Bulgarr Ngaru
Medical Aboriginal Corporation

NSW GOVERNMENT Health
Northern NSW
Local Health District

MEMORANDUM OF UNDERSTANDING

A commitment to partnership between

Bulgarr Ngaru Medical Aboriginal Corporation

And

Northern NSW Local Health District
Chronic Care for Aboriginal People Program

Background

Bulgarr Ngaru Medical Aboriginal Corporation (BNMAC) and Northern NSW Local Health District (NNSWLHD) Chronic Care for Aboriginal people Program (CCAP) have collaborated on a number of programs and continue to share clients and goals for improving health outcomes and providing support to Aboriginal people within the LHD. The establishment of such agreement is to ascertain and monitor the scope of works agreed to in this document.

This Memorandum of Understanding (MOU), between BNMAC and NNSWLHD, reflects the commitment to working collaboratively and outlines the basis for supporting a collaborative approach to the provision of care for Aboriginal persons.

Bulgarr Ngaru Medical Aboriginal Corporation

BNMAC makes a difference by providing comprehensive primary health care services which include medical and dental services, chronic disease management, mental health, and health education programs covering substance use, sexual health and lifestyle management.

National research shows that there are a number of social determinants that impact on a person's health and that the models of care that respond to a wide range of medical, social and emotional needs are more likely to produce the best results. Research also shows that the Community Controlled primary health care model is highly effective in providing much needed culturally appropriate health services to Aboriginal people.

BNMAC has a strong track record of achieving effective health outcomes for Aboriginal people in the mid-coast and northern rivers districts of NSW. This is evidenced through better than national averages in areas such as immunisation, chronic disease management and preventative health strategies.

A strong focus on client health assessments is central to our model of care to prevent disease, detect early and unrecognised disease, and promote healthy lifestyles. In 2015 our effectiveness in conducting targeted health checks and assessments with key target groups continue to exceed national averages according to Australian Institute of Health and Welfare National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care data comparison

Northern NSW Local Health District

NNSWLHD covers an area of 20,732km^2, spanning from the Local Government Areas of the Clarence Valley in the south to Tweed in the north. With an estimated population of 311 299 residents, 16 227 of which identify as Aboriginal (5.21%) from the 2021 census data.

Our vision of *A Healthy Community Through Quality Care* captures our commitment to working together with our community and service partners to deliver quality and safe health services to the communities of Northern NSW. Our LHD Strategic Priorities are: Value, Develop and Empower Our People; Our Community Values Our Excellent Person-Centred Care; Empowering Aboriginal Health; Integration Through Partnerships; Effective Clinical and Corporate Accountability; and Champions of Innovation and Research. These Strategic Priorities position the LHD to achieve our purpose to Work Together to Deliver Quality Health Outcomes Across Our Communities.

Purpose

The purpose of this MOU is to outline terms of engagement and shared ways of working between the services that are provided in partnership with BNMAC and NNSWLHD CCAP team to enhance the clinical service provision to the Aboriginal Community in a culturally safe environment and assist in enhancing the work undertaken by Bulgarr Ngaru Medical Aboriginal Corporation. Catchment of the CCAP program, specific to this MOU are Casino, Kyogle, Urbenville and Coraki including Muli Muli and Jubullum village.

Expected outcomes

1. Collaboration and strengthened partnership between BNMAC and NNSWLHD CCAP team for the purpose of a common goal and better health outcome for the Aboriginal Community.
2. Improved relationship with the Aboriginal Community by ensuring best practice health care through enhanced service provision.
3. Innovation through the development of programs and services to meet the needs of the Aboriginal community.

Governance

Scott Monaghan Chief Executive Officer, BNMAC and Kirsty Glanville (Executive Director Aboriginal Health, NNSWLHD) hold authority over this agreement including execution and management.

Terms of the MOU

This MOU is effective from the date of signature by both parties and remains so for a period of 2 years at which time a review on continued partnership shall be undertaken.

