

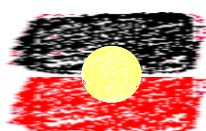
NSW Health

The Walgan Tilly Project: Chronic Care for Aboriginal People Final Report

April 2008



Bronwyn Bancroft 2007



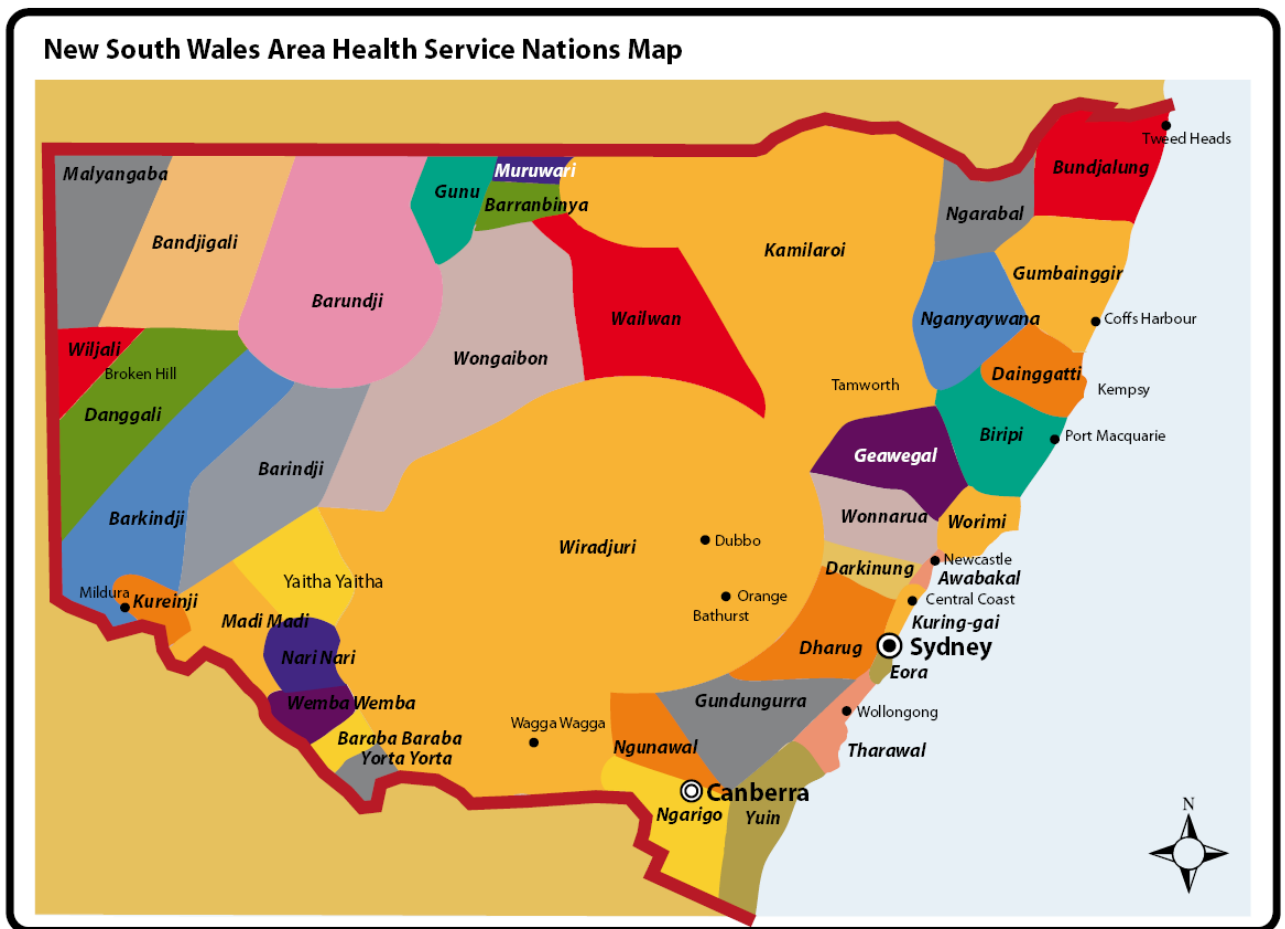
Walgan Tilly Project
Chronic Care for Aboriginal People

NSW Aboriginal Nations Map

The maps presented in this report were developed based on the Aboriginal Australian wall map developed by the Australian Institute of Aboriginal and Torres Strait Islander Studies.

