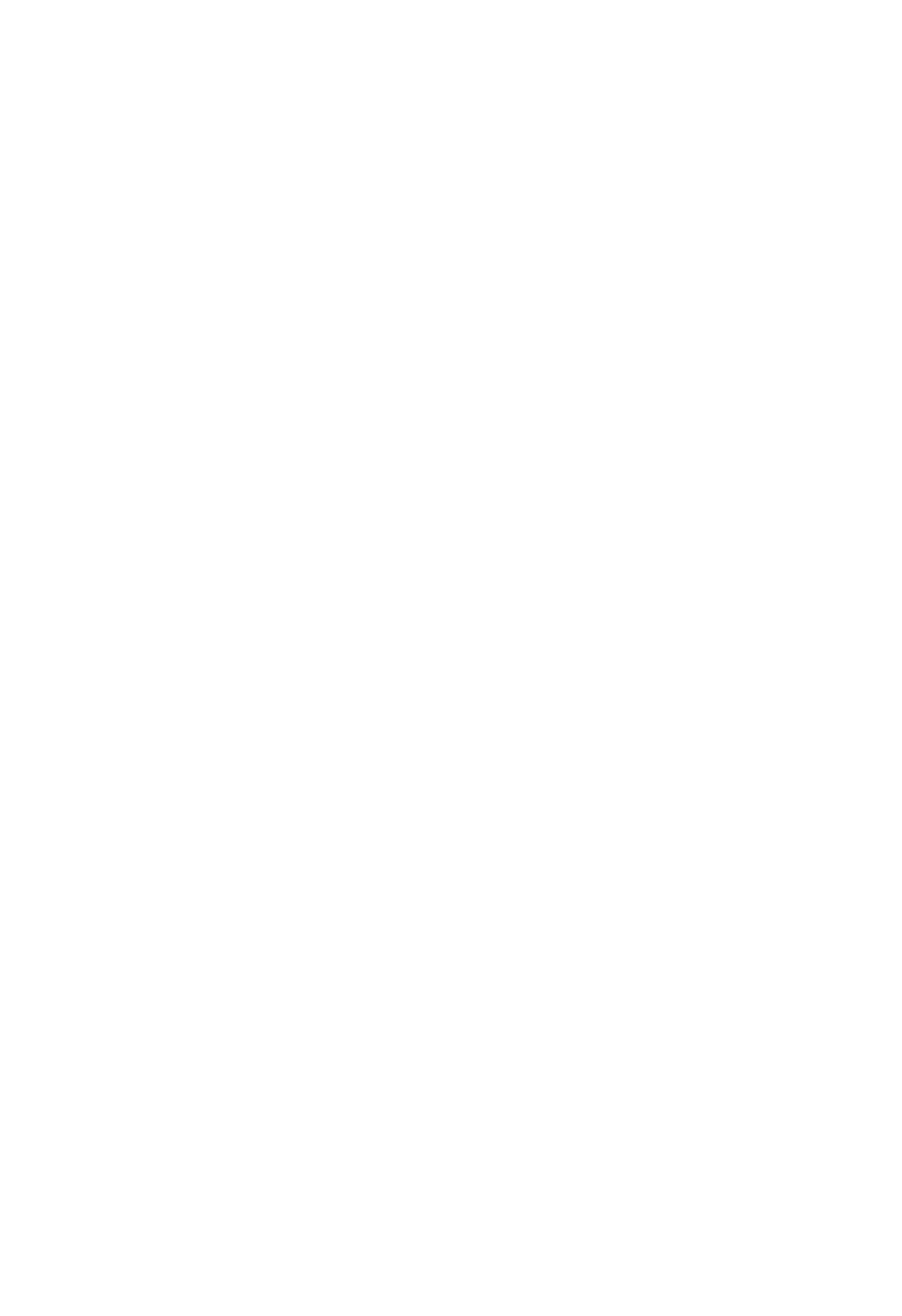
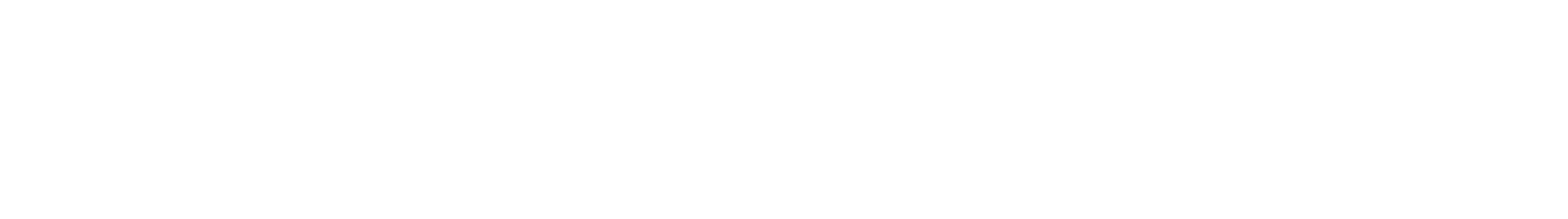
###### Due to the systems-change approach, the AHTO roles were only one of a number of inter-connected strategies.

#### Conclusions

###### The Client Journey Project has had positive impacts on clients’ experience of hospital and on their health literacy. The project is a useful example of the length of time and scale of work required to implement systems change, and the need for work to continuously learn and improve.

Chronic Disease Prevention and Management program

### Ballarat and District Aboriginal Cooperative (BADAC)



### Introduction

#### The Chronic Disease Prevention and Management program funds the engagement of a Chronic

#### Disease Nurse within BADAC’s

#### Health Program to support to

#### clients with a chronic disease better manage their conditions or for

#### those at risk of developing a

#### chronic disease, take preventative actions.

#### Working closely with other

#### members of the Health team, the Chronic Disease Nurse undertakes health assessments, develops

#### individualised care plans, provides

#### health promotion education, monitors social and emotional

#### wellbeing needs and refers clients

#### to BADAC services and external services.

#### Project Background

###### Aboriginal people experience significantly more chronic disease compared with non- Aboriginal Australians.

###### The Program at BADAC is designed to improve health care for Aboriginal people, particularly those who have chronic diseases.

Through the work of the Chronic Disease Nurse, this program provides care coordination and support for Aboriginal people and their families with chronic health conditions or at risk of developing a chronic disease. This program is delivered at BADAC, a multidisciplinary Aboriginal Community Controlled Health Organisation (ACCHO) incorporating primary health services, Koori Family Services, Home and Community Care and Active Lifestyle programs.

**What is the aim of the program?**

The program began in 2009, and in 2014 with funding provided through the Koolin Balit initiative, a full-time Chronic Disease Nurse was appointed to work closely with Aboriginal clients and their families.

The Chronic Disease Nurse leads the program with the aim of:

* increasing clients’ access to health services (mainstream and non-mainstream)
* ensuring Aboriginal people with complex health conditions receive effective and sustainable health care when they need it
* supporting Aboriginal people to learn how to manage their health conditions and encouraging them to participate in programs to support a healthy lifestyle.

**What has happened so far?**

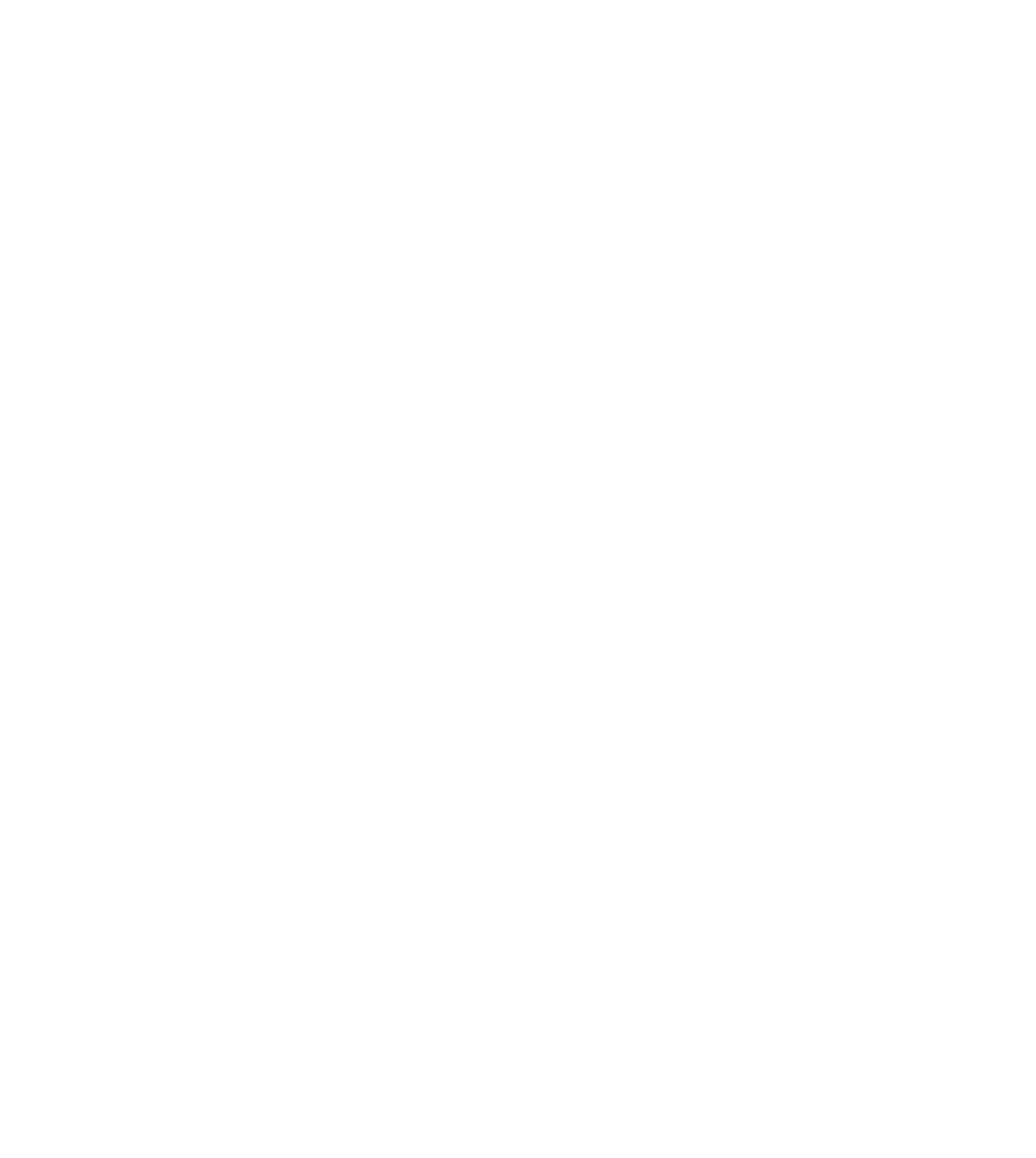
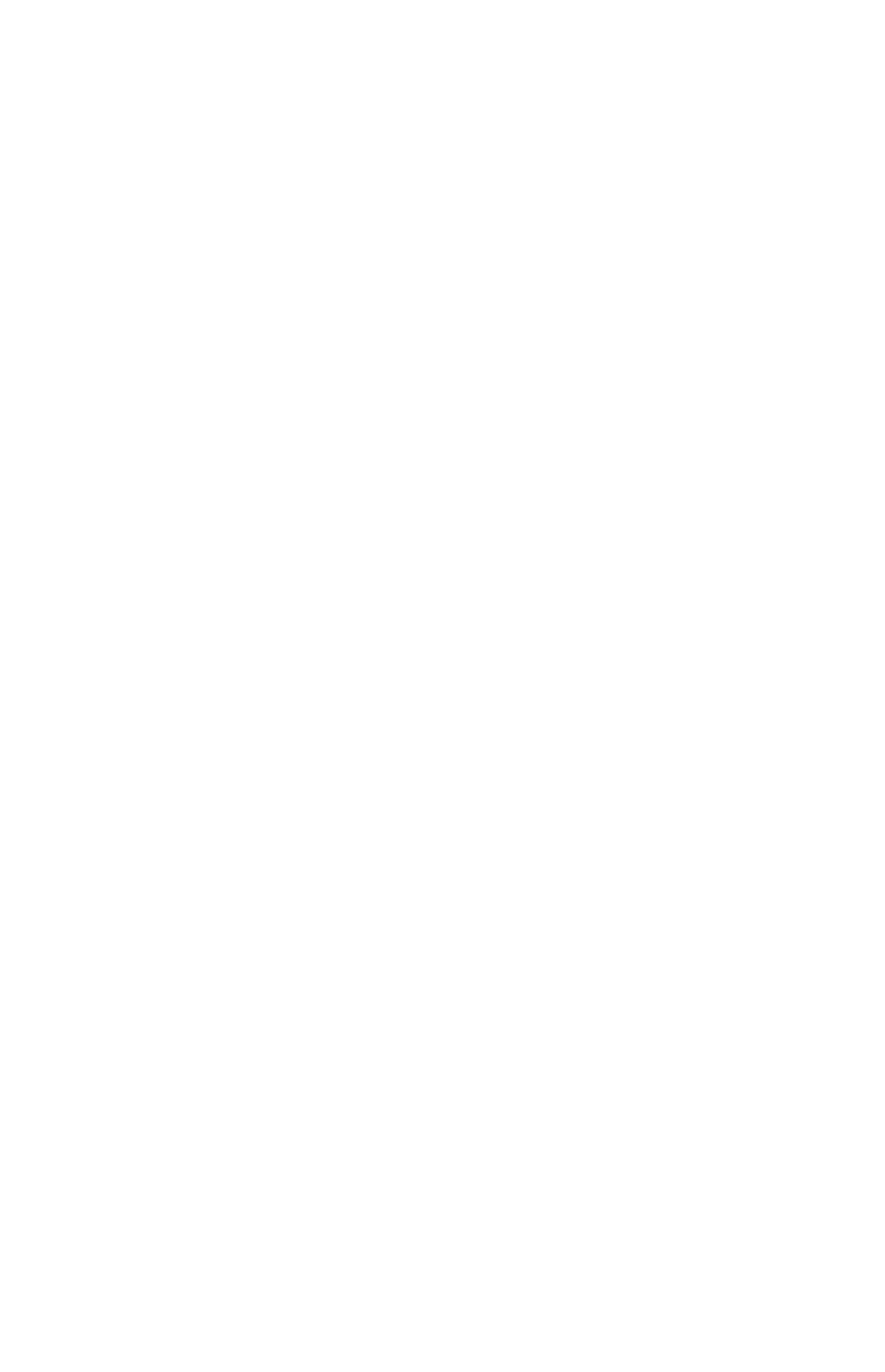
Since implementation:

* the number of annual individual health assessments conducted has increased
* the number of individual care plans developed and reviewed has increased
* participation in smoking cessation programs has increased
* the number of clients attempting to quit

smoking has increased.

* 55% of clients in the cessation program reported they now smoke less cigarettes per day.

**What did clients say about the program?** Aboriginal clients of the program were very satisfied with the support they received, and said that it helped them improve their health.



“I recently had melanoma cut out (positive), and I wouldn’t have had the spot checked unless the Chronic Disease Nurse and BADAC staff had [reminded me] and made the referral…. [Without the program] I probably [would] have skin cancer..”

“I am treated well and respectfully… They’re really good to me…everybody’s pretty good. I get on well with everybody.”

“My health has improved, my body doesn’t feel old, I feel healthy in myself, and feel young, I think feeling good is linked to coming here.”

**What do staff say?**

Staff at BADAC report that clients are using more services more frequently, are more likely to come to follow-up appointments, and to identify personal goals and work towards achieving them.