Information regarding dispute resolution and termination of agreement:

- Disputes between the two parties are to be managed in the first instance by the identified officers. Where issues are not resolved at this level, either party shall refer to their organisations' external dispute management processes.
- Either party may terminate the Agreement at any time in writing to the other party.

Ways of Working

The below items specify engagement and ways of working with shared clients and services between BNMAC and NNSW LHD CCAP team members.

1. When sharing information about clients and services, all parties are to adhere to patient Privacy and Confidentiality guidelines and Code of Conduct as outlines within NSW Health and BNMAC.
2. Any request for information regarding patient referrals, new or shared clients, a formal request for information will be sent via email, attached completion of the '**Consent to obtain Health Information From External Agencies**' form (see Appendix E) from the relevant CCAP team member (identified below) to the treating medical Officer/Practice Manager at BNMAC, marked 'confidential' in the email heading. Patient consent will be obtained using this form.
3. Establishment of monthly meetings between BNMAC team member/s, via Marnie Smith, CCAP members and NNSWLHD Nurse Manager Aboriginal Health to regularly review and discuss opportunities for improvements in shared care and collaborative projects to avoid duplication of service. Meetings will be hosted at BNMAC and scheduled in advance.
4. CCAP members and BNMAC will make contact to discuss any complex management plans or client requests outside of the monthly meetings.
5. Service descriptions for CCAP are attached in appendix for identification of scope of work.

Shared Care Model

The Shared Care Model represents a collaborative and patient-centred approach to healthcare that involves multiple healthcare professionals working together to provide comprehensive and integrated care. This model recognizes that optimal patient outcomes are often achieved through the combined efforts of various healthcare providers, each contributing their unique expertise. This collaborative approach ensures that patients receive well-coordinated, holistic care that addresses their physical, mental, and social needs.

In this Shared Care Model, different healthcare professionals, such as primary care physicians, specialists, nurses, and allied health professionals, actively participate in the care of a patient. Communication and

information sharing among these providers are fundamental aspects of the model, facilitated by advanced health information technologies and electronic health records. This ensures that everyone involved in the patient's care is well-informed and aligned with the treatment plan.

The model promotes a seamless flow of information and responsibilities. Patients benefit from a more personalized and coordinated approach to their healthcare needs, reducing the likelihood of fragmented or duplicated services. This shared care model is particularly effective for managing chronic conditions, where ongoing collaboration and proactive management are crucial.

Key elements of the Shared Care Model include:

1. **Interprofessional Collaboration:** Different healthcare professionals collaborate as a team, leveraging their unique skills and expertise to provide comprehensive care, achieved with establishment of monthly MDT meetings between Bulgarr Ngaru and AHU.
2. **Patient-Centred Approach:** The model prioritizes the patient's needs, preferences, and goals. Shared decision-making is emphasized, empowering patients to actively participate in their care.
3. **Information Sharing:** Open communication and shared access to patient information promotes a unified understanding of the patient's health status and treatment plan among all involved providers. Patient information may be requested through email or in person between LHD CCAP and AMS staff.
4. **Care Coordination:** The model emphasizes coordination across various healthcare settings, ensuring a smooth transition of care between primary care, specialty care, and other healthcare services. LHD Automatic Discharge Notifications will assist in transition of care.
5. **Preventive and Proactive Care:** By addressing both immediate health concerns and focusing on preventive measures, the Shared Care Model aims to improve overall health outcomes and enhance the patient's quality of life.

Referral pathway

AMS staff and their service provider partners can refer patients to the CCAP service.