The maps indicate only the general location of larger groups of people, which may include small groups such as clans, dialects or individual languages within a group. The spelling of the nations and the boundaries are based on those in the maps and are therefore traditional boundaries.

The maps are in draft format and are yet to be approved by the Australian Institute of Aboriginal and Torres Strait Islander Studies and by the appropriate Aboriginal Land Councils. The maps in this report are not for redistribution.



This report has been prepared for NSW Health and is not to be used for any other purpose or distributed to any other party without their approval. We do not accept any responsibility for losses occasioned to NSW Health, the Area Health Services, and Justice Health or to any other party as a result of the circulation, reproduction or use of our final or draft report contrary to the provisions of this paragraph.

The report is based on information supplied by NSW Health, the Area Health Services, Justice Health and interviews conducted with their staff. This information has not been independently verified and we therefore do not provide any assurance as to its completeness, reasonableness or accuracy.

© 2008 PricewaterhouseCoopers. All rights reserved. "PricewaterhouseCoopers" refers to the network of member firms of PricewaterhouseCoopers International Limited, each of which is a separate and independent legal entity.

Acknowledgements

NSW Health recognises the unique position of Aboriginal people in the history and culture of NSW. Aboriginal peoples in NSW have a strong connection to their traditional lands, cultures and heritage. NSW Health would like to acknowledge the traditional owners of the lands referred to in this report and remind people we are on Aboriginal Land. We would also like to acknowledge and pay respect to elders of the communities covered in this report.

Bronwyn Bancroft is the artist who developed the cover artwork.

The project team would like to say thank you to the local project representatives who helped to coordinate data collection activities, workshops and the development of their proposed solutions and implementation plans. This project would not have been possible without your support and enthusiasm.

These local representatives were:

Area Health Service (AHS)	Representatives	
South Eastern Sydney Illawarra Area Health Service (SESIAHS)	Gail Daylight Wendy Sue Forder	Eunice Simons
Sydney West Area Health Service (SWAHS)	Elaine Buggy Trish Heal	Tim Agius Karen McNulty
Sydney South West Area Health Service (SSWAHS)	Vicki Wade George Long	Steven Johnson
Northern Sydney Central Coast Area Health Service (NSCCAHS)	Coralie Lifu Annette Marley	LaVerne Bellear
Hunter New England Area Health Service (HNEAHS)	Tony Martin Angela Hudson Caroline Bailey	Lisa Orcher Candice Dalhstrom
North Coast Area Health Service (NCAHS)	Robyn Martin Anthony Franks Jeff Richardson	Kerry Wilcox Lynn Hopkinson
Greater Western Area Health Service (GWAHS)	Wendy Moore David Peebles	Craig Shields
Greater Southern Area Health Service (GSAHS)	Greg Packer Marjo Roshier-Taks	Michelle Honey Lee Simpson
Justice Health	Maureen Hanley	Liz McEntyre

We would also like to thank all staff who participated in the various data collection activities and workshops and the patients and carers who took the time to share their stories and experiences with us.

Thank you to the project Steering Committee who provided support and guidance throughout the project.

The project team consisted of the following individuals:

NSW Health	PricewaterhouseCoopers	
Raylene Gordon	Christine Callaghan	Elizabeth Sweeney
Ashley Young	Ray Quigley	Deanna Pyper
Lynette Mieni	Rebecca Jessop	Karen Lee
Lisa Donnelly	Karen Milward	Lorraine Acheson
	Sarah Johnson	Kimberly Loudon

This report has been approved for circulation by Dr Tony O’Connell, Acting Deputy Director General, Health System Performance, NSW Health.