Staff also reported that clients have better general mental health and wellbeing, they are more relaxed and comfortable when they come to BADAC despite their chronic and complicated health conditions.

“…. People are coming back to the Chronic Disease Nurse and BADAC.”

“…. Mental health patients are more stable, more relaxed, interacting with others, initiating conversations, out socialising.”

**What do external service providers say?** External providers reported that referrals to BADAC are more streamlined and having a key point of contact improves communication and

relationships. These factors improve the quality of the services clients receive, and can flow through to benefits for their health and wellbeing.

“The [program] helps our agency to build relationships with the Aboriginal community.” (External stakeholder)

#### Learnings

###### Factors that have helped to increase the effectiveness of the program include:

###### Collaborative relationships and communication between the Chronic Disease Nurse and other health professionals at BADAC, particular within the Health Team and in other health services.

###### The Chronic Disease Nurse’s culturally informed communication and listening skills – listening ‘between the spaces’ for what is, and is not said, letting clients tell their story at their own pace, and respecting the client’s story.

###### Services are adaptable to suit each individual’s personal goals, capacities and physical and mental health.

###### The environment at BADAC is supportive and welcoming, and this encourages clients to attend on a regular basis.

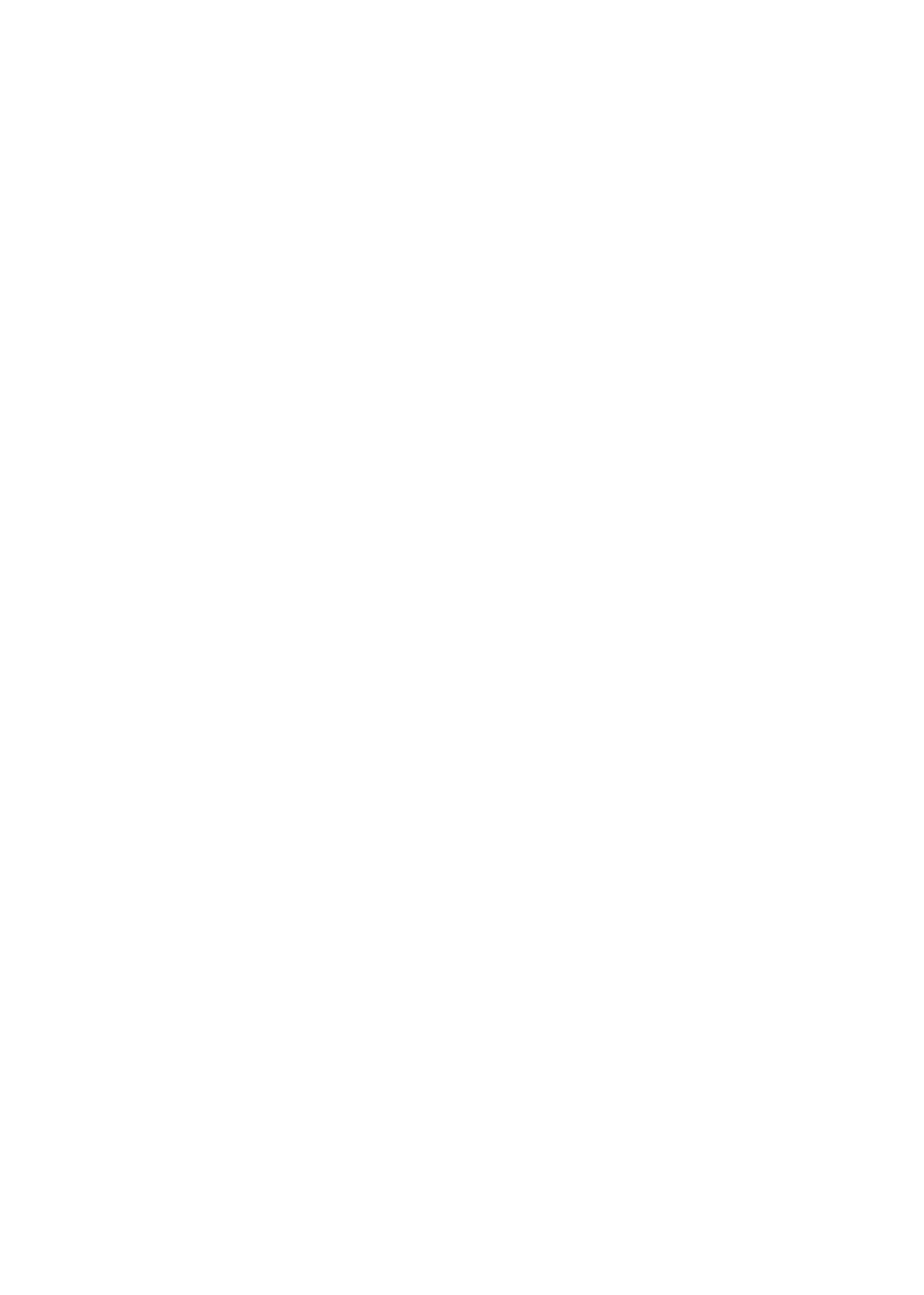
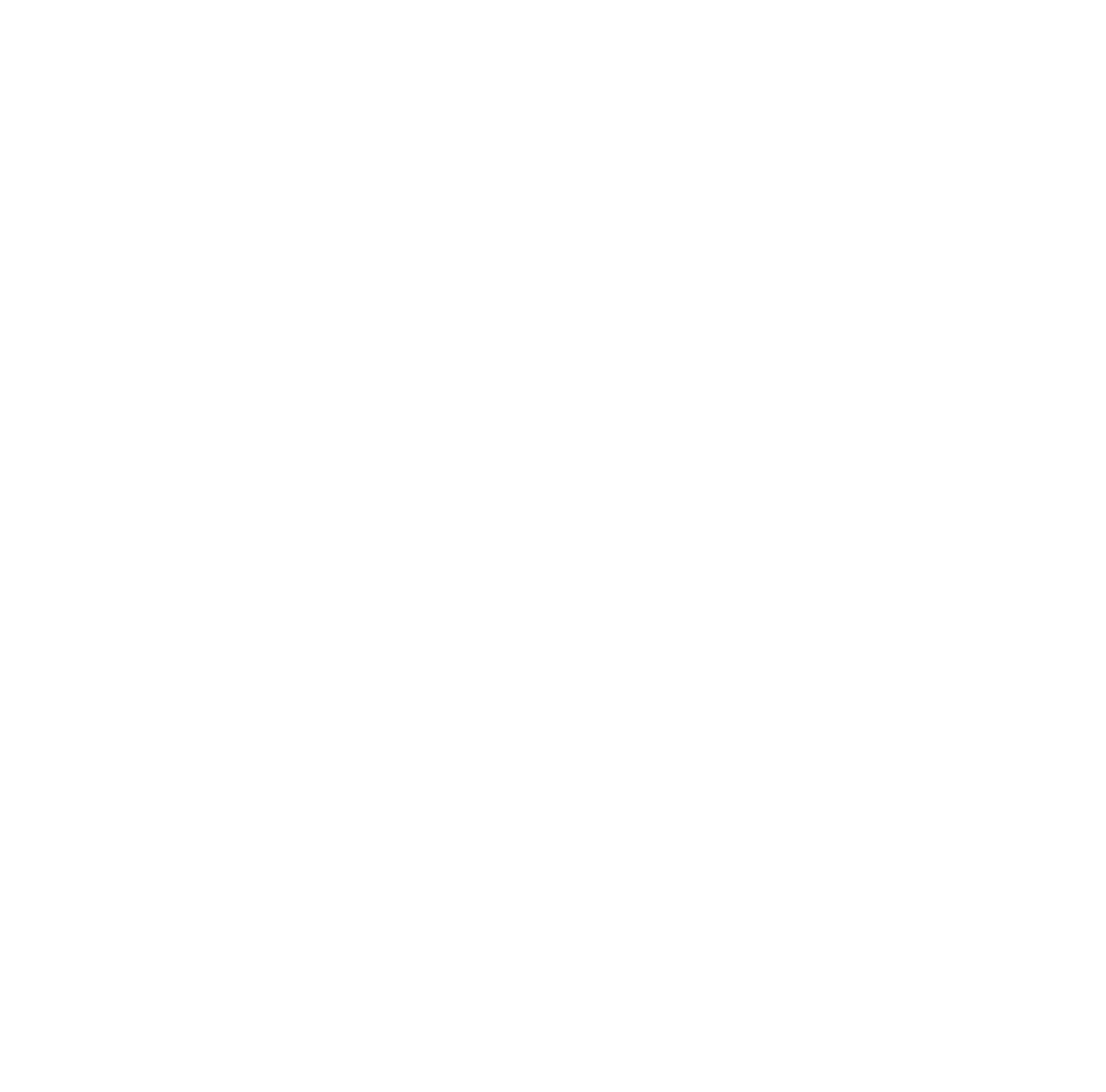
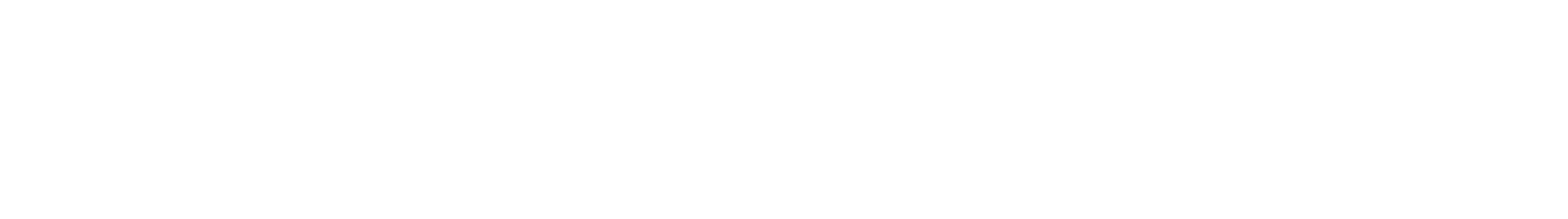
#### Conclusions

###### The Chronic Disease Prevention and Management program at BADAC delivers culturally appropriate care coordination for Aboriginal clients and their families who experience chronic health conditions. Through effective communication, healthy working relationships, quality multidisciplinary health care and involving the local community, the program is improving the management of risk factors for a number of chronic diseases, and empowering clients to manage their own health.

Integrated Koori Services

### Monash Health

### Introduction



#### Integrated Koori Services (IKS) provides care coordination to Aboriginal people through Monash Health. It aims to better integrate Aboriginal clients presenting to Monash Health Emergency Departments, or those who have had an admission to a Monash Hospital, to community services. Located in the community, the IKS coordinates care through an assertive outreach program and develops individualised care pathways for clients.

#### Project Background

###### The IKS commenced in 2012 through Closing the Gap Healthcare Pathways funds in response to the lack of integration to community services for Aboriginal clients presenting at hospital.

###### Hospital data and community concerns indicated that many Aboriginal people presenting to Monash Health were discharged from hospital without an admission, and/or were not accessing follow-up services and vulnerable to ‘slipping through the gaps’. These people often need support and assistance to access community/mainstream services.

###### The IKS model was initiated to provide an integrated model of care for Aboriginal patients moving from the acute to community sectors.

**About the service**

Through a Care Coordinator position and applying a person-centred and culturally appropriate approach clients are assisted to access a range of required services. This can involve discussion and establishment of client health and wellbeing needs, referrals, making appointments on behalf of the client, providing transport support, accompanying the client to the appointment if required and client advocacy. Anticipated outcomes for clients include:

* the development of individualised care pathways
* an increase in follow-up care
* a reduction in Emergency Department admissions
* improved health outcomes.

The Care Coordination position is located within a multidisciplinary team which includes the support of Aboriginal Access and Support Officers who provide a bridge and a pathway into the IKS from the community. The service also has access to brokerage services that enable essential responses or interventions to be employed at critical times.

The Care Coordination approach is guided by social justice, cultural respect and health and wellbeing frameworks.

