Gold Coast Health CD&PAP's RHP

Better Cardiac Care Mungulli Program

Presented by: Amy Tooley CNC
Better Cardiac Care Program

Better Cardiac Care Program (BCC)

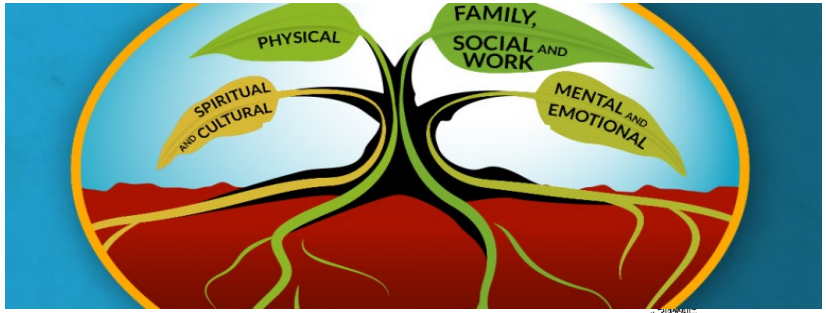
- *Is a culturally and clinically focused model of care improving Aboriginal and Torres Strait Islander Peoples outcomes in cardiac care*.
- National initiative supported by the Australian Health Ministers' Advisory Council (AHMAC) as part of the Australian Government's commitment to closing the gap in life expectancy for Aboriginal and Torres Strait Islander peoples.
- The program started in MSHHS at the Princess Alexandra Hospital (PAH) in 2015 and has now received funding to expand across Queensland.
- The Better Cardiac Care Program aims to reduce mortality and morbidity from cardiac conditions by increasing access to services, better managing of risk factors through community education and by improving coordination of care.

Better Cardiac Care Program (BCC)

- **MDT**- Clinical Nurse Consultant, Indigenous Health Worker and Pharmacist.
- The projects aim is to improve access, support and knowledge to evidence based culturally safe cardiac care for Indigenous people.
- The team provides support and advocacy for patients and families during their hospital admission.
- At the point of discharge, the team actively links the patient to community support, **arranges GP follow up within 7 days of discharge** and ensures Specialist follow up is arranged and attended.
- In the community the team supports, navigates and co-ordinates cardiology care pathways for patients and provides a link to specialist investigations.
- From a prevention perspective, the team provides cardiovascular disease risk factor education to the community, in collaboration with local AMS and A&TSI community events.

Better Cardiac Care- Health Strategy

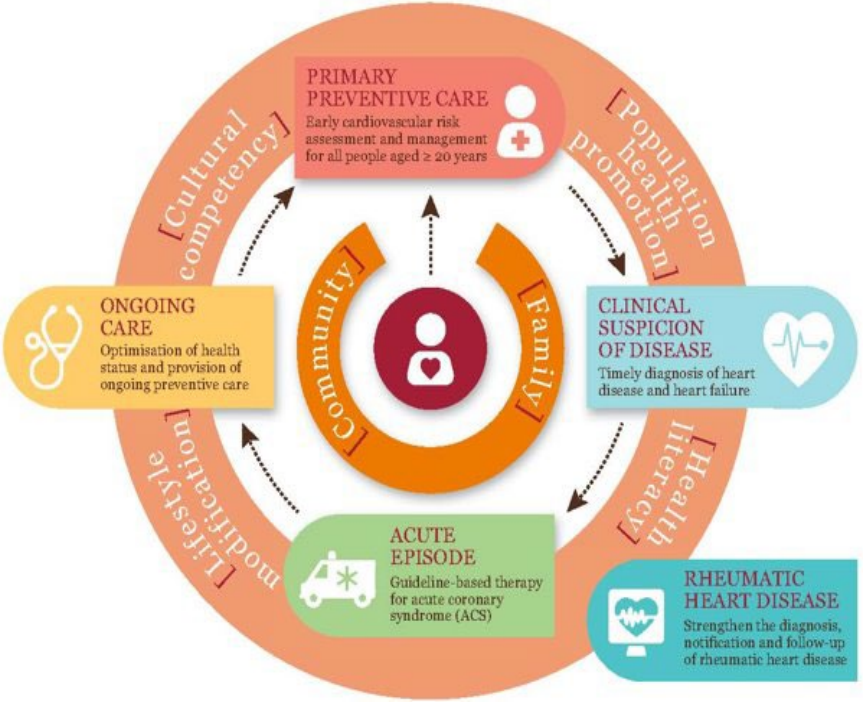
1. **Primary Preventive Care-** Early cardiovascular risk assessment, education and management.
2. **Clinical Suspicion of Disease**- Timely diagnosis of heart disease and heart failure.
3. **Acute Episode**- Guideline-based therapy for acute coronary syndrome.
4. **Ongoing Care-** Optimisation of health status and provision of ongoing preventive care.
5. **Rheumatic Heart Disease-** Strengthening the diagnosis, notification and follow-up of rheumatic heart disease.