Executive summary

Project objectives, approach and milestones

There are around 134,888 Aboriginal people¹ living in New South Wales (NSW), representing approximately 2% of the total NSW population and 29% of the total Australian Aboriginal population² (however, approximately 90,000 Aboriginal people were in scope for this project). While many people living in NSW have experienced significant health gains in recent years, these improvements have not been equally shared by Aboriginal people who continue to experience greater health risks, poorer health and shorter life expectancies than non-Aboriginal people³.

The disproportionately high burden of chronic conditions, such as cardiovascular disease, kidney disease, chronic respiratory disease and diabetes, significantly contribute to the greater morbidity and premature mortality in Aboriginal populations. There are a range of factors which contribute to chronic health conditions in Aboriginal Communities. These factors, although well-documented, are complex and often result in Aboriginal people presenting to health services late in the course of their disease, which in turn leads to significantly higher rates of complications and death.

The Chronic Care for Aboriginal People (Walgan Tilly) Clinical Services Redesign⁴ project is the first Aboriginal Redesign project and was developed from a number of established NSW Health initiatives in an attempt to address the disparities in health care and improve access to and utilisation of chronic care services for Aboriginal people in NSW.

The Chronic Care for Aboriginal People project was named Walgan Tilly. Walgan is a Kamilaroi word meaning 'Aunt', a title of respect to Aboriginal women and 'Tilly' is short for the name Matilda. The project was given this name to help ensure that the focus of the project remained on the patient experience.

The main goals of the project were as follows:

- Develop practical steps and real solutions to improving access to chronic disease services for Aboriginal families and communities.
- Build working relationships between Aboriginal and chronic disease services.
- Identify and share of best practice in meeting the needs of Aboriginal people with chronic disease.

The high level objectives of the project as stated in the NSW Health work order were:

- Understand and reduce health system barriers to access of mainstream chronic disease services for Aboriginal people in the community setting.
- Develop effective systems between Area Health Service's (AHS) Acute and Chronic Care teams, Aboriginal Medical Services (AMS) and the Aboriginal Vascular Health projects for the diagnosis and care of Aboriginal people with chronic conditions.
- Provide development and support for implementation of evidence based strategies for Aboriginal communities that prevent chronic disease and/or reduce hospital admissions.

¹ The term Aboriginal people is used throughout the document to represent both Aboriginal and Torres Strait Islander people.

² NSW Department of Health. (2006). *E-CHO Report of the New South Wales Chief Health Officer: Aboriginal and Torres Strait Islander Peoples*. Sydney. NSW Department of Health.

³ NSW Department of Health. (2007). *A new direction for NSW: State Health Plan Towards 2010*. Sydney. NSW Department of Health

⁴ Hereafter referred to as Redesign.

The approach to undertaking this project was focused on the application of Redesign methodologies to review the patient journey of the Aboriginal person (aged 15 and over) who have, or are at risk of, chronic conditions and was underpinned by the principles of collaboration and partnership.

This was achieved through a structured approach that captured and analysed the 'as-is' environment through extensive stakeholder consultation and data collection activities, which was then used to inform the development of the recommended solutions (or the 'to-be' environment).

The project was comprised of three key phases:

Phase 1: Project planning and mobilisation

Phase 2: Diagnostic phase-understanding the 'as-is' environment

Phase 3: Solution design and implementation planning phase-designing the 'to-be' environment.

The following section describes the key outcomes of the project, that is, the proposed solutions at the local and state level.