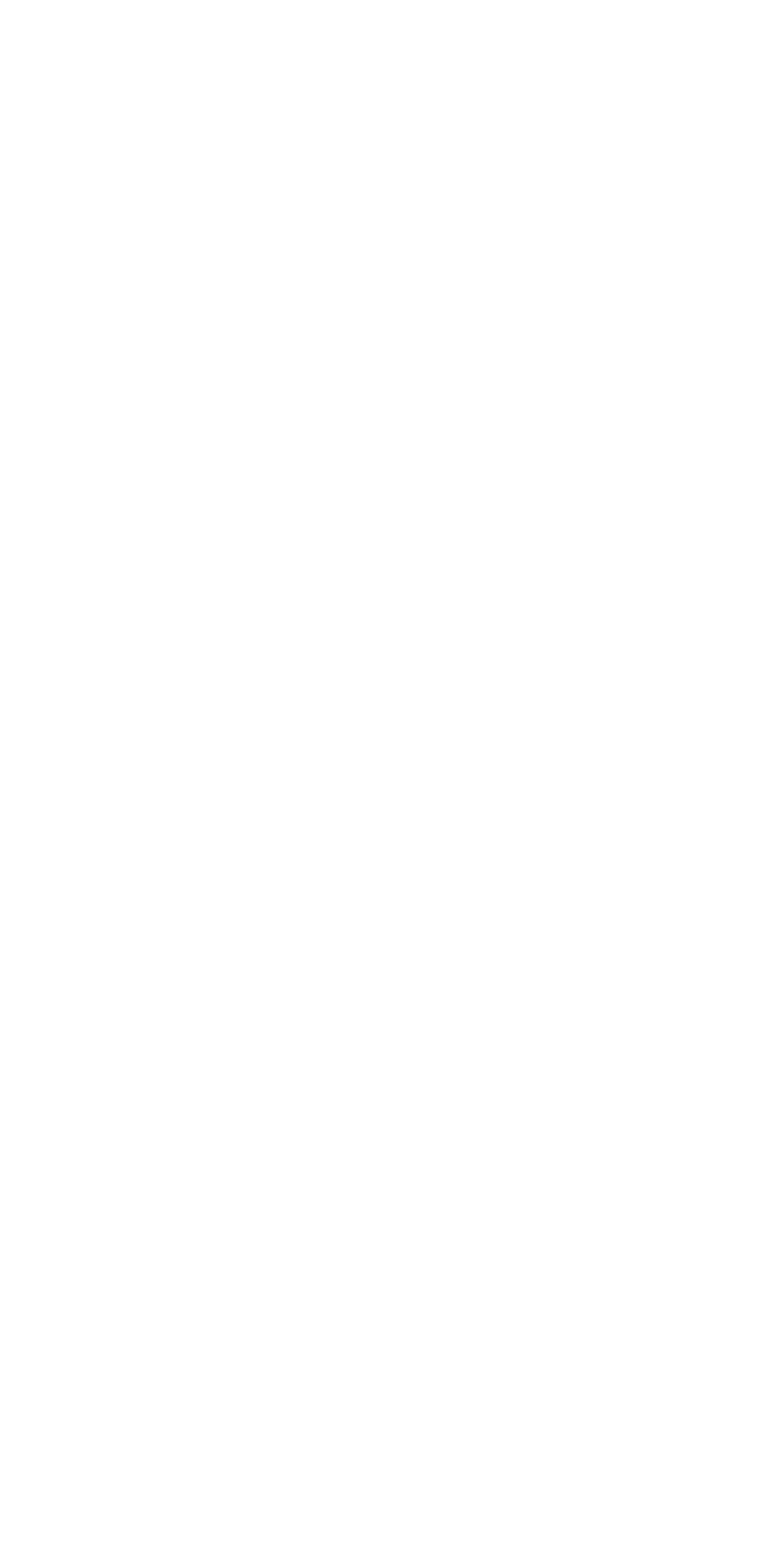
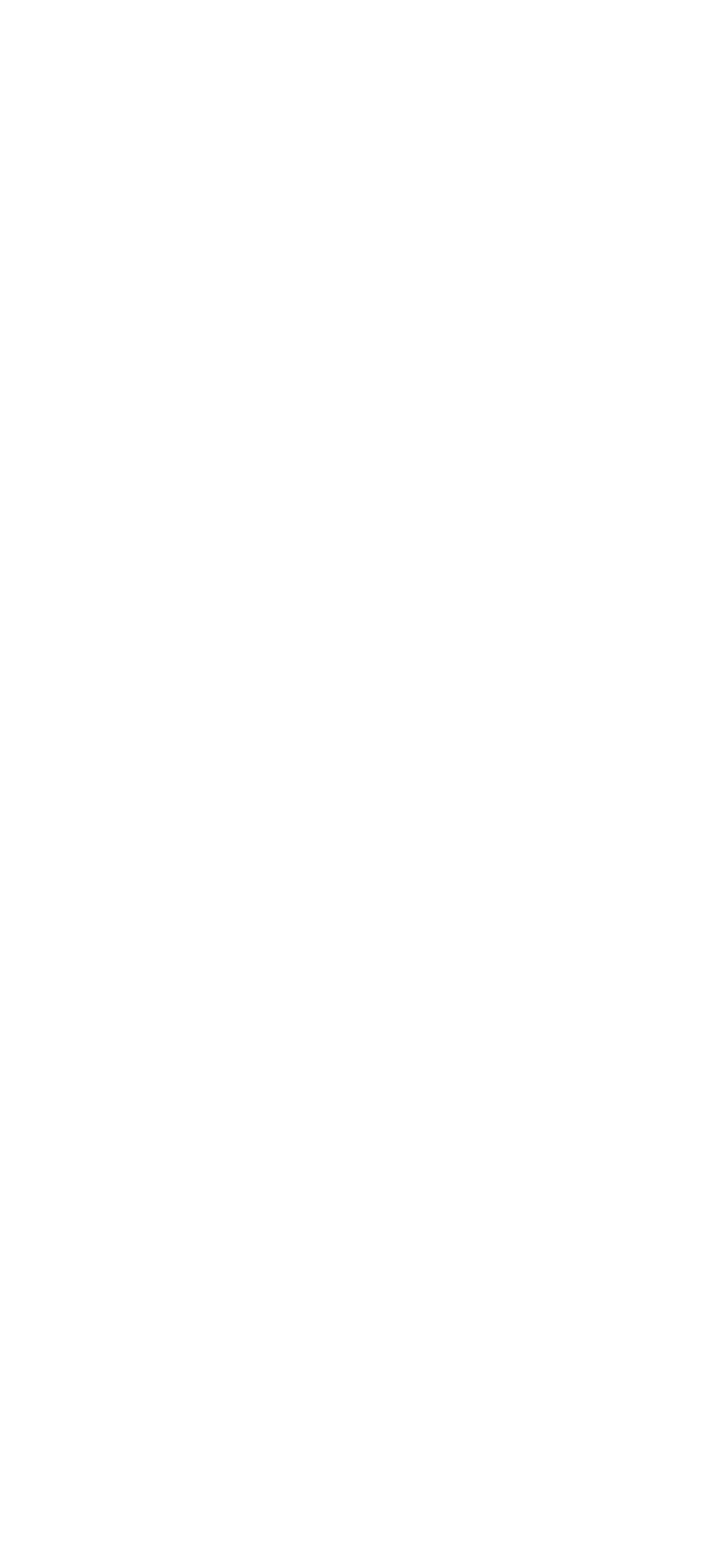
**The IKS target group**

People targeted by the service have complex medical, psychosocial and wellbeing issues. The complexity of the medical and psychosocial issues can quickly exacerbate to a serious or life threatening situation.

Clients may also be experiencing a range of complex issues including homelessness, chaotic lifestyles, family or domestic violence, loneliness, drug and alcohol issues, financial issues and poor health literacy.

### Learnings

###### The Evaluation identified a number of outstanding features of the IKS including:



###### considerable attention is given to building trust and relationships with clients, family and community. This approach and focus is crucial to establishing successful engagement and ongoing relationships between client, family, community and service.

###### the Care Coordinator position has a deep understanding of and sensitivity to kinships and culture and cultural competency skills. Cultural competency skills include the capacity to join in with community events and social groups and/or engage clients through participation in activities such as weaving, cooking, art.

###### the skills, experience and qualifications

###### of the Care Coordinator are invaluable in understanding chronic illnesses and how to navigate this part of the health system.

###### IKS clients are invariably involved with a number of different services and service providers. The importance of negotiating clear roles and role boundaries and communication within Aboriginal health services was reported in the evaluation. Maintaining close and effective relationships and connections with other service providers is important to support access to appropriate care for Aboriginal people with complex medical and wellbeing conditions.

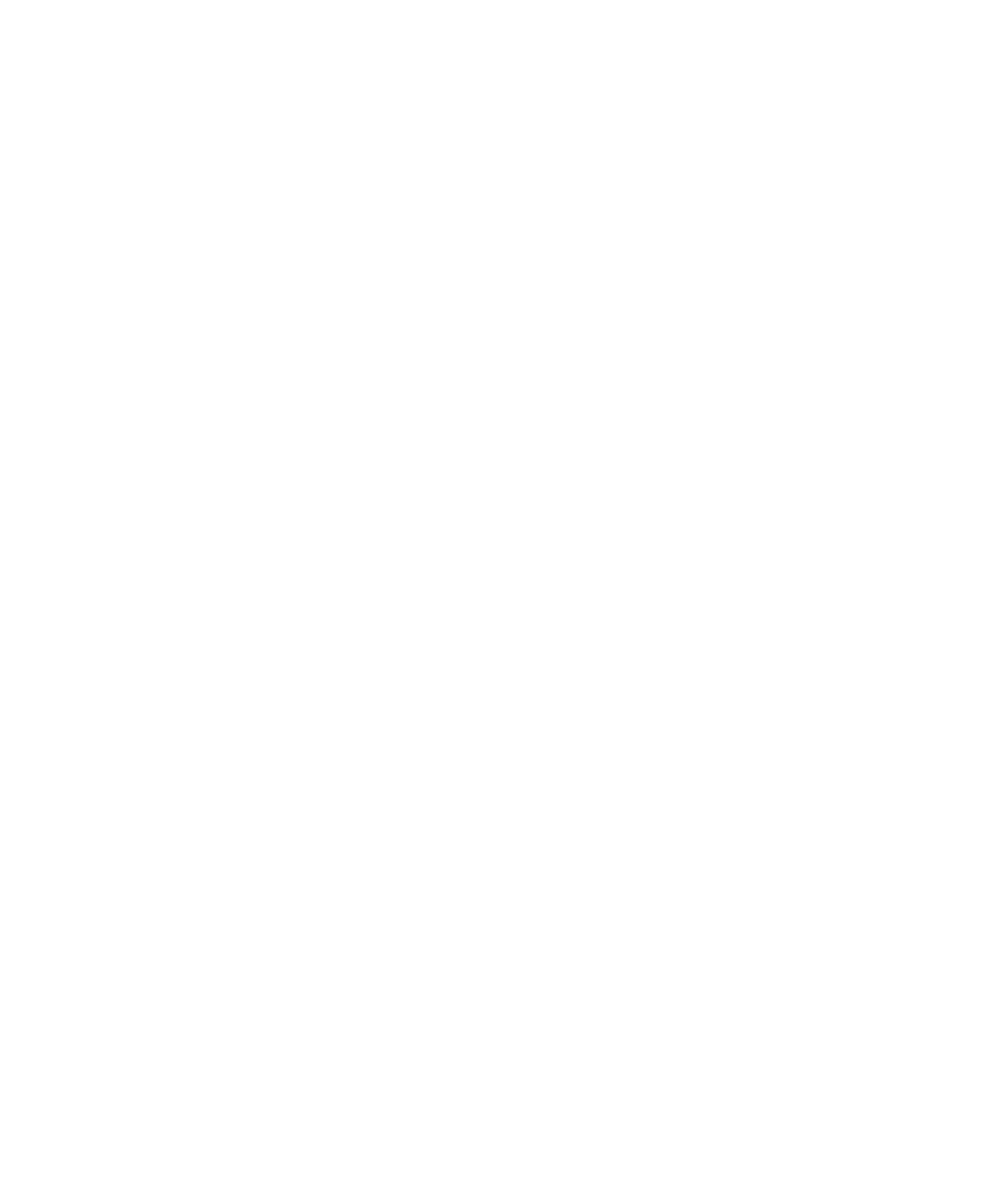
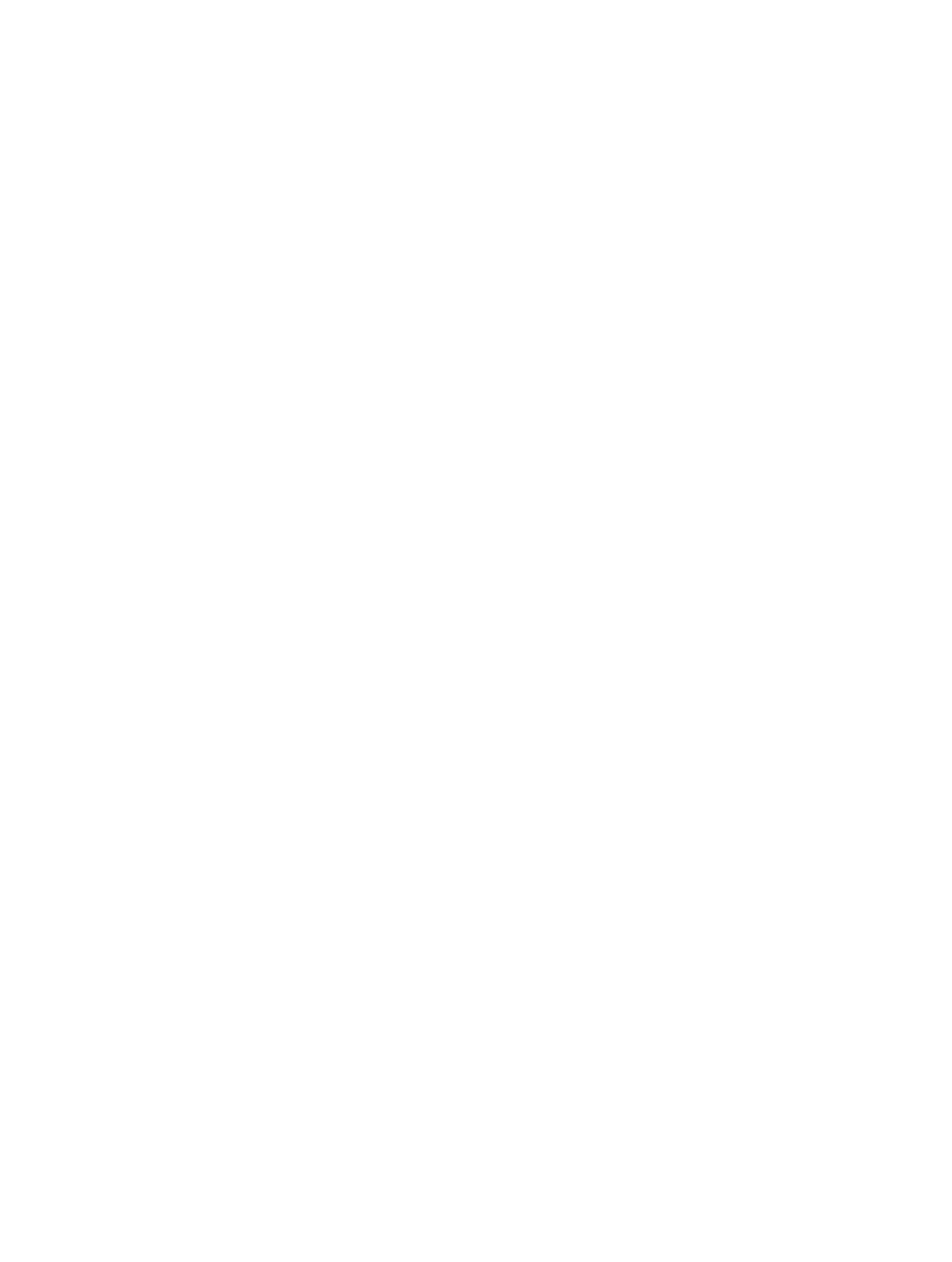
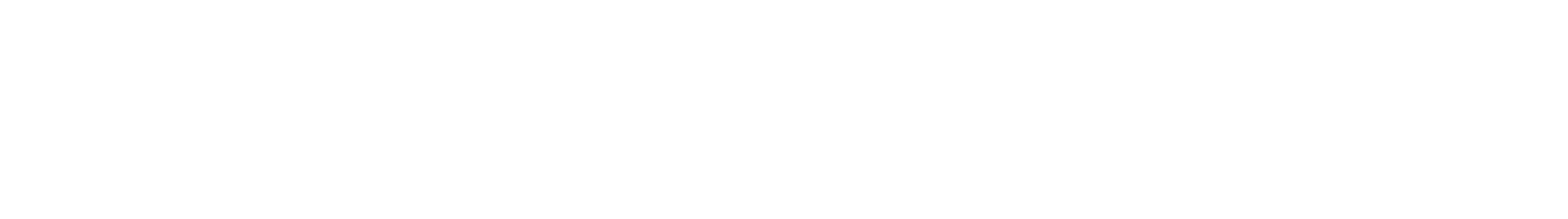
#### Conclusions

###### The IKS aims to intervene before the crisis point, avoiding devastating occurrences for the client and their family. This aim is realised by a highly qualified team applying culturally appropriate practice within Aboriginal and Torres Strait Islander cultural concepts of social and emotional wellbeing and mental health.

###### IKS has been able to assist Aboriginal people to access services in the community through both facilitating support and assistance to clients as well as inform and educate mainstream services in culturally competent practice.

Aboriginal Health Care Coordinator in the Health Independence Program

#### St Vincent’s Hospital Melbourne and North Richmond Community Health



### Introduction

#### The Health Independence Program is a statewide program to support people with complex medical and/or psychosocial needsto manage their health in a community setting. St Vincent’s Hospital Melbourne (SVHM) and North Richmond Community Health (NRCH) work in a multi- disciplinary partnership to deliver these services to the community through a range of programs, including the Hospital Admission Risk Program (HARP).

#### In 2015, an Aboriginal Health Care Coordinator was recruited to provide care coordination for Aboriginal people and their families.

#### Project Background

Despite the over-representation of Aboriginal people in terms of the incidence of chronic disease, such as diabetes Aboriginal clients were under-represented in SVHM’s Health Independence Program. In fact the data showed that many Aboriginal clients did not engage with the program at all, or did not remain engaged.

This under-representation was of concern to the project partners. The Koolin Balit initiative provided the opportunity for SVHM to recruit an Aboriginal Health clinician to the Health Independence Program.

After a lengthy recruitment process, an Aboriginal-identified Registered Nurse was recruited to the role from SVHM’s Adult Mental Health Services.

The Aboriginal Health Care Coordinator is responsible for:

* engaging more effectively with Aboriginal

clients and increasing the number of clients receiving services supporting their transition from hospital to the community

* improving the health linkages and health outcomes for Aboriginal clients.

