Kelso Indigenous chronic disease clinic—your one-stop health clinic

Anne Vail[1], **Jacqueline Gibbs**[2]
[1]Western NSW Medicare Local; [2]Kelso Indigenous Chronic Disease Clinic, NSW

The benefits of a collaborative team approach model to Indigenous health care will be discussed in the presentation. Communication is the vital link between providers and referrers into the clinic for improved cohesiveness within the patient journey.

The weekly run health clinic is in an Indigenous suburb of Bathurst in western NSW. The clinics aim is to improve chronic disease outcomes for Aboriginal patients within the community and enhance access to support services. In the quarter Jul–Sep 2014, 80% of patients seen accessed three or more providers at the clinic.

Seven allied health and specialists are involved at the Thursday clinic which runs out of a local council community venue. Different providers are available on different weeks to offer patients a holistic approach to chronic disease management through targeted health goals. Providers include endocrinologist, diabetic educator, dietitian, exercise physiologist, podiatrist and clinical psychologist. The position of respiratory physician is currently vacant.

Our lovely Aboriginal health worker is the frontline face who runs the clinic ensuring that patients are able to access the clinic by coordinating referrals, booking appointments, providing reminder calls and assistance with coordination of transport. The AHW provides monthly clinic attendance letters to general practitioners and connecting care staff within the Local Health District and Western NSW Medicare Local regarding any referred patients as part of our Team Care Arrangement collaboration.

The team at the clinic work within the same building utilising the same clinical software which allows for a shared clinical patient file. This allows for joint goal setting for the patient in line with best practice clinical management. The team coordinates case conferences for clients if required and also assist with facilitation of telehealth visits when required. This has worked well for patients travelling >100kms to access the clinic as well as during pregnancy for our visiting endocrinologist.

Patient survey and feedback is regularly sort for ongoing improvement of the clinic. Analysis of the health improvements of the patients who have been accessing the clinic for greater then one year will be assessed through review of clinical markers such as HbA1c levels, weight and BMI measures as well as health outcome scores such as K10 scores and fitness rating scales. These findings and recommendations for ways to replicate this health service delivery model will be provided in the presentation.