Project processes and milestones to date

Over the course of the project, a number of milestones were achieved, these included:

- 23 proposed AHS and Justice Health solutions and implementation plans.
- Six proposed state-wide solutions and implementation plans.
- Development of Aboriginal Nation maps for each AHS and Justice Health.
- A state-wide workshop was held in Sydney (with over 65 attendees) to facilitate the sharing of local and state-wide solutions, to agree the next steps and to build the commitment for change.
- Solution design training workshop which provided skills transfer from NSW Health and PricewaterhouseCoopers (PwC) to over 35 AHS and Justice Health representatives.
- A total of 12 validation workshops were held across the state, with a total of 206 attendees, with a minimum of one workshop per AHS.
- A total of 11 local solution design workshops (AHS and Justice Health) were held across the state, with a total of 201 attendees
- Three site visits for the purpose of in-depth data collection activities in a metropolitan, regional/rural and remote location, these sites were:
 - Mt Druitt, SWAHS
 - Casino, NCAHS
 - Condobolin, GWAHS.
- A total of 111 key informant interviews were undertaken, along with five expert interviews.
- A total of 45 staff and patients were involved in five process mapping sessions.
- Engagement of a total 34 patients and carers through interviews, the Patient Assessment of Chronic Illness care (PACIC) and process mapping.
- A total of 84 survey responses to the online General Practitioner (GP) and general service provider surveys were received.

“ It (the Solution Design Training Workshop) brought all the Areas together, which was most beneficial as it allowed us to do some networking and discuss common issues and innovations being considered ”

- Development of a literature scan to provide a brief and practical review of good practice in the field of chronic care and self-management, both nationally and internationally.
- The collection of 17 good practice exemplars of what has worked well/exemplars of best practice from the AHSs and Justice Health.
- The development of a food for thought document which was developed to assist the AHSs and Justice Health with solution design.
- Development of a Quantitative Data Supplement which addressed the Key Performance Indicators (KPIs) outlined in the work order request.
- Skills transfer undertaken with the NSW Health project team and project representatives state-wide.

Key outcomes of the project

State-wide solutions

The following is a summary of the proposed state-wide solutions. The problem statements, solution summaries and prioritisation matrices can be found in Section 1.

The proposed solution and implementation plans can be found in Appendix X to Appendix BB.

Table 1 Overview of the state-wide solutions

Solution	Related themes	Table	Appendix
Models of Care for Aboriginal People	Provision of care Infrastructure/accountability	Table 36	Appendix X
Integration of Aboriginal Health and mainstream chronic care	Cultural sensitivity Provision of care Infrastructure/accountability	Table 37	Appendix Y
Greater Aboriginal cultural awareness and cultural sensitivity of services	Cultural sensitivity Provision of care	Table 38	Appendix Z
Justice Health Linkages	Provision of care Infrastructure/accountability	Table 39	Appendix AA
Improved access to primary care	Provision of care Infrastructure/accountability Communication	NA	NA
Improved data quality	Infrastructure/accountability	Table 40	Appendix BB

Local AHS and Justice Health solutions

The following is a summary of the proposed AHS and Justice Health solutions. The problem statements, solution summaries and prioritisation matrices can be found in Section 5.

The proposed solution and implementation plans can be found in Appendix O to Appendix W.

Table 2 Overview of the local AHS and Justice Health solutions

AHS/Justice Health	Solution	Related themes	Table	Appendix
South Eastern Sydney Illawarra (SESAHS)	Link the Aboriginal community into existing mainstream transport systems and work in partnership with the “Transport for Health” project to ensure Aboriginal people have equitable access to services.	Geography	Table 13	Appendix O
	Compile a resource directory of mainstream health services to distribute to the Aboriginal community by extracting information from existing applications such as The Health Establishment Registration Online (HERO) and Human Services Network (HSNet) to better inform the Aboriginal community of how to access services.	Infrastructure/ accountability	Table 14	Appendix O
	Provide and promote evidence based chronic care education to the Aboriginal community using the NSW Aboriginal Chronic Conditions Area Health Service Standards (ACCAHSS) framework, focusing on Heart Failure, Respiratory Disease, and Cancer to better inform the Aboriginal community on disease management and prevention.	Communication Prevention	Table 15	Appendix O
Sydney West (SWAHS)	Models of Care-Identify and Modify.	Provision of care Infrastructure/ accountability	Table 16	Appendix P
	24-48 Hour follow-up service.	Provision of care Infrastructure/ accountability	Table 17	Appendix P
	Model of Care-Health Checks.	Provision of care Infrastructure/ accountability	Table 18	Appendix P
Sydney South West (SSWAHS)	Culturally sensitive and effective discharge including 24 hour follow-up service.	Provision of care Cultural sensitivity	Table 19	Appendix Q
	Provision of Care/Prevention.	Provision of care Prevention	Table 20	Appendix Q
Northern Sydney Central Coast (NSCCAHS)	Further consultation (including with Aboriginal community) in solution design.	Communication	Table 21	Appendix R
	Identify Aboriginal patients/clients with documented process and follow-up.	Provision of care Infrastructure/ accountability	Table 22	Appendix R