The Coordinator also contributes to:

* developing the skills of clinical staff to work with Aboriginal clients
* advocating for change to increase the access and quality of care for Aboriginal clients.

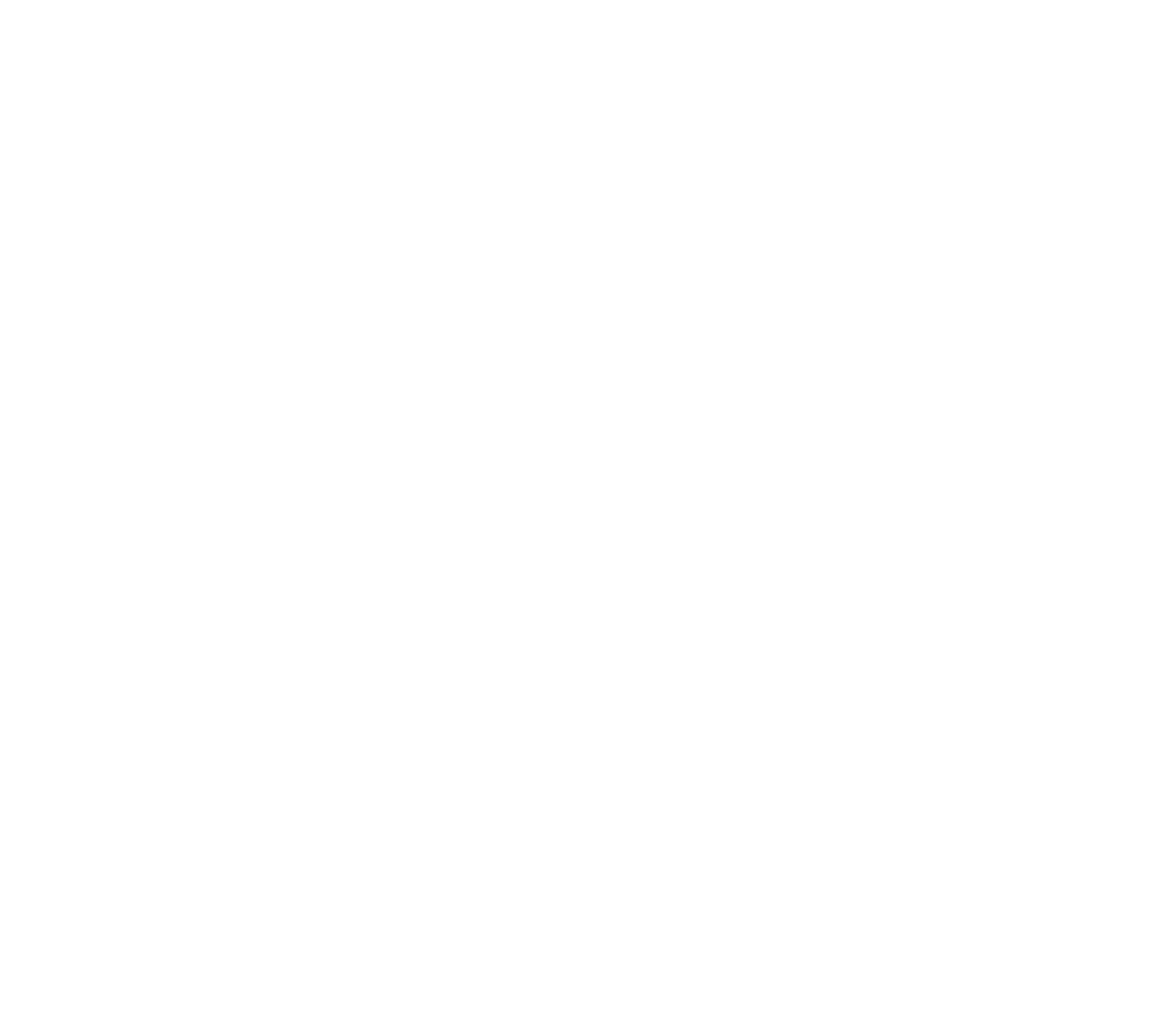
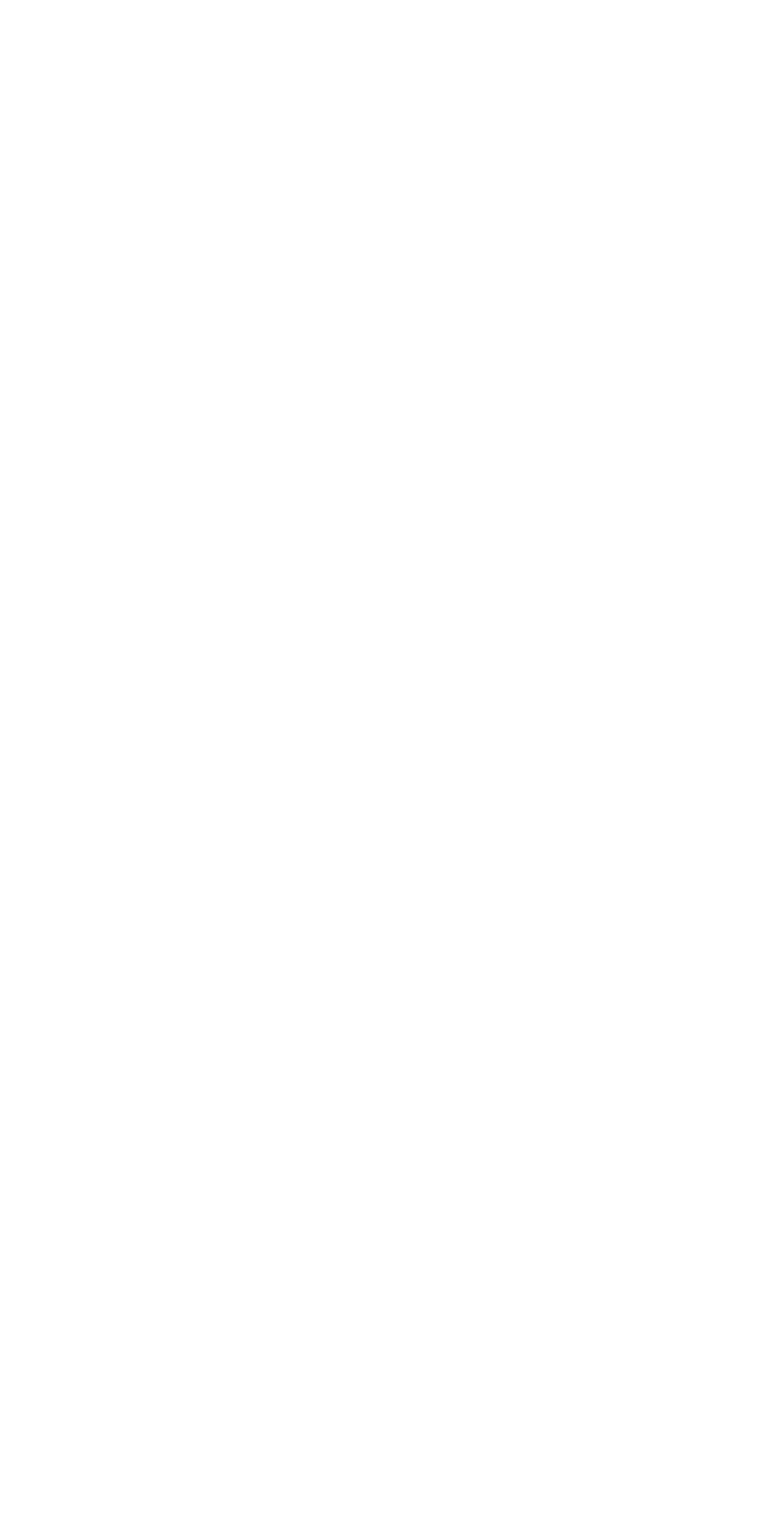
**How does the role work?**

The Coordinator works in the multi-disciplinary Assessment, Liaison and Early Referral Team, which provides complex psychosocial care. The position is based at SVHM for three days, and the NRCH site for two days per week.

Most internal referrals come from St Vincent’s Aboriginal Health Liaison Officers, emergency department, social work department or from community-based programs. External referrals are received from Aboriginal Community Controlled Health Organisations (ACCHOs), community health or self-referrals.

The approach to care coordination is consistent with Health Independence Program guidelines, with an empowering approach, encouraging independence and self-management.

The Coordinator develops a health and wellbeing care action plan for clients accepted to the program. Clients are most frequently contacted by phone, but the Coordinator also visits clients at home or in the community. The Coordinator may accompany clients to medical appointments, arrange transport or assist with needs for material aid. Each contact provides an opportunity to educate clients about health issues and health management. The Coordinator can advocate on behalf of clients with other services or organisations when needed.



The Coordinator also works in partnership with other clinicians to manage the healthcare for each client. Contact with other services may be through case conferences, visits to agencies or phone and email contact.

**Early outcomes**

In the first full year, since the appointment of the Coordinator, **67 clients** have been supported with two thirds (66%) of clients identifying as Aboriginal.

Based on feedback from clients, staff at SVHM and NRCH and external agencies, early outcomes of the work include:

* more effective engagement with Aboriginal clients and better retention of clients
* improved compliance with healthcare
* better quality of service for clients
* better health and wellbeing outcomes for Aboriginal clients.

At the service system level:

* coordination of care between SVHM, NRCH and external agencies for Aboriginal clients is improving
* communication between SVHM and external agencies around patient progress and outcomes is improving.

“We didn’t know the value of such a position, we didn’t know the number of clients who were not able to access hospital and external services because of their Aboriginality.” (SVHM stakeholder)

**What did clients say?**

“Without the Coordinator, I wouldn’t be where I am today. Without her I’d still be at home thinking about whether to have the operation.”

“The Coordinator hooked me up with a doctor and encouraged me to attend rehab…I pulled through with flying colours…I feel more confident and I’m living off the streets in the country.”

“I now have a much better idea what to look out for when I am not well. I recognise the signs.”

#### Learnings

This project is demonstrating the impact an Aboriginal clinician in a mainstream program, such as the Health Independence Program, is having on client engagement and retention and the cultural competence of the team delivering the program. Agencies working with Aboriginal clients are more involved in the joint coordination of their care, and understand more about accessing services within the hospital.

The careful and thoughtful approach to the implementation of the position by SVHM is a key element of its success. The position was designed from the outset to include a developmental aspect, recognising that the organisation needed to grow and learn in parallel with the new appointee. The recruitment process took six months and several rounds, but SVHM was prepared to wait for an applicant with the appropriate clinical and community engagement skills.

SVHM recognised the need to provide cultural mentoring to the Coordinator through the staff of the Aboriginal Health Unit, as well as clinical supervision through line management.

The Coordinator was provided with time to establish relationships and networks with ACCHOs, local Aboriginal community groups, and community agencies, allowing promotion of the role and referral processes.

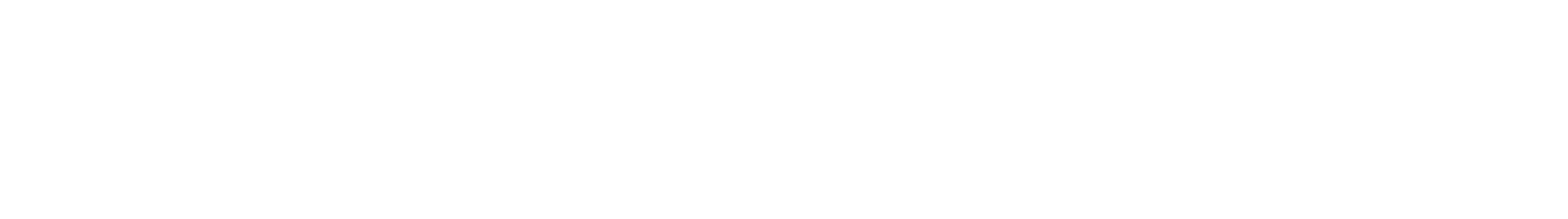
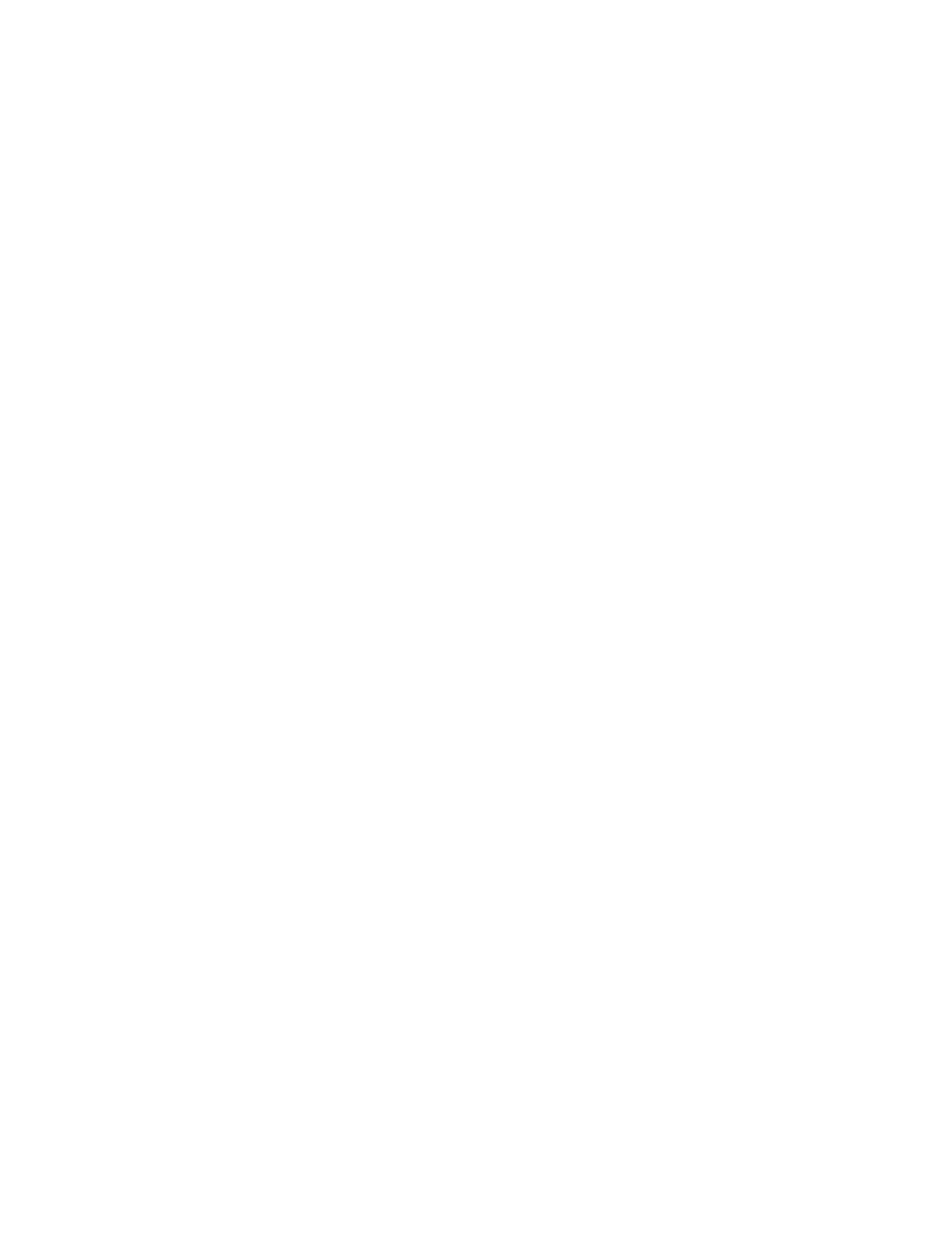
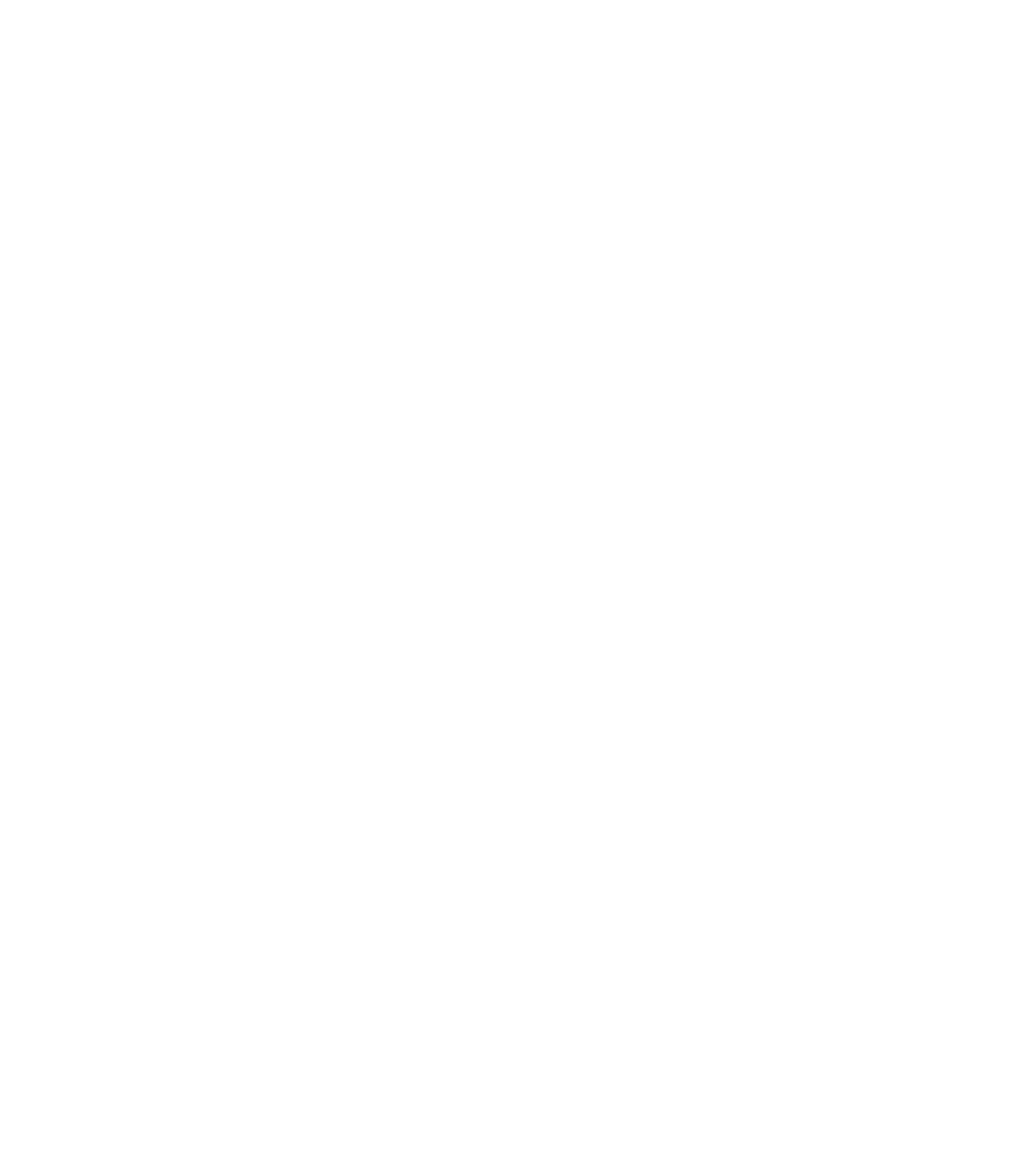
#### Conclusions