Referrals are welcomed via phone and email. Aboriginal Health Service Referral/Intake Form attached (to be included in the MOU document) Please see link below for referrals;
Aboriginal Health Service Referral/Intake Form

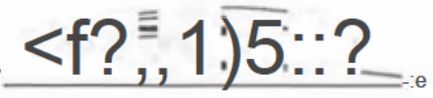
A list of contacts for the CCAP team can be found in within this document. Additionally, information on the CCAP program, contacts and eligibility can be found at;
https://nnswlhd.health.nsw.gov.au/services/aboriginal-health/chronic-care-management

Contact details

The identified personnel responsible for coordinating and/or undertaking agreed activities are:

Scott Monaghan		Kirsty Glanville
Chief Executive Officer	and	Executive Director Aboriginal Health
Bulgarr Ngaru Medical Aboriginal Corporation		Northern NSW Local Health District
[redacted]		[redacted]

Signatures to this Agreement

Signed: 

Dated: \'5/I(J-oeJ.__,f

Scott Monaghan
Chief Executive Officer
Bulgarr Ngaru Medical Aboriginal Corporation

Signed: 

Dated: 05/07/2024

Kirsty Glanville
Executive Director Aboriginal Health
Northern NSW Local Health District

CCAP Team Members

CCAP Service	Location	LHD Team
Nurse Manager Aboriginal Health	LHD	AHLT
Clinical Nurse Specialist 2	Richmond	CCAP
Aboriginal Chronic Care Worker	Casino/Kyogle	CCAP
Aboriginal Chronic Care Worker	Lismore	CCAP
Clinical Nurse Specialist 2	Tweed/Byron	CCAP
Aboriginal Chronic Care Worker	Tweed/Byron	CCAP
Clinical Nurse Specialist 2	Clarence	CCAP
Aboriginal Chronic Care Worker	Clarence	CCAP
Aboriginal Chronic Care Worker	Ballina	CCAP

APPENDIX A – Service Description CCAP Richmond CNS 2 & ACCW

Service Description
CCAP Richmond ACC

APPENDIX B – Chronic Care for Aboriginal People Model of Care

CCAP-MoC.pdf

APPENDIX C – Aboriginal Health Service Referral / Intake Form

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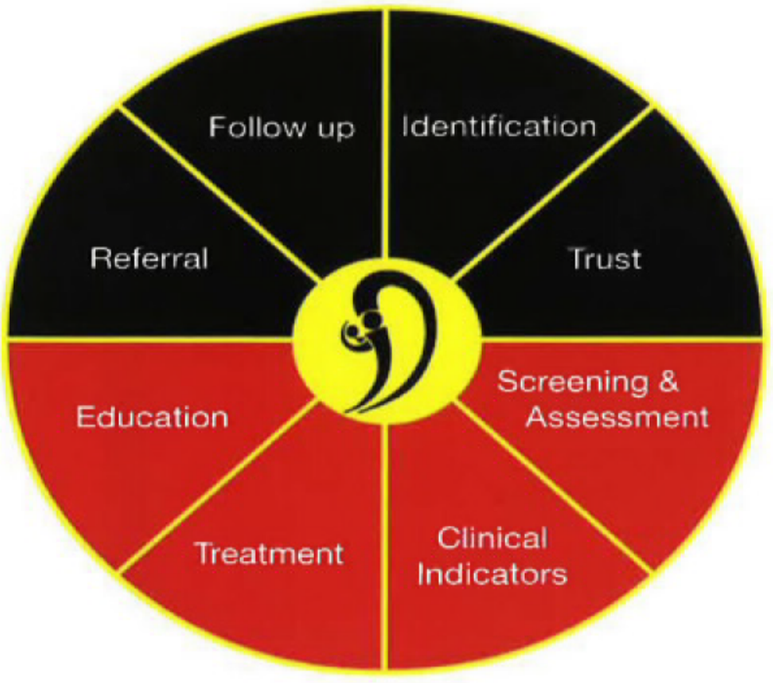
APPENDIX D – Chronic Care for Aboriginal People Model of Care



8 KEY ELEMENTS TO MAKE THE MODEL WORK

1. IDENTIFICATION – Identification of an Aboriginal person is the starting point for the delivery of appropriate care. Identification involves 3 main areas for implementation:

1. Asking the question" Are you of Aboriginal and / or Torres Strait Islander origin?"
2. Recording of Aboriginal status
3. Establishing a local process for clients who identify as Aboriginal

2. TRUST – Gaining trust with an Aboriginal person underpins the relationship required to engage the person and their family in their process

3. SCREENING AND ASSESSMENT – Relates specifically to targeted screening for Aboriginal people at risk of a chronic disease. This assists to identify the burden of disease as well as recognise the high levels of at risk behaviour in Aboriginal communities.