Better Cardiac Care & Queensland Aboriginal and Torres Strait Islander- Cardiac Health Strategy

Overall- 5 Priority Areas have an aim to:

- Better support people to prevent/manage their cardiovascular health
- Reduce gap in CVD mortality, *particularly under 50 years old.*
- Reduce rate of progression to moderate or severe RHD.



Health system perspective.

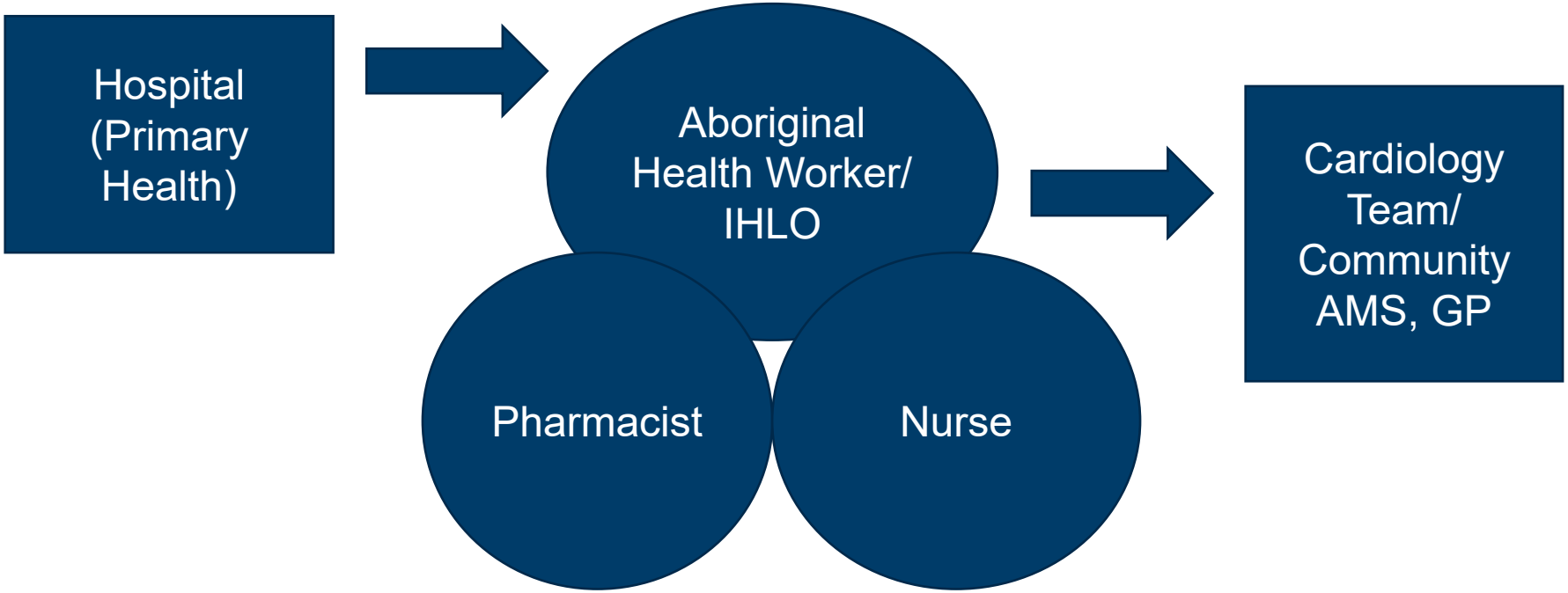
- High FTA rates for follow up appts- GP and Specialist appts.
- High readmission rates
- Disconnect between community and acute settings
- High DAMA- discharge against medical advice rates

