



What models of Care Coordination for Aboriginal and Torres Strait Islander people, with complex chronic care needs work?

Naccarella, Lucio; The Australian Health Workforce Institute, The University of Melbourne
Freijser, Louise; The Australian Health Workforce Institute, The University of Melbourne
Stamford, Lee; General Practice Victoria

Objective

To evaluate what models of Care Coordination (funded through the Supplementary Services and Care Coordination Program by the Commonwealth Department of Health and Ageing) work, at a health workforce, organisational and system level, for Aboriginal and Torres Strait Islander people, with complex chronic care needs, and in what circumstances?

Method

Care Coordinators were surveyed with regard to demographics and roles. In depth interviews were also conducted with Care Coordinators located across three settings (General Practice Clinics; Aboriginal Health Services; Regional PHC Organisations-Medicare Locals) regarding their roles, outcomes, contextual influences, and resource requirements.

Results

Care coordinator survey respondents (n=43, a 72% return rate) were predominantly female, mature aged, had nursing qualifications, with an average of 18.7 years working in health care. Models of Care Coordination varied according to patient and system contexts. An Indigenous community engagement and outreach strategy is essential. Care coordinators performed multiple clinical care and patient support roles. Contextual influences included: community engagement, workforce characteristics, and resource requirements (time, funding, reporting duties). Expected outcomes ranged from: clinical (health assessments, care plans) to patient support (access to specialist care, preventing hospitalisations). Resource requirements reflected contextual influences.

Conclusion

Three key mechanisms are critical to the future of the Models of Care Coordination and Care Coordinator workforce, namely: a workforce capability framework, appropriate clinical governance; and a supportive authorising environment.

Discussion

What works? No particular Model of Care Coordination was superior, as they varied according to local patient and system context. The setting within which Care Coordinators worked is key to understanding the mechanisms that make the model and the Care Coordination functions work. We hypothesise that five interdependent key mechanisms are essential: 1) connections with Aboriginal and Torres Strait Islander communities; 2) workforce role clarity and capability; 3) know-how of service systems of care; 4) appropriate clinical governance arrangements and 5) a supportive authorising environment.

For whom? High levels of agreement exist between the Care Coordinators, and across the three settings in relation to the key essential mechanisms. We acknowledge that the sample was small and not representative, but illustrative of Care Coordinator roles.

In what circumstances? Given the interdependencies between the essential mechanisms, our evaluation has limited ability to reveal in what specific circumstances the models and Care Coordinators work best. We hypothesise that the models of Care Coordination and Care Coordinators will contribute to optimising care for Aboriginal and Torres Strait Islander patients with chronic conditions where there are higher levels of connections with Aboriginal and Torres Strait Islander communities, greater workforce role clarity and capability, know-how of systems of care, appropriate clinical governance arrangements and a supportive authorising environment

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