AHS/Justice Health	Solution	Related themes	Table	Appendix
	Closer local analysis of causes of cost issues.	Infrastructure/ accountability	Table 23	Appendix R
Hunter New England (HNEAHS)	Improve the access to mainstream renal and chronic disease services for the Aboriginal community across Hunter New England Area Health.	Provision of care	Table 24	Appendix S
North Coast (NCAHS)	Model of care.	Provision of care Infrastructure/ accountability	Table 25	Appendix T
Greater Western (GWAHS)	Implementation of the Women's Elders program.	Prevention Communication	Table 26	Appendix U
	Reintroduction of the Well Person's Health Check.	Prevention	Table 27	Appendix U
	Introduction of the S100 medication program.	Communication Affordability	Table 28	Appendix U
	IPTASS education for Medical Offices.	Geography Affordability	Table 29	Appendix U
	Enhanced use of the AHW in the client/doctor interaction.	Workforce	Table 30	Appendix U
	Introduction of care plans by multi-disciplinary teams.	Infrastructure/ accountability	Table 31	Appendix U
	Standardise the hand-over procedure between services.	Infrastructure/ accountability Communication	Table 32	Appendix U
Greater Southern (GSAHS)	Deliver an Aboriginal cultural awareness program to be included in essential (mandatory) training for GSAHS staff, and offered to other service partners.	Cultural sensitivity	Table 33	Appendix V
	To carry out shared planning between current private and public health service providers to develop a holistic model of care for Aboriginal people with or at risk chronic disease, as per NSW Aboriginal Chronic Conditions Area Health Service.	Provision of care Communication Infrastructure/ accountability	Table 34	Appendix V
Justice Health	To ensure that Aboriginal people in custody in NSW Correctional Centres and Juvenile Justice Centres with and at risk of chronic conditions access and utilise existing chronic disease and care services.	Infrastructure/ accountability Communication Provision of care	Table 35	Appendix W

Recommendations

The following are the recommendations for the next steps in the project.