4. CLINICAL INDICATORS – Clinical indicators are useful in detecting disease and showing a pattern of management over a period of time. There are 4 clinical indicators which relate to this model – HbA1c, ACR, Spirometry, Blood pressure.

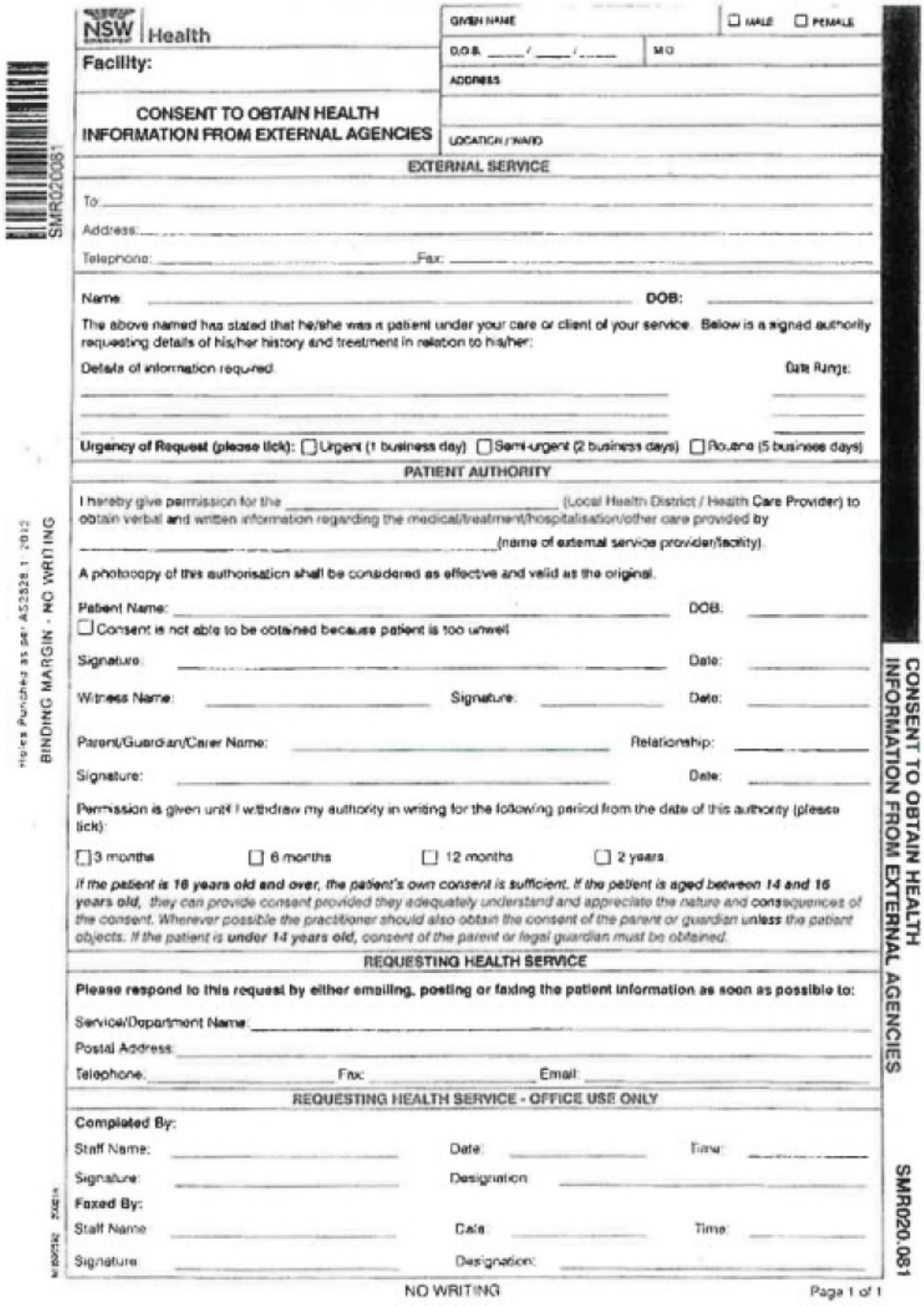
5. TREATMENT – Timely treatment is the key for Aboriginal people. Evidence shows that Aboriginal people often present late in the stage of disease and have many issues relating to access of health services. This affects the treatment and options available to the Aboriginal client.