The evaluation found that the introduction of a clinical Aboriginal Health Care Coordinator role to a HARP team providing complex psychosocial care in the community is resulting in more Aboriginal clients being reached and engaged with the service, and it is making a difference to the quality of service Aboriginal clients receive. Through this new role, services are also becoming more accessible and more culturally sensitive coordination of care for Aboriginal clients is being provided at the intersection of acute and community health services.

Close the Gap

### Gunditjmara Aboriginal Cooperative

### Introduction



#### The Close the Gap (CTG) project at Gunditjmara Aboriginal Cooperative provides care coordination and case management to Aboriginal people. Clients may have a range of health and wellbeing issues which may relate to alcohol and other drugs issues, family violence, mental health or social and emotional wellbeing needs. Clients self- refer or are referred by local organisations and services. CTG also provides support to make the client’s health journey more accessible, by providing cultural awareness training to local health services.

#### Project Background

A lack of access to health services is a major impediment to improving the health of Aboriginal people in the South West of Victoria. This project aimed to provide culturally informed case management support for clients and to actively address service access. A consortium of local health services comprising South West Healthcare, Kirrae Health Services and Gunditjmara Aboriginal Cooperative developed a project plan which was approved and overseen by the (then) Barwon South West Closing the Health Gap Steering Committee. The project commenced in 2010, located at South West Healthcare.

Staff turnover in 2012 provided space for informal review of the project, and it was decided at this time to retain the partnership, but transfer the project location to Gunditjmara Aboriginal Cooperative. This enabled the service to be run from a non- institutional setting, community controlled setting.

**About the service**

The CTG service is focused on family and engagement with Community, not just the individual. This is underpinned by the overarching National Aboriginal Social and Emotional Wellbeing (SEWB) Framework which places connections or reconnections to Culture and Community as a core strategy in responding to individual presenting needs.

CTG supports people to engage with the program, access a Family Support Worker and, where agreed, to work with the client and their family to establish client directed goals. Practical assistance such as food vouchers and transport can also be provided where appropriate.

“My worker comes to my home. We talk about a lot of stuff. She rings me when community things are on. Getting close to the community is best. I could not have done that without her.” (Client)

The CTG team include a Coordinator and three Family Support Workers. Support is provided through role modelling, mentoring and advice. Clients are commonly introduced to cultural experiences and groups, which provide strong peer support. Expected client outcomes include:

* engagement of clients and families with the project case workers
* visible referrals and support pathways for

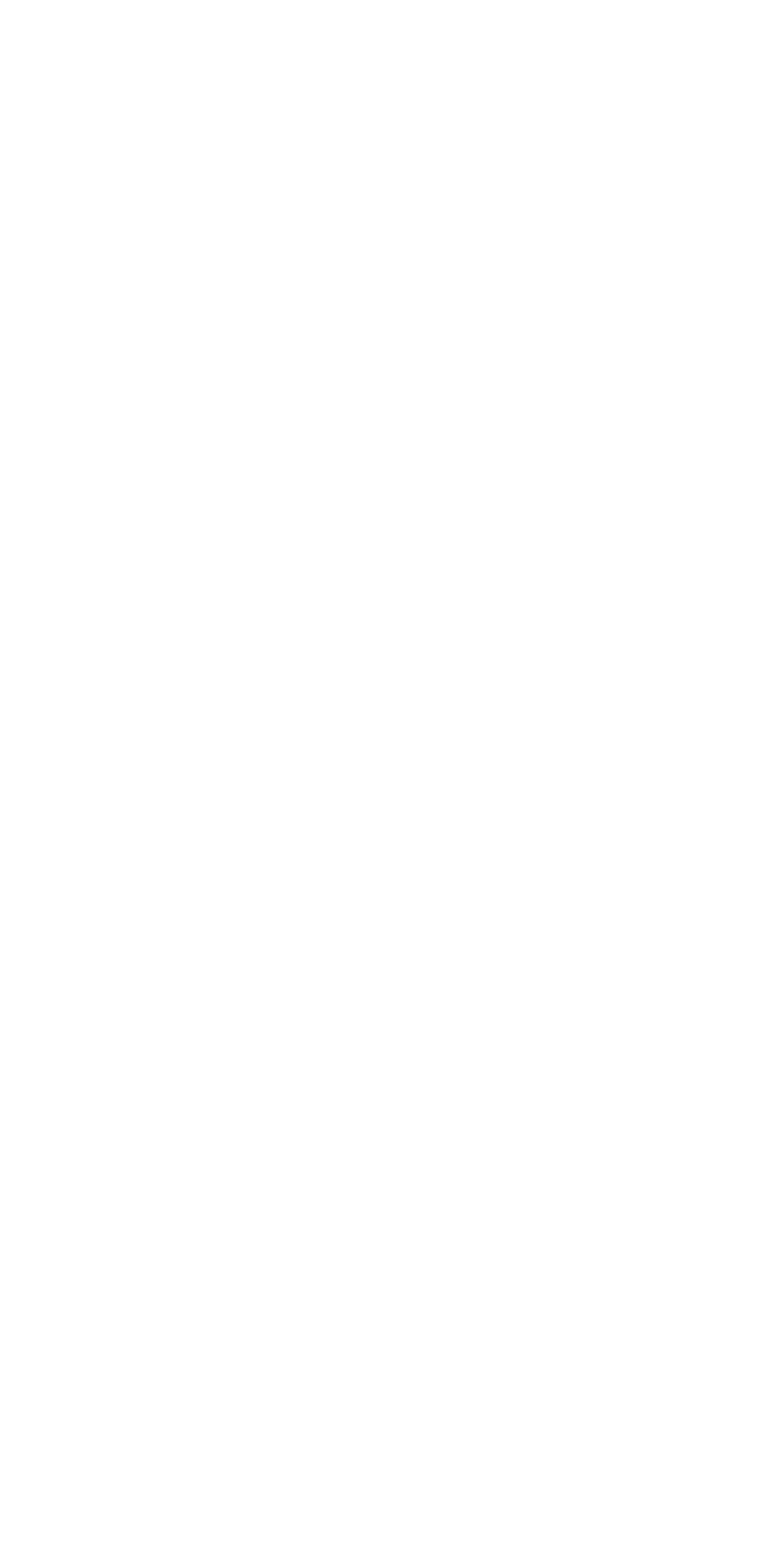
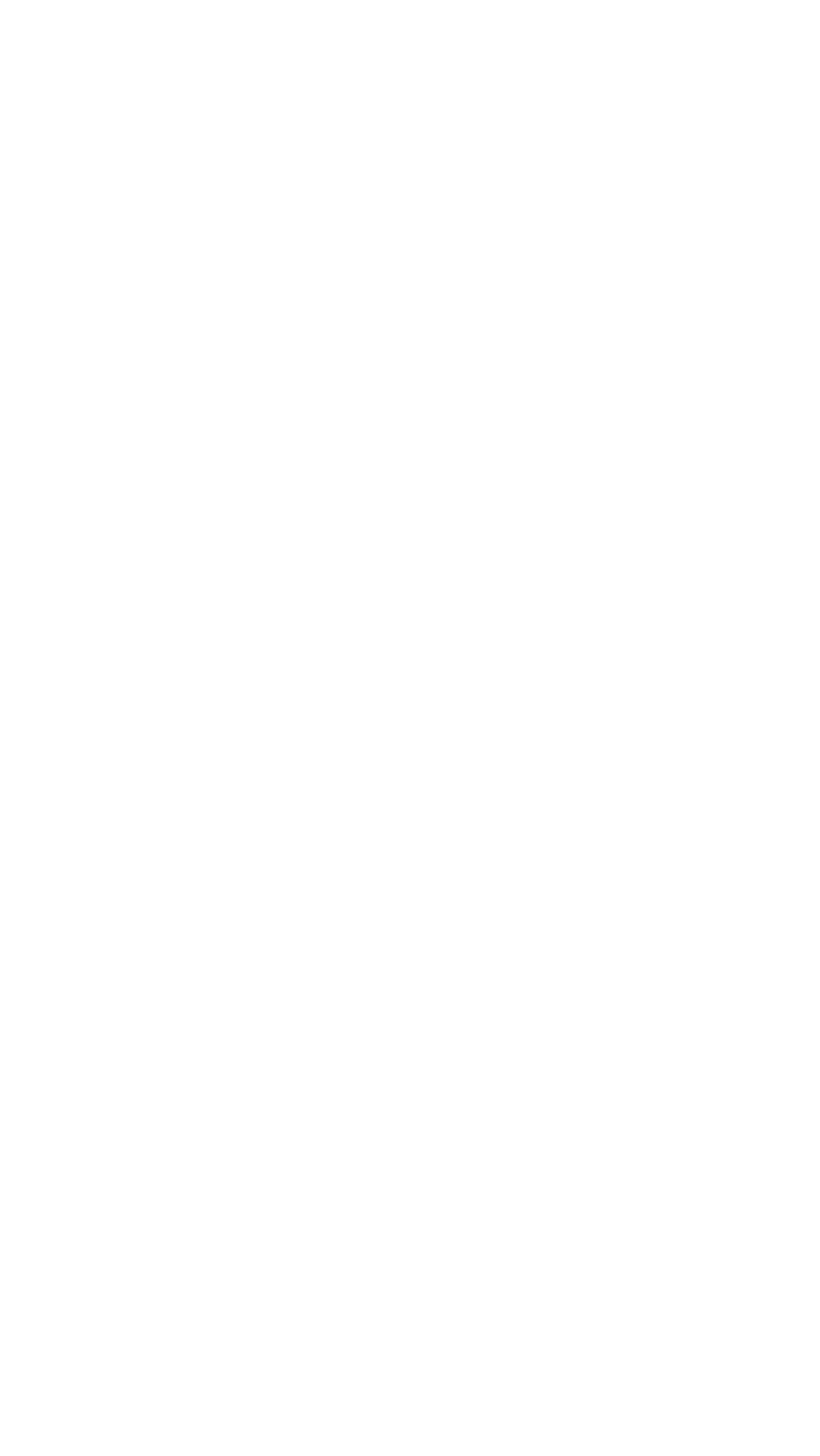
clients

* behavioural change for clients
* reconnection with family and Community.

A long term aim of the program is to achieve a break in inter-generational cycles of poor health.

#### Learnings

###### The evaluation identified a number of features of the CTG service. The care coordination and case management approach involves engaging clients and families through:



###### empowering clients to define the problem

###### active and careful listening

###### applying a strength-based approach

###### reinforcing culture and spiritual health

###### providing linkages to Aboriginal and mainstream health services.

###### Connections to Community and Culture are made separately for each client including one-on-one support and connections with the Elders support group.

###### The CTG service plans to strengthen its work with clients and families by providing a greater emphasis on empowering clients and building client resilience and independence. There will be a stronger focus on goal setting and skill development.

###### Challenges identified in the evaluation include the complexity of clients’ circumstances, staff changes, changes in auspice and insecure funding.

#### Conclusions

###### The connections and linkages between CTG and other Gunditjmara Aboriginal Cooperative health services, as well as external health and mental health services supports clients in their journey across and between services as required. An important component of the CTG service model is the provision of support to agencies in the wider service system.

###### The strong commitment to working with Elders helps reinforce connections to the community for clients and their families.

###### The CTG has achieved an impact at various levels including clients, external agencies and the service system. Some clients have achieved highly successful outcomes and the CTG provides a clear avenue for individuals and external agencies seeking support for Aboriginal people.

###### “My worker is a proud Aboriginal women. She is different; she does Aboriginal things… She has made culture stronger… I am going to school. I don’t mind it now. I have some friends.” (Client)

Fresh Tracks

### Wathaurong Aboriginal Co-operative

### Introduction

#### This Social and Emotional Wellbeing (SEWB) project provides care coordination to assist clients in the management of their health and navigation of the health service system, using an assertive outreach model. Clients have complex psychosocial and/or medical needs. Care planning is undertaken with the client, and support provided through single or multiple contacts and/or complex care coordination.

