Peel Sector ICCAPP, Tamworth

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Entry details

Team Contact Surname	Crawford
Team Contact First Name	Matt
Contact Position Title	Clinical Nurse Consultant
Contact Phone Number	+61408404914
Alternative Contact Number	+61427619407
Facility / Dept/ Service unit:	Chronic & Complex Care Team, Tamworth Community Health Service
Facility / Dept/ Service unit address	Dean Street, Tamworth Hospital
Contact Email Address	Matthew.Crawford1@health.nsw.gov.au
Number of people in entry team	5
Team Members	Tanikka Moore Tamarla Smith Ali Harding Dr Patrick Oakley
Is footage available of this project?	No

Project Name

'Usual Care – Does one size fit anybody?

Partner Organisation

Tamworth Aboriginal Medical Service
Walhallow Aboriginal Corporation
Coledale Community Centre
Healthwise Gunnedah
HNE Aboriginal Health Unit

Abstract

The Peel Sector Integrated Chronic Care for Aboriginal People, (ICCAPP) team, (includes Aboriginal 48 HrF/U) work in the community with Aboriginal & Torres Strait Islander people >15 years; with/at risk of chronic illness within the Peel area.

The team includes an AHP, RN and CNC and provides truly excellent, evidence-based and culturally safe clinical care that frequently extends the traditional health boundaries.

This submission presents the model of 'usual care' used by Peel ICCAPP. The team's routine method of work is flexible, holistic, collaborative, responsive and patient and family centred.

ICCAPP are often referred clients when traditional health approaches have not worked. Clients may present with a range of complex and multifaceted health problems that can only be addressed by being creative, persistent, and individualised to change patient's health trajectory.

ICCAPP's routine care involves genuine working partnerships with ACCHOS's (Tamworth Aboriginal Medical Service; Walhallow Health Corporation); Coledale Community Centre; Gunnedah/Tamworth Healthwise; HNE Aboriginal Health and other HNE services and NGOs. The partnerships, collaboration and shared care between agencies is core as is the involvement of patients and families in their health goals and decision making.

The work of ICCAPP aligns neatly with the first 3 strategic outcomes of Future Health 2022-2032.

Innovation and originality - *Maximum Score = 5*

ICCAPP's model of care starts where the patient is at and builds from there. Listening to understand is key. The following patient stories illustrate ICCAPPs innovation.

1. MB, (48yrs) has Type 1 Diabetes and multiple admissions to Tamworth Hospital. She could not tolerate long-acting insulin and became critically unwell with Diabetic KetoAcidosis. After 20+ admissions, (248 admitted days over 3 years) ICCAPP worked with an Endocrinologist who endorsed trialling an insulin pump using short acting insulin. Within 48 hours MB's sugar levels stabilised.

2. In 2019 NG 20yrs weighed 287kg with decompensating Type 2 Diabetes. Virtually bed bound he mobilised over short distances with a 4WWW.
   ICCAPP worked with Hydrotherapy staff; WHS & TAMS to commence an exercise program. Guidelines were reviewed, equipment purchased and ICCAPP and TAMS worked with NG in the pool.

3. AG aged 56yrs lived in Walcha with advanced COPD. He had not left his house in 2yrs due to significant dyspnoea and anxiety. NSW Ambulance received 365 emergency 000 calls Dec 2019-June 2020 (highest caller in NSW). Senior NSWAS staff contacted ICCAPP for assistance. ICCAPP facilitated specialist telehealth in the home and numerous other health interventions.

4. HP aged 28yrs lives with epilepsy in a community 20kms from town. After HP experienced seizures requiring hospitalisation, the treating team suspended his driver's licence. Unable to access a Neurologist for 8months, ICCAPP approached another Neurologist (at a conference) who agreed to see HP via telehealth. Medications were optimised which stabilised his seizures and regular telehealth reviews were undertaken.

Sustainable - *Maximum Score = 5*

ICCAPP teams are provided across HNELHD. These are coordinated by HNE Aboriginal Health. Peel ICCAPP is well integrated with other ICCAPP teams and there is a strong culture of collaboration, networking and teamwork.

The work of ICCAPP is only sustainable via collaborative care. The culture and ethos of ICCAPP recognises the need for shared care between different providers and that each provider makes an important and necessary contribution.

ICCAPPs integration with other providers (ACCHOs, NGOs) is well embedded in their usual work. Health plans are designed to meet the needs of patients and require participation of multiple services formalised in shared care eg GP provided by TAMs,

Diabetes monitoring by ICCAPP, gym facilitation by TAMS and Aboriginal Health, housing assistance by Homes North etc.

