



## What's the project about?

Over the last 7 years, Moreton ATSICHS Caboolture clinic and the Institute for Urban Indigenous Health (IUIH) worked to build a system of care that delivers primary health care services for mob. The System of Care that has been developed aims to provide an integrated, comprehensive, safe, high quality, culturally safe health care service. Increasingly, community have been able to access the services they need. Our community is growing rapidly, and we have an obligation to continue to provide and improve how we care for mob. A change was needed so we can meet this obligation and continue to support people in improving their health and wellbeing. Making connections and relational care is how we connect with people - to walk with them on their health journey and how care providers work together to do this is integral.

Following extensive investigation of international best practice, including the Native American Nuka model of care in Alaska, IUIH and MATSICHS Caboolture have designed, adapted and piloted a new model of care: IUIH System of Care 2 (ISoC2) also known as the "Pod" model. In this system, a core team of health providers (a Pod) work closely together to support clients and their families, at every visit and throughout their health journey over the long term. Importantly, each team has a dedicated Aboriginal and

Torres Strait Islander Health Worker (AHW), because we know that being cared for by our mob not only improves the quality of their care but also empowers them. This new way of providing care builds on the current system, so that our care providers know our clients better, and communicate and work together better. Through this, we can continue to build strong and healthy Aboriginal and Torres Strait Islander families and communities in South East Queensland.

To learn from this, an evaluation was undertaken to understand how the model was implemented and the impact of this on access and quality of care. The evaluation used a range of different methods (mixed-methods)—such as interviews and yarns, analysis of administrative and survey information—based on best evidence and that which aligns with Aboriginal ways of knowing and doing. The methodology for the study was designed through a series of collaborative workshops with community members, service providers and researchers, and review of the literature. Cultural and methodological oversight for the appropriate conduct of the evaluation is supported by an Evaluation Advisory Committee.

This research represents an Aboriginal led and governed partnership between community, service providers and researchers, addressing our obligation to meet identified community priorities. The knowledge and learnings from this study will inform policy and service delivery in the broader Australian Primary Health Care sector, as well as build the evidence-base of 'what works' to bring about real change in the health and wellbeing of Aboriginal and Torres Strait Islander communities living in SEQ.

## What did we do and what did we learn?

A similar model of care, the Patient centred medical homes (PCMH) is one that has been trialled throughout the world, including Australia, and is also what the Nuka model in Alaska was developed from. We reviewed published, international and national literature that investigated how the PCMH way of delivering care has been implemented and how effective this model of care is for improving care, health outcomes and reducing costs. Common important components of the PCMH reported in the literature were:

- comprehensive patient-centred care
- team of health professionals delivering coordinated care
- enhanced access to care
- systems based approach to improving quality and safety
- sustained partnership and personal relationship with the client over time; and
- structural changes to traditional practice.

Building relationships with teams, focusing on leadership and commitment were important factors for effective transformation. Transformation to a new way of doing things takes time, and seeing the benefits of this usually takes two years. From the literature, we know in many settings this model of care reduces presentations to the emergency department and costs. However, there is still much to learn about how this model changes primary health use and quality of care, people's physical and mental health and wellbeing and their satisfaction with the care provided. The Nuka model in Alaska remains the sole experience of implementing a PCMH by and for First Nation's people that has been reported in the literature. What is happening at Caboolture is new and very important for understanding how we can deliver better care for our communities.

We interviewed staff and yarned with clients to learn about their experiences with ISoC2, the acceptability of the new model, and whether things had changed in the way expected. From the staff interviews, we learned that working closely together in a Pod team helped improve communication between team members, and increased the sharing of responsibility for caring for clients and their families. The way the layout of physical space of the clinic was redesigned also helped teams work more closely together and plan care throughout the day together. Findings from staff interviews also suggested that there are many things about the way the clinic operated already (for example range of services, type of staff, how staff worked together) that helped changing to the new model. Having time set aside for reflection and make sense of the changes was important for understanding roles, problem solving and empowerment. Busy clinic periods required adaptation of the model, in order to meet demand while ensuring the Pod team were able to continue work together in this new way. Most importantly, a social health worker in Pod teams proved crucial for addressing medical issues created by social determinants of health. The social health worker helped coordinate clients' social health needs, which allowed other team members to focus on medical needs.

Clients talked about feeling connected with the Caboolture clinic through their relationships with health staff and other clients; that this contributes to their sense of belonging in the local Aboriginal and Torres Strait Islander community. The Pod teams help strengthen the relationships between clients and staff by increasing client's contact with a core team of workers throughout their health journey. Since the new model has been implemented clients report seeing more of the Aboriginal and Torres Strait Islander health worker and nurse and that their care is better, now that they see more of the same staff.

We also examined anonymised health record information to understand the impact of ISoC2 on how our clients are accessing our clinic, the quality of care and types of services, how it supported relationship-based care and the change in their health. Nearly all regular clients (90%) are aligned with a care team, and the distribution of care between providers is improving – in particular, from GPs to the Aboriginal and Torres Strait Islander health workers. The numbers of services provided overall and to each person, has been steadily increasing. Services for preventative care, chronic disease care planning and care coordination have progressively improved over the years. Results from happy or not kiosks reported a client satisfaction of 75% with the service, with many stating this because they were able to see the staff they preferred or the felt respected by staff.

To help understand the impact on clients' wellbeing we looked at two important and common health conditions—diabetes and cardiovascular disease (e.g. people who have had a heart attack, stroke or angina). Clinical indicators related to diabetes screening (HbA1c) and use of guideline recommended therapy for the primary and secondary prevention of cardiovascular disease have gradually improved or maintained over the study period. This was this case even though, like everywhere, the clinic has experienced significant disruptions caused by the COVID-19 pandemic over the first half of 2020.

## What we are doing next?

This two-year pilot period has been essential as it creates an opportunity to test and refine evaluation tools and methods, and gather important learnings that could support the potential larger scale roll-out of the ISoC2 model of care. This project has helped develop and refine the processes and resources required for service redesign and managing large-scale change.

Some important things we learned for implementing and evaluating a new system of care include:

- Major service system change is challenging and requires significant planning, time and effort. This is even more so the case with the COVID-19 pandemic and the changes to the way we provide health care that occurred with this. With the learnings from this project, MATSICHS, Caboolture clinic and UIIH are investing in building the methods, tools, resources and training to support and guide ongoing change at Caboolture and when implemented at other clinics—for our staff, and our clients and their families.
- We have learned a great deal about the impact of the Pod model on staff and client experiences, services clients have received and some aspects of client health and wellbeing. We plan to gather more information to further understand how ISoC2 impacts clients experiences with relationship-based care, their social wellbeing and, most importantly, their cultural wellbeing.
- Timely feedback of the findings from our study to allow service redesign and realignment is key to successful change. We are working on integrating this with the quality improvement and reflective practice that occurs on regular basis at Caboolture clinic.
- We have learnt a great deal about how the Pod teams work together and we will continue to build on this. We also know that there is more work to be done in implementing the Pod model, so that we can better support our clients in their health journey. This includes: working more closely with clients about the Pod model and how it works; adapting care provider roles and providing specific training to staff to support clients through the Pod model; and better meeting the social health needs of our community through new care provider roles and upskilling for current staff.