#### Fresh Tracks is resourced by a part- time psychologist/care coordinator who is part of Wathaurong’s Health Services team.

#### Project Background

###### Fresh Tracks commenced in 2014. It is a community-controlled project and was developed by Wathaurong Aboriginal Co- operative when the Koolin Balit funding offered an opportunity for a new approach.

###### The community wanted to address not only the impacts of chronic illness but also the impacts of psychological distress.

Fresh Tracks’ care coordination support is based on an understanding of the Aboriginal health Social and Emotional Wellbeing Framework. This framework takes into account the importance of connections to body, mind and emotion, family and kinship, community, culture, country, spirituality and ancestors, and the impact disconnections across these domains have on the health and wellbeing of Aboriginal people.

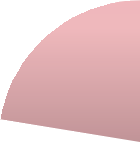
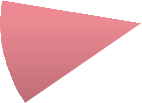
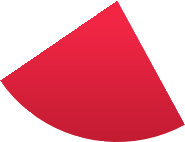
**How does Fresh Tracks work?**

Fresh Tracks considers clients from a ‘whole person’ perspective which includes thinking about the impacts of cultural, community and family needs. There is no single service for clients. Clients may need help getting to one medical appointment or to many. They may need practical support, they may need psychological support and assistance to help themselves and their family to cope with a chronic illness or they may need long-term therapeutic support to deal with the impacts of trauma.

**Client demographics**

Over two years (from July 2014 to June 2016), Fresh Tracks has assisted **107** people. This included people dealing with chronic illnesses, mental health conditions and often, other factors such as homelessness, family violence, or drug and alcohol issues. Women and men make up almost equal numbers of clients and people of all ages have used the service, as the graph shows.

Client age groups



###### While some community members may be dealing with chronic illness or psychological distress, many people are confronting the combined impacts of illness and psychological distress.

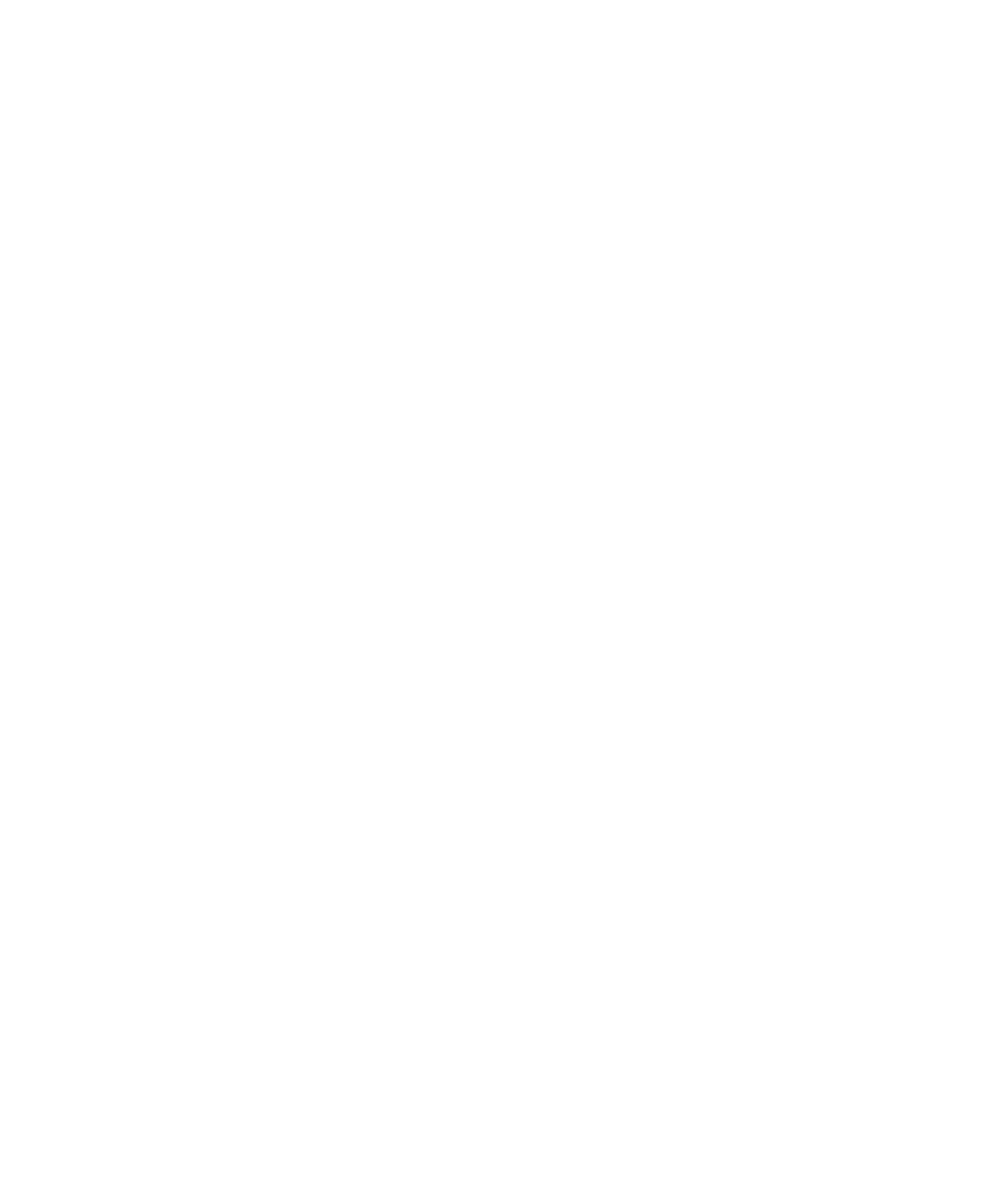
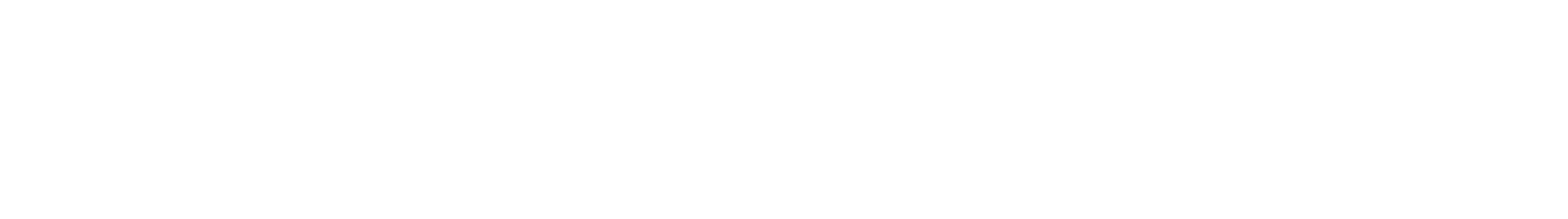
**>50 years old 23%**

**40-49 years old 12%**

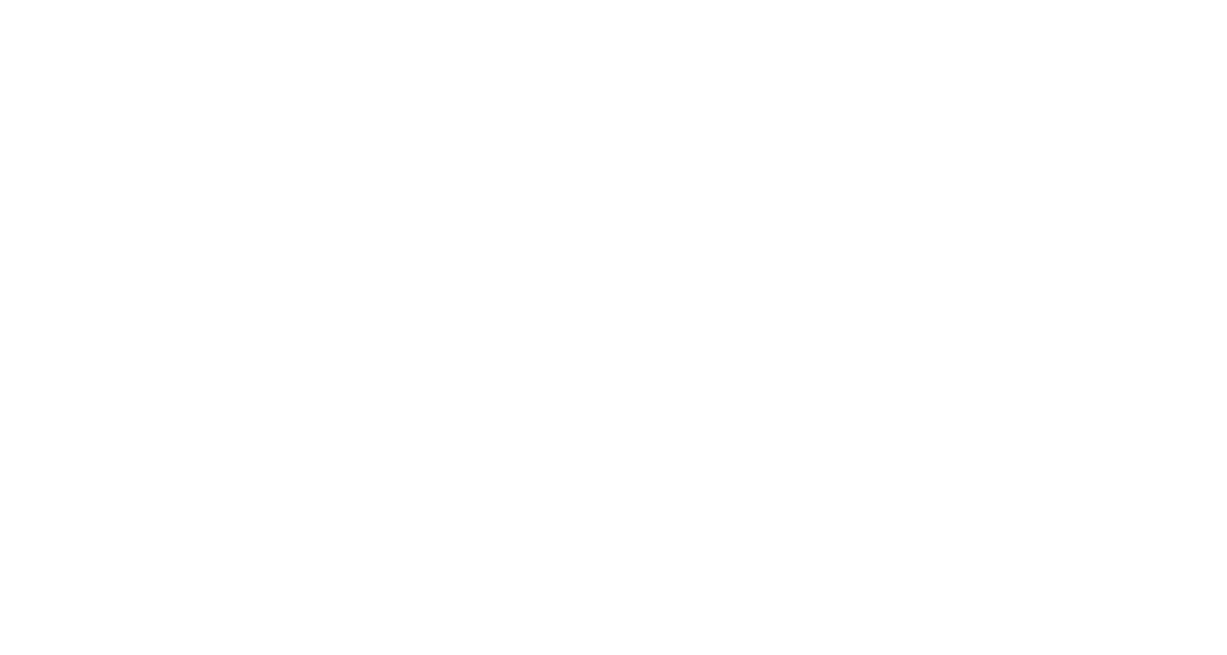
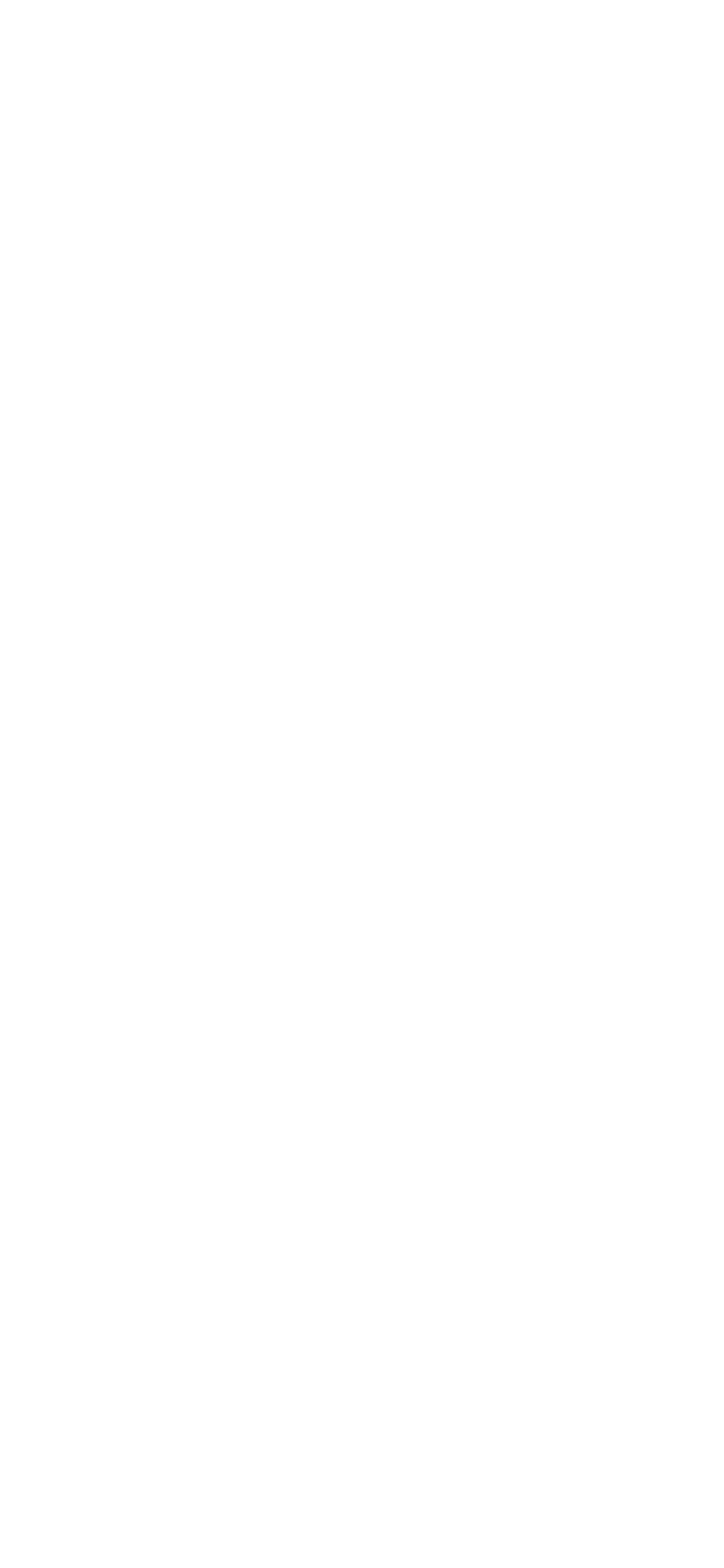
**0-19 years**

**old 17%**

**20-29 years old 25%**



**30-39 years old 23%**



**How are people referred to Fresh Tracks?** People are referred to Fresh Tracks from local services such as the hospital, housing services, Centrelink or community corrections. They are also referred from services within Wathaurong, such as the General Practitioners or men’s or women’s programs.

**How do services work together?**

When more than one service is involved, the Fresh Tracks Coordinator consults and plans with other case managers to ensure the client receives the best service.

“Between (the case managers) we can work out who is doing what, and each can focus on their own area. Fresh Tracks has advised on supports for clients that I wouldn’t have known about. By working together, the client benefits.” (Local hospital)

**What are the outcomes for clients?**

From combined feedback from clients, program staff, Wathaurong health service staff and external clinicians and program data, outcomes for clients have included:

* getting people to treatment
* getting people to the right treatment
* self-management support
* re-uniting with family members
* supporting families to stay in tact
* assisting parents to maintain or re-gain access to children
* opening up conversations about culture
* transitions to stable health, stable housing
* reducing chaotic lifestyles, gaining control
* maintaining community corrections orders
* reducing presentations to emergency departments.

**What do clients say about Fresh Tracks?**

“It’s pulled me out of a severe hole - I was in deep and couldn't find my way out. I had issues that weren't being addressed, now I’ve got an answer. There has been a vast improvement in my mental health. My health is good and I get regular support.”

“I’m heaps better. I actually care about my health and my mental health now. Before, I wouldn't go to see doctors, I don't know why*.”*

#### Learnings

One skilled and supportive case coordinator can reduce the number of clinicians and services a client needs to deal with – making a substantial difference for people who are vulnerable and disengaged from health services.

Care coordination works well for clients who need support but don’t fit the criteria for other services.

Care coordination support can ‘make the difference’ in sustaining clients through long journeys in health and community service systems.

Therapeutic support informed by Aboriginal perspectives of health allows clients to explore and address root causes of psychological distress when they are ready, as well as address the symptoms of this, such as depression or anxiety.

Providing therapeutic support for clients ‘on country’ at Wurdi Youang, an Indigenous Protected Area and site of historical and cultural significance is a significant innovation and is supporting clients in their journey to re-connect to culture.

By connecting with internal and external health professionals, and services outside the health system, such as justice or employment, a genuinely wrap-around service can be provided to the client.