Scalable - *Maximum Score = 5*

The success of Peel ICCAPP is attributed to the culture of the program and the team's lifelong commitment to closing the health gap for Aboriginal people.

ICCAPP is experimental and tailors approaches according to individual needs. People are treated uniquely and health plans are designed to address the specific issues affecting them. While solutions always vary (eg sourcing an insulin pump, helping in hydrotherapy pool, referring directly to a Neurologist, visiting Centrelink with patients), the patient centred methodology is consistent and responsive.

This approach is scalable, transferrable and requires time. It is consistent with the strategic outcome of 'patient/carers having positive experiences and outcomes that matter'. To enable such flexibility, a culture that accepts and encourages the nudging of usual service boundaries is required.

Better patient outcomes - *Maximum Score = 5*

ICCAPP is a busy service. In 2022, 514 patients were seen over 2075 appointments; 95.6% patients are Aboriginal/Torres Strait Islander. The metrics highlighting ICCAPP's joint success with their patients is reflected in the individual patient outcomes.

1. ICCAPP was able to permanently acquire the insulin pump for MB and her glycaemic control remains optimal (routinely monitored by ICCAPP). While MB carries the legacy of diabetes related complications, she has not required any diabetes related hospital admissions for more than 5years. MB actively cares for her family & grandchildren.

2. NG continues his training program attending the gym twice a week. NG has lost 143 kgs and plays social tennis each Tuesday.

3. Following ICCAPPs initial intervention, AG's primary GP care transitioned to TAMS. ICCAPP continued an ongoing health monitoring and care coordination role. Importantly '000' calls to NSW Ambulance significantly reduced.
   Sadly AG passed away in late 2022.

4. Following the telehealth consults with the neurologist, HP driver's licence was re-instated and he is able to maintain his employment.

Productivity and value for money - *Maximum Score = 5*

As a small service with a big footprint, ICCAPP's achievements are individualised. The case examples highlight significant value for money.

• Significant reduction in hospital bed days - including critical care bed days
• 140 kg weight loss, positively impacting on quality of life
• Substantial reduction in '000' calls and attendance by Ambulance Officers to AG's house
• Maintaining employment and independence

Importantly in each of the above examples, ICCAP's intervention and ongoing support has assisted in restoring the person's dignity and patient's ability to lead a more productive and fulfilling life whilst in turn reducing public health costs.

Collaboration - *Maximum Score = 1*

Collaboration is demonstrated through the patient centred care provided with each patient and the multiple partnerships ICCAPP has with other services in delivering care.

A feature of ICCAPP is the weekly telehealth clinics with Dr Pat Oakley, patient's, their family and ICCAPP staff.

Frequently ICCAPP attend the patient's house and bring their laptop to facilitate the telehealth appointment. Patients discuss problems they feel comfortable raising, and when necessary, ICCAPP will raise or prompt other issues. These clinics are

genuinely collaborative and patient directed.

Openness - *Maximum Score = 1*

Openness: ICCAPP has an ethos of 'rapid access' for new referrals and respond quickly to requests for service.

ICCAPP deliberately present as an open, engaging and accessible service, helping to reduce patient anxiety and eliminate service barriers. ICCAPP has an open approach to referral sources and willingly accept self-referrals, family referrals as well as referrals from other health professionals.

Respect - *Maximum Score = 1*

Respect: ICCAPP has an inherent respect for the dignity of the individual. ICCAPP recognise the gap in health status for Aboriginal people and the limitations imposed on everyday life for people living with the burden of chronic illness (eg diabetes, COPD, poor kidney function, incontinence etc).

ICCAPPs tenacious way of problem solving (eg using networks to acquire an insulin pump for a patient, direct referral to JHH Neurology, seeking medication reviews) is underpinned by the fundamental respect for the person and the understanding that no-one enjoys poor health.

Empowerment - *Maximum Score = 1*

Empowerment: As well as empowering patients in their health journey, ICCAPP staff are empowered to initiate discussions and take actions on behalf of their patients. On occasions, these actions are bold and may not follow traditional health pathways (eg CNC referring directly to a Neurologist) but are made with integrity and an understanding of the consequences of previous decision making.

ICCAPP are strong advocates for their patients and work hard in navigating systems to create solutions for their patients.

Teamwork and Partnerships - *Maximum Score = 1*

Partnership and teamwork are key to ICCAPP. The team is a small and cohesive and well supported by their NUM. Cultural expertise and cultural respect are vital elements within the team and are reflected in the everyday work. ICCAPP routinely seek assistance and practical support from other staff, ACCHSs and other agencies to deliver the care required for patients. ICCAPP truly recognise that services collaborating as a whole network is greater than the sum of its parts.