- ***Symptoms of health systems and services that don't support patient centered care.***

"Aboriginal people often feel uncomfortable, fearful, or powerless when they try to use the health care system, and often avoid going to hospital or to the GP even when they are very sick,"

-Better Cardiac Care measures for Aboriginal and Torres Strait Islander people- Fifth national report 2020.

Support through an integrated care model

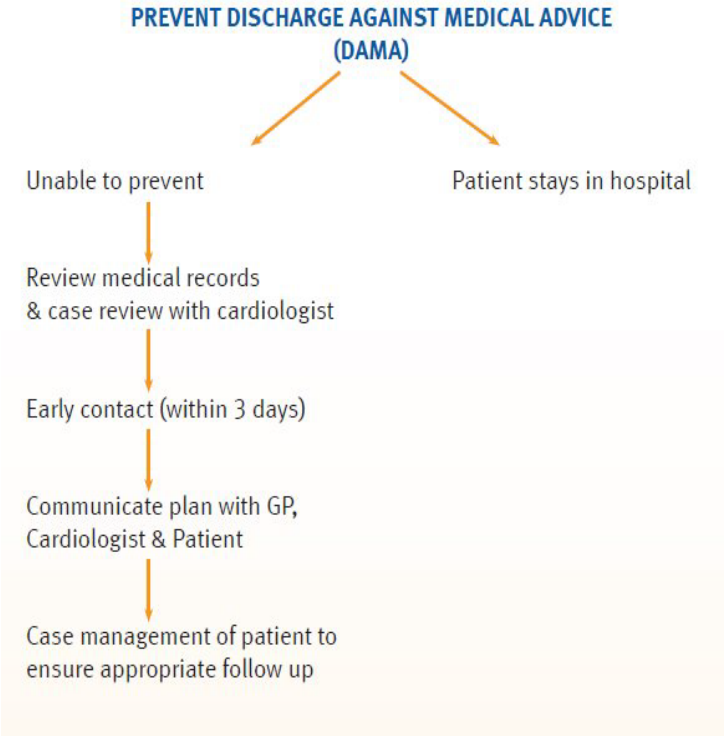


Support for patients who DAMA

DAMA rates for Aboriginal and Torres Strait Islander patients are 5 times the rate of non-Indigenous patients.

DAMA is associated with complications, mortality and morbidity, high readmission rates.

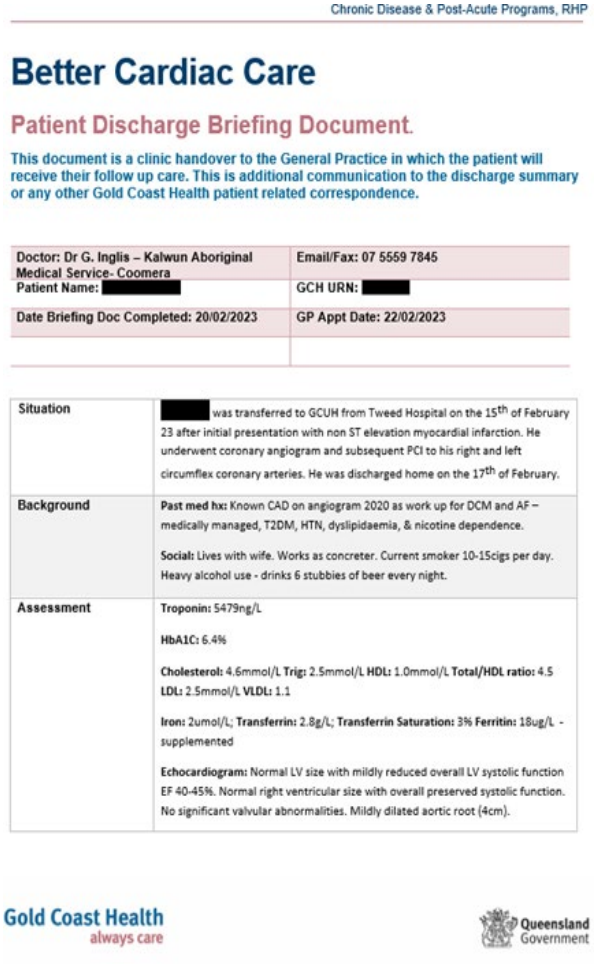
- Increased health expenditure.