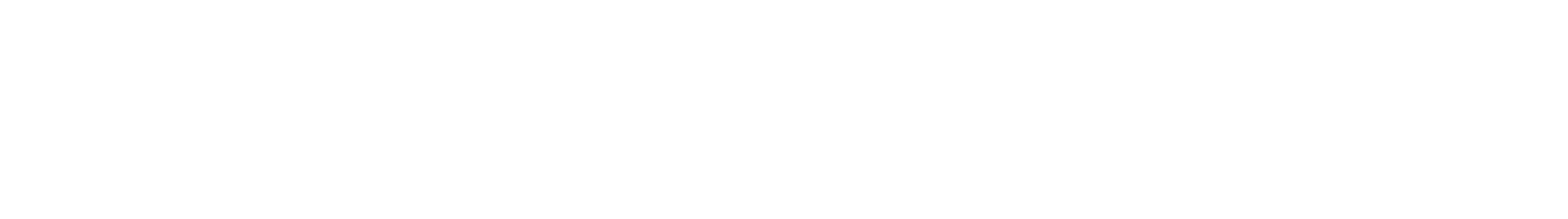
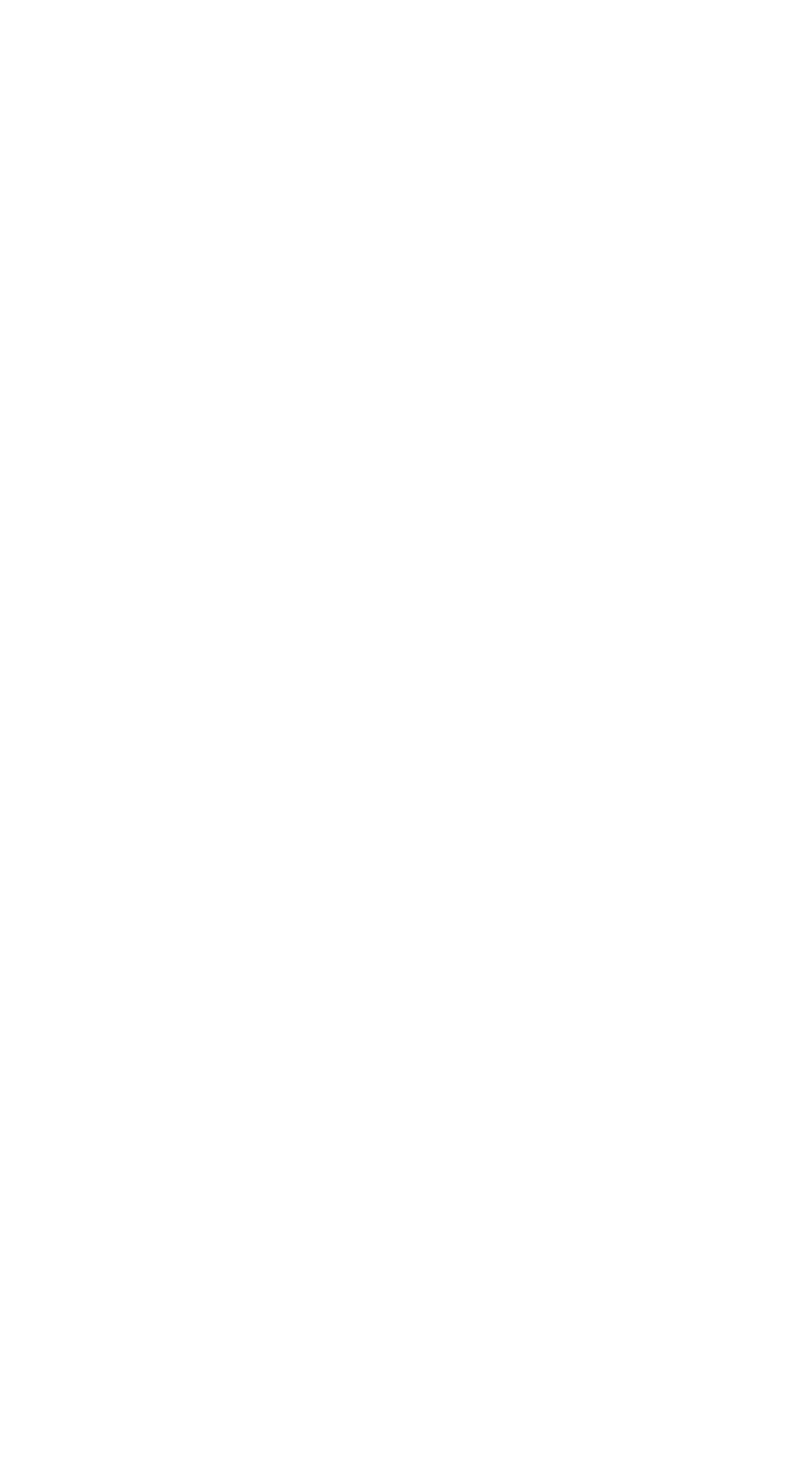
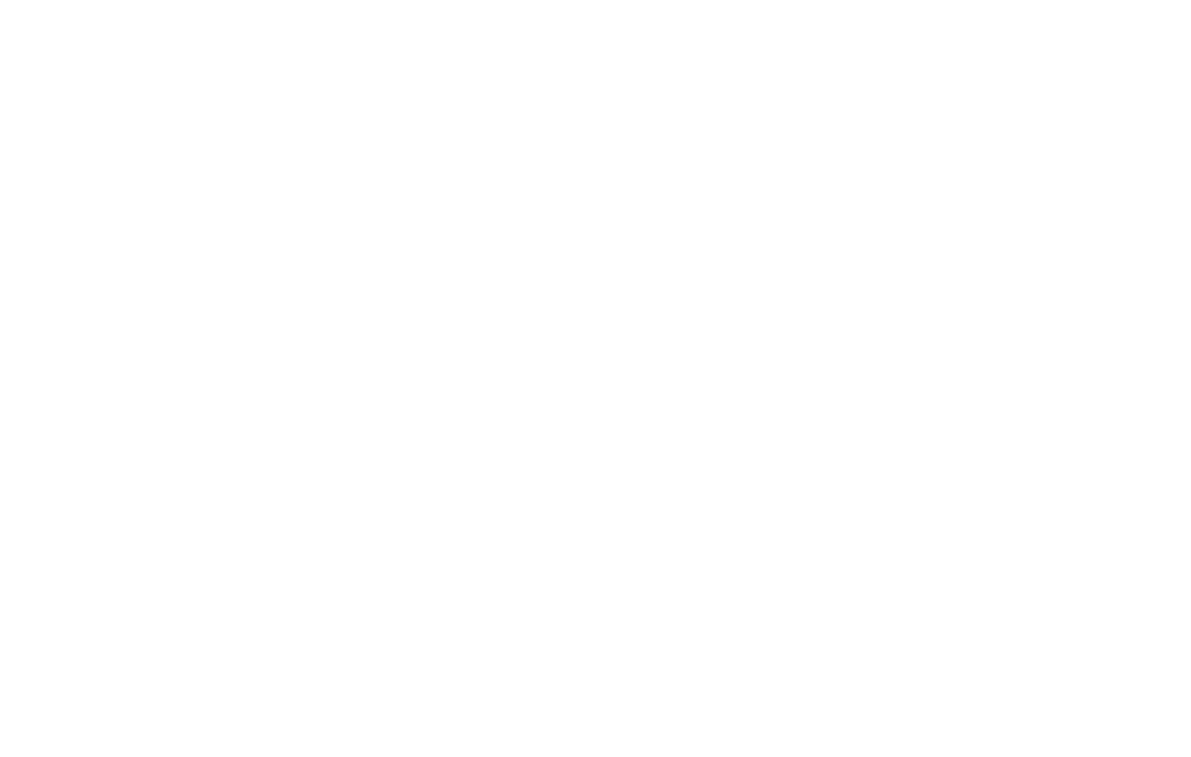
An outreach approach – providing support in the community or a place where the client feels comfortable – makes the service safe and accessible for clients. An assertive approach – following up clients who appear to be disengaging – sends a clear message to clients that they are cared for and this strategy is working to keep people engaged in care for their health and wellbeing.

#### Conclusions

###### The Fresh Tracks approach of culturally informed, assertive outreach care coordination support, based in an ACCHO, has demonstrated significant benefits for clients’ health and wellbeing, for the organisation and for the local service system.

Early Years Services

### Mallee District Aboriginal Services (MDAS)



### Introduction

#### The Early Years Services at MDAS provide a range of services to Aboriginal families with children under school age, including case management and care coordination through the Family Support Services.

#### Project Background

Commencing in 2012, the Early Years Services build on and integrate earlier programs focusing on vulnerable mothers and children at risk under the one umbrella.

The Early Years Services was initiated to respond to both individual and systemic failures of the existing service system. It was widely acknowledged that mainstream specialist services were unable to support many Aboriginal clients, and that Aboriginal people themselves were unwilling to access these services for various reasons. The tragic suicide of a young pregnant woman crystalised the need for a comprehensive response. Through the Early Years initiative, early intervention services can be provided to families and young children, proactively addressing low levels of health and wellbeing experienced by families with young children in the community.

Over four years, a complex model of care has evolved to provide intensive support to women while they are pregnant and families with babies and young children up to school age. The Queen Elizabeth Centre, the Royal Women’s Hospital and the Royal Children’s Hospital have all contributed to the evolution of the model over this period.

**About Early Years Services**

Early Years Services provide an integrated model of care through four complementary services:

* Maternity Services
* Maternal and Child Health (MCH)
* Family Support Services
* Family Capacity Building Groups

The Early Years Services are strongly informed by a theoretical base and resourced through a Lead Practitioner position. The Lead Practitioner is central to supporting and training staff in the application of the various strands of theory, including attachment theory, trauma-informed practice and Newborn Behavioural Observation.

The service is funded through a range of funding bodies and delivered within the context of the wider MDAS agency by a team of 21 staff.

The service aims for clients to get the right care, at the right time, by the right team and in the right place. Expected client outcomes include:

* regular attendance and active engagement with Early Years Services
* the child remains safely within the family
* improvement in parent’s/carer’s overall connection with the child
* the child is meeting milestones
* the child is school ready.