Strategic relevance to Future Health Please tick each appropriate priority your project is linked to; please note you can select more than one:	✓ Patients and carers have positive experiences and outcomes that matter ✓ Safe care is delivered across all settings ✓ People are healthy and well
Facility / Dept / Service Manager Name	Yvonne Patricks
Facility / Dept / Service Manager Position Title	Peel Sector General Manager
Facility / Dept / Service Manager Email Address	Yvonne.Patricks@health.nsw.gov.au

Team Photo (required)

Log in to hnehealth.awardsplatform.com to see complete entry attachments.

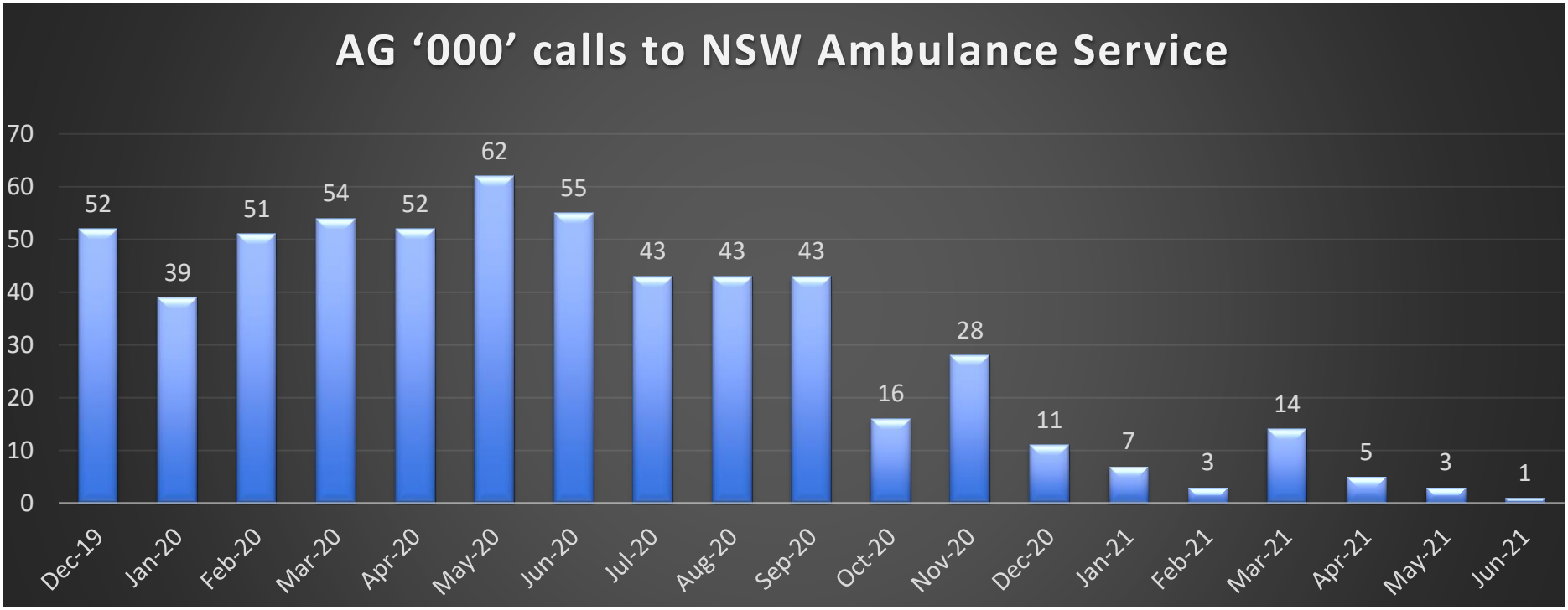
NG pool.jpeg 2.2 MiB

DOCX

AG ambulance c... 31 KiB

DOCX

MB Hospital Cos... 17 KiB



Source: NSW Ambulance Service Frequent User Program – Clinical Systems Integration

MB – Approximate Hospital Inpatient Stay Costs 2014-2017

	2014	2015	2016	2017	Total
Critical Care	7days @ $3218/day	5days @ $3218/day	7days @ $3218/day	8days @ $ 3218/day	
Sub-Acute	39days @ $1295/day	23days @ $1295/day	77days @ $1295/day	82days @ $1295/day	
Sub-Totals	$73,031	$45,875	$122,241	$131,934	$321,160

Health Services Act 1997-Scale of Fees for Hospital & Other Health Services, NSW Health June 2017 PD2017_018