6. EDUCATION – Information needs to be delivered in a meaningful way and at multiple stages throughout the Aboriginal client's journey. It needs to be practical, reinforced and related to everyday experiences.

7. REFERRAL – Considerations of referral services need to include affordability/ cost, access to transport, availability of Aboriginal specific programs if appropriate, consultation with the client and timeliness of the referral. It is also key to assist the client to navigate the different services.

8. FOLLOW-UP – A systematic, local approach to follow-up of Aboriginal people is essential. Evidence suggests that follow-up of client's mean improved health outcomes.

APPENDIX E- Consent to obtain health information from external agencies form



NSW Health

Facility:

CONSENT TO OBTAIN HEALTH INFORMATION FROM EXTERNAL AGENCIES

SMR020.061

GIVEN NAME ☐ MALE ☐ FEMALE

D.O.B. ___/___/___ M.O

ADDRESS

LOCATION / WARD

EXTERNAL SERVICE

To:

Address:

Telephone: Fax:

Name: DOB:

The above named has stated that he/she was a patient under your care or client of your service. Below is a signed authority requesting details of his/her history and treatment in relation to his/her:

Details of information required: Date Range:

Urgency of Request (please tick): ☐ Urgent (1 business day) ☐ Semi-urgent (2 business days) ☐ Routine (5 business days)

PATIENT AUTHORITY

I hereby give permission for the (Local Health District / Health Care Provider) to obtain verbal and written information regarding the medical/treatment/hospitalisation/other care provided by (name of external service provider/facility).

A photocopy of this authorisation shall be considered as effective and valid as the original.

Patient Name: DOB:

☐ Consent is not able to be obtained because patient is too unwell

Signature: Date:

Witness Name: Signature: Date:

Parent/Guardian/Carer Name: Relationship:

Signature: Date:

Permission is given until I withdraw my authority in writing for the following period from the date of this authority (please tick):

☐ 3 months ☐ 6 months ☐ 12 months ☐ 2 years

If the patient is 16 years old and over, the patient's own consent is sufficient. If the patient is aged between 14 and 16 years old, they can provide consent provided they adequately understand and appreciate the nature and consequences of the consent. Wherever possible the practitioner should also obtain the consent of the parent or guardian unless the patient objects. If the patient is under 14 years old, consent of the parent or legal guardian must be obtained.

REQUESTING HEALTH SERVICE

Please respond to this request by either emailing, posting or faxing the patient information as soon as possible to:

Service/Department Name:

Postal Address:

Telephone: Fax: Email:

REQUESTING HEALTH SERVICE - OFFICE USE ONLY

Completed By:

Staff Name: Date: Time:

Signature: Designation:

Faxed By:

Staff Name: Date: Time:

Signature: Designation:

Holes Punched as per AS2828.1 2012 BINDING MARGIN - NO WRITING

CONSENT TO OBTAIN HEALTH INFORMATION FROM EXTERNAL AGENCIES SMR020.061

NO WRITING

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