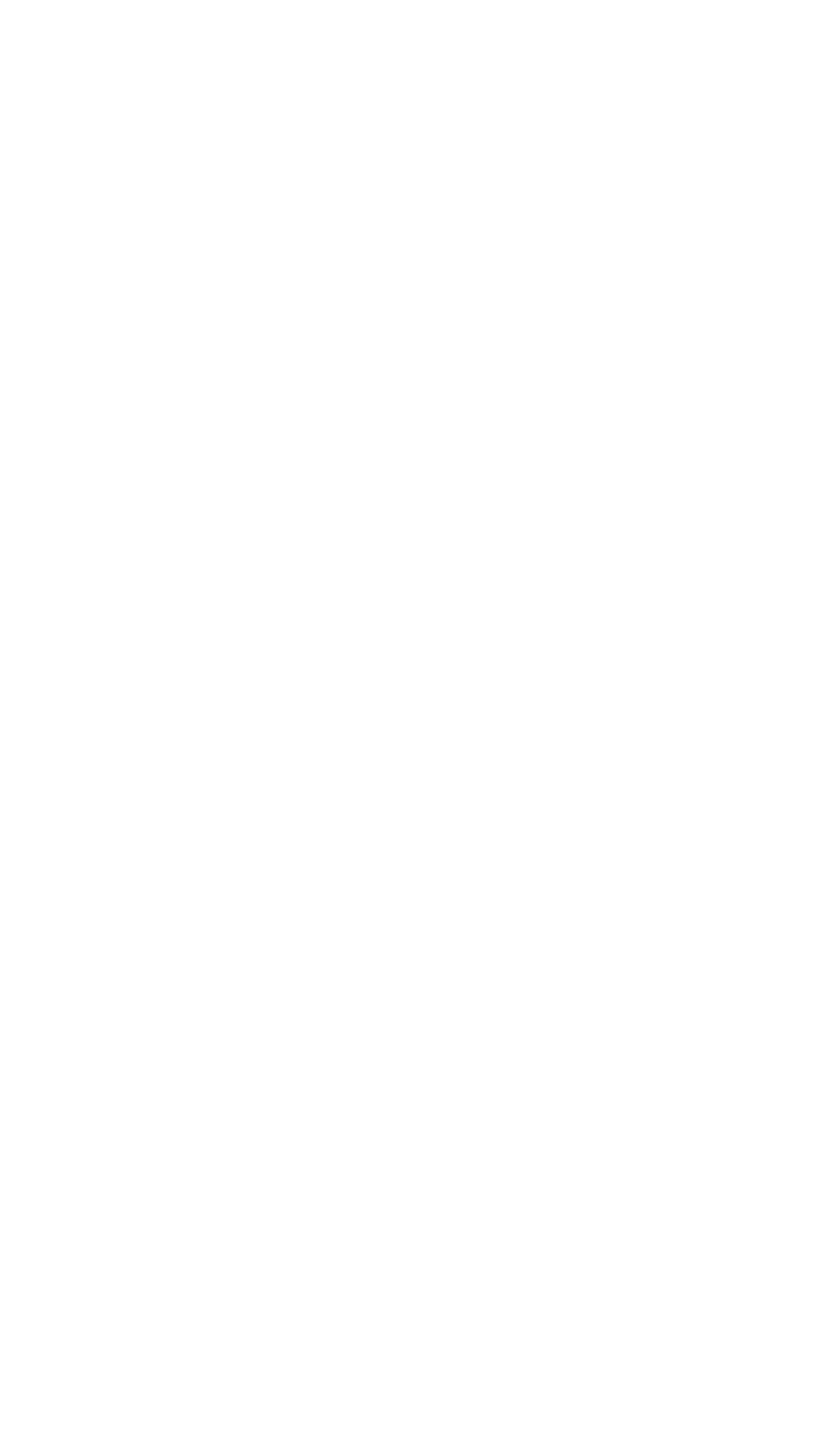
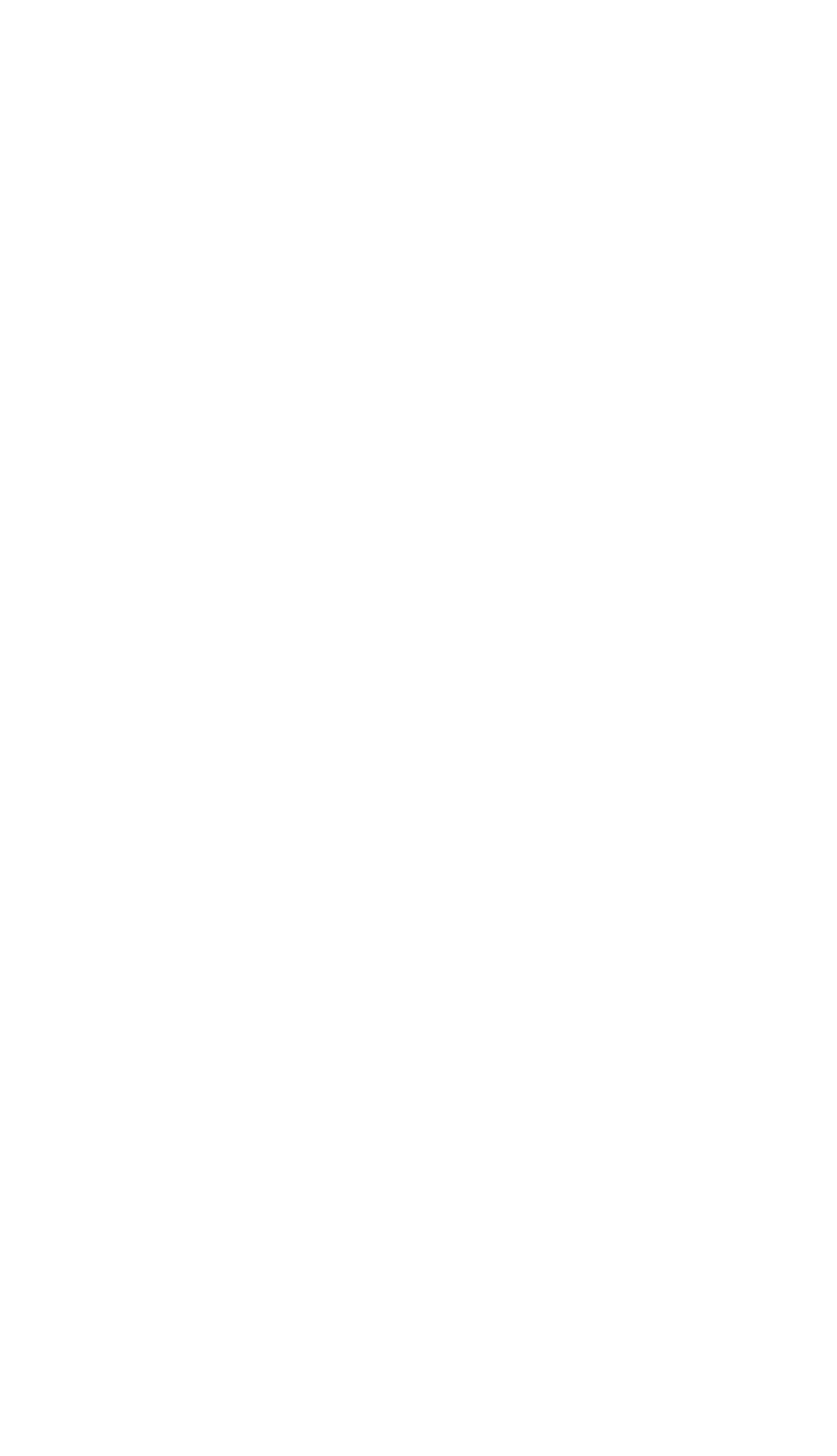
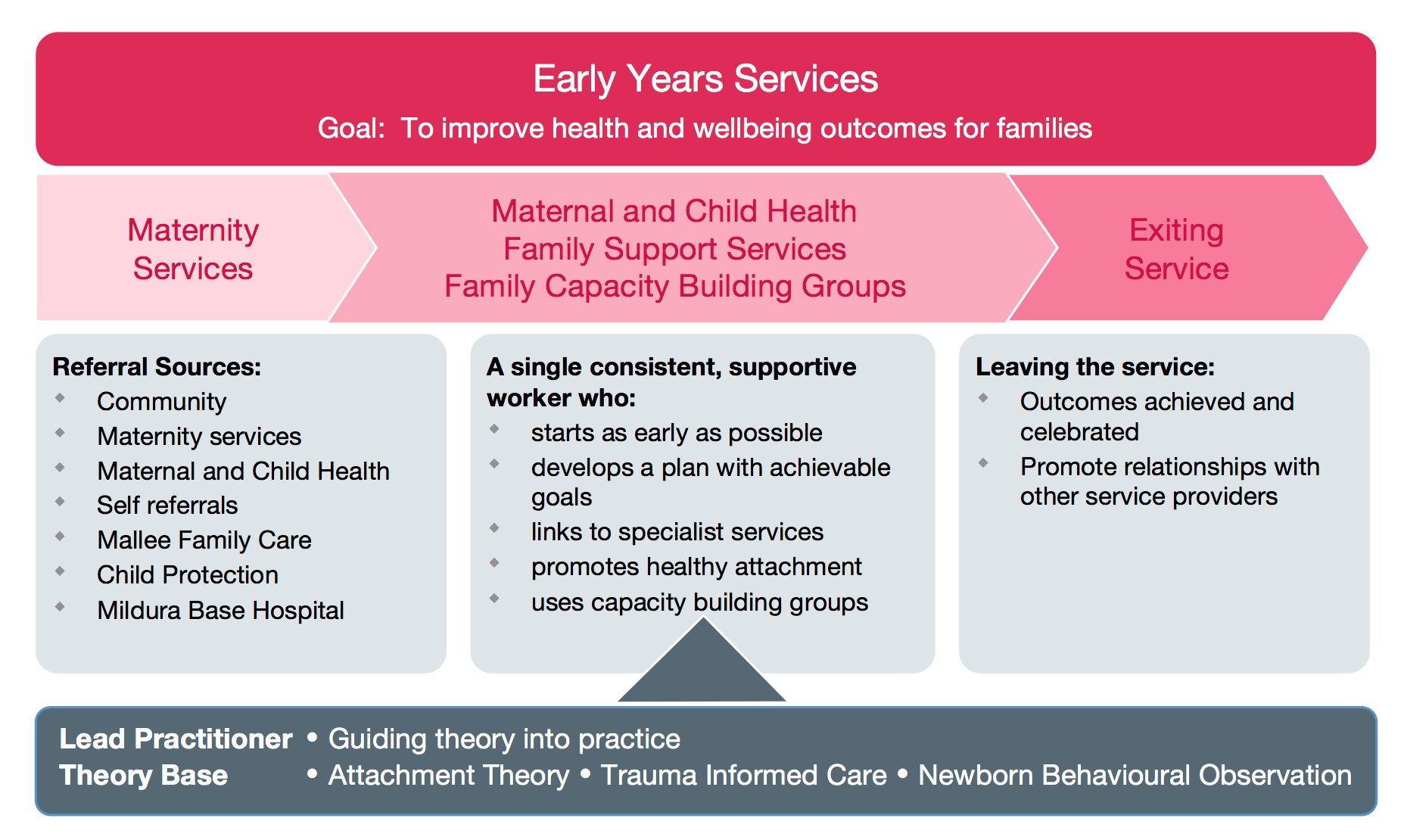
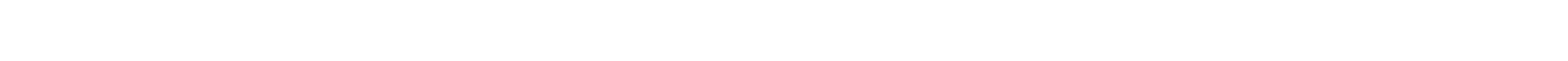
**What did clients say about the service?**

“MDAS has helped me with parenting. They have shown me films, have given me things to read, done courses here and they show me how to do things with my son. They also helped me make decisions and they helped me with housing. MDAS has been good to me. They are respectful.”

“Everything has changed. I had no clues then. I did not know what to do with the kids. I had no idea how to keep a home, like shopping and cleaning. It made a lot of difference. I am now confident and have a home. I am going to TAFE. I would score them 10 out of 10. I don’t know where I would be without them.”

**Figure 1: Early Years Services Model**

#### Key findings



###### The evaluation found Early Years to be a highly effective service.

###### Early Years data shows:

###### an increasing number of women receiving regular antenatal checks

###### very high proportions of children up to date with their immunisation schedules

###### very high proportions of children up to date with MCH ages and stages visits.

###### Most significantly, over the past two financial years (2014/15 and 2015/16) no children receiving Early Years’ Family Support Services were permanently removed from their parents’ care.

###### The evaluation found that the grouping of Early Years services under a common umbrella, enables a comprehensive, intensive and increasingly integrated service to be provided to clients. The single, consistent Family Support Services caseworker who works with the family further supports this integration through linking clients across services, interpreting services to the client and the needs of clients to services.

#### Conclusions

###### Over a period of four years, the MDAS Early Years Services have evolved into a complex model of care, based on theory and evidence, which was found to be both innovative and effective. The service is highly respected by stakeholders and clients, has made a substantial impact on the lives of a number of its clients and is a highly visible entry point for Aboriginal families into the MDAS and wider service system.

###### Outstanding features of the service include:

###### the strong emphasis on culture and theory to inform practice

###### the high standard of training and support provided to staff by the Lead Practitioner

###### the excellent practice of staff.

###### The inter-relationships across the four complementary services, and for Family Support Services clients, the intensive support of a consistent case worker, provides for delivery of a highly integrated service. The outstanding leadership support and vision at the agency, management and practice levels is key to the success of the model.

**Early Years Team**

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/ **Lead Practitioner** \

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### ,------------,

**1 Complex Care** 1

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I • Early Years Manager I

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/ **Lead Practitioner** '

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**Referral source:**

MDAS Early Years Koori Maternity Services

MDAS Early Years MCH MDAS Early Years Playgroup

MDAS Health Service or other

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: • Lead Practitioner :

**1** • MDAS Maternity, MCH, 1 I and/or MDAS Health I IL Services as relevant \_)I

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|  |  |
| --- | --- |
| rl | **Housing** |
| H  H | **Child Protection** |
| Family Violence |
| H Alcohol and other drugs | |
| H  '-1 | Health |
| Other |

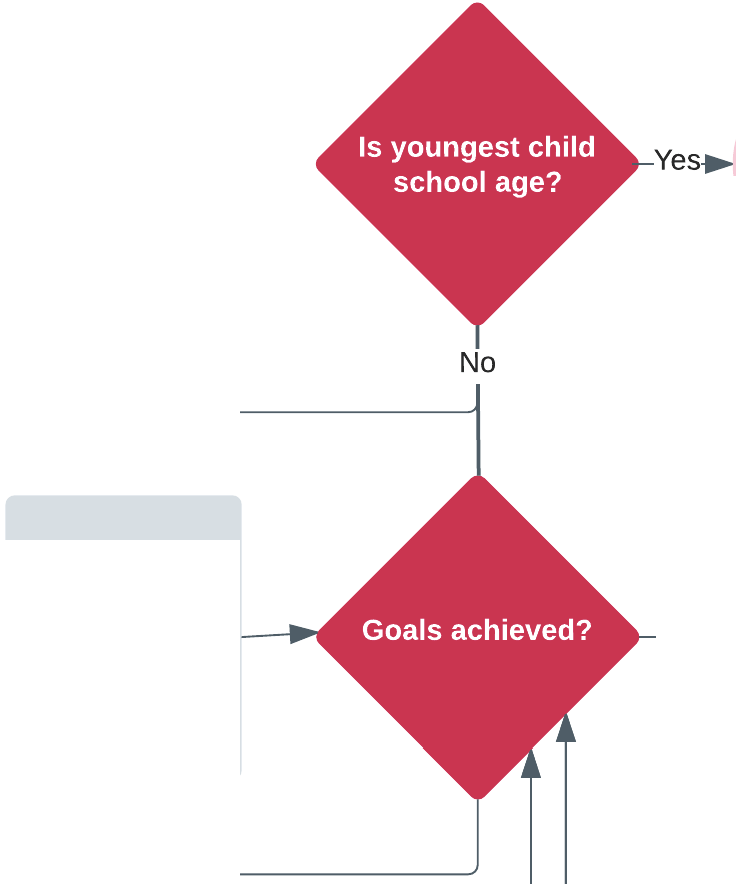
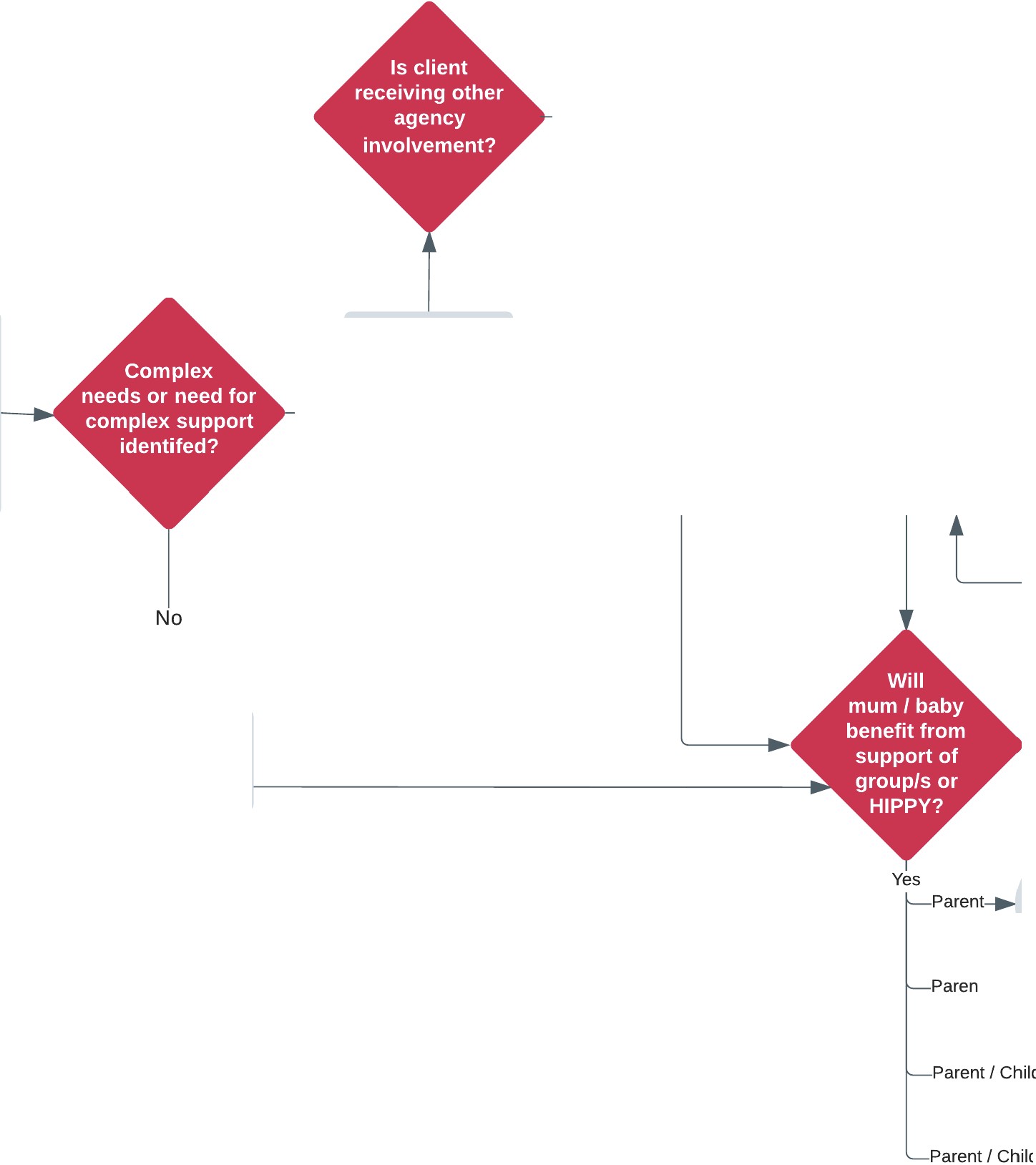
Regularly consult

other case

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Celebrate achievements Refer to other services

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program

Mum or family member External agency

eg. MCH, family services

Child protection or Child First GP, hospital or health service

**Screening:**

Yes. managers and

establish care team

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##### 3

Mum and/or child are Aboriginal Child has not started primary

Family Support

. Intake and

Family Support

Yes. Case Worker

Set goals with

mum *I* family and Provide on-going

----.care coordination-. case work

Regularly monitor

Celebrate achievements

Yes Exit Family Support Services

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school

Can benefit from MDAS Early Years Services

Assessment

process

Monitor need for family support

allocated to

family

process support

commenced

... and review

Circle of Security

1 Collaborative -----------'

Therapy

1 Community -----

Playgroup

I HIPPY

Refer to other services

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