Recommendation	
State-wide	
1	Agreement needs to be reached on the overarching governance structure for the implementation phase of the project, possibly considering the role of the Aboriginal Chronic Care Advisory Group (ACCAG) or the current Walgan Tilly Steering Committee.
2	Those responsible for the implementation of both the state and local solutions must, where appropriate, ensure a collaborative partnership approach between the AHSs and AMSs.
3	At the conclusion of this phase of the Walgan Tilly Redesign project, at least one person within NSW Health must be identified as taking responsibility for the next stage of this project. This responsibility should only extend for the time required to develop an appropriate project team (see recommendation 4). Identifying this person for the immediate term will ensure that the momentum of the project is not lost. It is also important that individual/s at the local level know who this person is so that any inquiries can be made.
4	NSW Health should only consider a supporting role in the implementation of solutions at the local level. Carriage of the local solutions should be left to the AHSs and Justice Health (see recommendation 3).
5	On achieving agreement on the AHS/Justice Health KPIs, a framework for the collection and monitoring of these indicators must be developed between NSW Health and the AHSs/Justice Health.
6	Roll-out of some local solutions may not be possible within current AHS/Justice Health budgets. Provided minimum criteria are met, such as implementation working groups (involving the Area Managers of Aboriginal Health (AMAHs), Redesign staff and Chronic Care managers), financial resources should, where appropriate, be made to assist in the roll-out of these solutions; such as the use of current under-spend.
7	NSW Health should consider, in the implementation of the state wide cultural sensitivity training, how it could work closely with GSAHS in developing and implementing their proposed cultural sensitivity solution. This could be done as a pilot, for subsequent state-wide roll-out.
8	Any further development of the state-wide solutions should consider collaboration between the different branches within NSW Health. This collaboration should come from the Aboriginal Chronic Care Team, the Redesign program, Workforce and Aboriginal Health. This consideration should be taken on a solution by solution basis.
9	The order of priority for NSW Health in the roll-out of the state-wide solutions should be: <ol style="list-style-type: none"> 1 Justice Health 2 Models of Care 3 Integration 4 Primary Health Care interface 5 Cultural Sensitively 6 Improvement in data collection.
10	NSW Health must continue to work closely with the Office of Aboriginal and Torres Strait Islander Health (OATSIH), the Alliance of GPs and the Aboriginal Health and Medical Research Council (AH&MRC) in the development of the Primary Health Care Interface solution. Starting immediately, monthly meetings should be organised involving all parties and facilitated by NSW Health.

Recommendation	
11	A strategy for the most effective use of the AHS Aboriginal nation maps, developed as a consequence of this project, should be considered.
12	Processes must be put in place for the collection of more complete information on the Aboriginal population. This would improve information in regards to: the number of Aboriginal people in an area; estimates of the prevalence of diseases; and hence an estimate of the number of people within an area that have a particular disease.
13	NSW Health must now apply a systematic prioritisation strategy to the 23 submitted proposed solutions, identifying those solutions which could be implemented immediately.
Local	
1	Competing demands on senior AHS management have seen various levels of involvement and buy-in to the Walgan Tilly project. In order for 'closing the gap' to become a reality (in the short to medium term), it is now necessary that Aboriginal health take a priority at both the state and local level. The implementation phase of the Walgan Tilly project needs to ensure this is a priority. Aboriginal health must become 'everyone's business' through the use of high level/high profile Key Performance Indicators (KPIs).
2	Successful development of local solutions and implementation plans have, to date, been a reflection of the level of buy-in from senior AHS management. Any further iteration and refinement of current plans must ensure the active involvement of the Director of Clinical Operations (DCO) and the Director of Population Health, Planning and Performance (DPPP) through the use of agreed AIM contracts.
3	Success in the development of local solutions has been a reflection of the level of involvement from the AMAHs, Chronic Care Managers and the Clinical Redesign Units. Where all three have been actively involved, then the proposed solutions have been robust and considered. It is recommended that the roll-out of local solutions should, at a minimum, involve these three positions. NSW Health should provide a supporting role as they have done through the first phase of the project.
4	A communication strategy is developed by each AHS/Justice Health identifying key stakeholders and types of information to be provided. The communication strategy should be implemented as soon as practically possible informing stakeholders of the status of the solutions and their implementation. The strategy should continue to focus on partnerships and build on the engagement of key partners such as the AMSs, relevant GP Divisions, key service providers and peak bodies.
5	The implementation of solutions at the local level must ensure ongoing consultation mechanisms with Aboriginal patients, carers and Aboriginal communities. Each AHS and Justice Health must develop a communication plan to inform service providers, peak bodies, patients and carers of their progress and achievements. The experience of the patient along the continuum of care must be continually reviewed and monitored, with appropriate mechanisms put in place in order to maximise their experience.
6	Given the tight timeframes on this project, where further time is required, AHSs/Justice Health should be afforded the opportunity to provide more detailed implementation plans for their individual solutions.
7	A state-wide workshop should be facilitated by NSW health, three to six months after the submission of this final report, so that AHSs/Justice Health can share their stories on the implementation of their solutions.