Aim- Improve Health literacy

My Heart Wellness Plan- Teach back booklet

GP Briefing Document



Chronic Disease & Post-Acute Programs, RHP

Better Cardiac Care

Patient Discharge Briefing Document

This document is a clinic handover to the General Practice in which the patient will receive their follow up care. This is additional communication to the discharge summary or any other Gold Coast Health patient related correspondence.

Doctor: Dr G. Inglis – Kalwun Aboriginal Medical Service- Coomera	**Email/Fax: 07 5559 7845**
Patient Name: [redacted]	**GCH URN:** [redacted]
Date Briefing Doc Completed: 20/02/2023	**GP Appt Date: 22/02/2023**

Situation	[redacted] was transferred to GCUH from Tweed Hospital on the 15th of February 23 after initial presentation with non ST elevation myocardial infarction. He underwent coronary angiogram and subsequent PCI to his right and left circumflex coronary arteries. He was discharged home on the 17th of February.
Background	**Past med hx:** Known CAD on angiogram 2020 as work up for DCM and AF – medically managed, T2DM, HTN, dyslipidaemia, & nicotine dependence. **Social:** Lives with wife. Works as concreter. Current smoker 10-15cigs per day. Heavy alcohol use - drinks 6 stubbies of beer every night.
Assessment	**Troponin:** 5479ng/L **HbA1C:** 6.4% **Cholesterol:** 4.6mmol/L **Trig:** 2.5mmol/L **HDL:** 1.0mmol/L **Total/HDL ratio:** 4.5 **LDL:** 2.5mmol/L **VLDL:** 1.1 **Iron:** 2umol/L; **Transferrin:** 2.8g/L; **Transferrin Saturation:** 3% **Ferritin:** 18ug/L - supplemented **Echocardiogram:** Normal LV size with mildly reduced overall LV systolic function EF 40-45%. Normal right ventricular size with overall preserved systolic function. No significant valvular abnormalities. Mildly dilated aortic root (4cm).

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	Coronary angiogram: Severe two vessel coronary artery disease with 90% mid RCA and 70% mid circumflex stenosis. Mild to moderate diffuse disease in LAD. **Coronary angioplasty:** Successful PCI (over 2 x procedures) of right and left circumflex coronary arteries - using drug eluting stents.
Recommendations	Please see attached discharge medication record and provide ongoing prescriptions as required. Secondary prevention for CAD including: 1. Smoking cessation 2. Aim LDL < 1.6mmol/L 3. Aim BP < 130/80mm/Hg 4. Aim BMI 18.5 -24.9 kg/m2 5. Aim HbA1c < 7% Cardiac rehabilitation or Better Cardiac Care program for assistance with above. Please re-check Iron, Cholesterol and HBA1C levels 3 months Cardiology follow up at GCUH with Dr Jayasinghe in 3 months.

Yours Sincerely

Amy Tooley
CNC, Robina Health Precinct
Better Cardiac Care Program
Ph: 1300 668 936

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Better Cardiac Care for Aboriginal & Torres Strait Islander Peoples

Cardiovascular conditions make the greatest contribution to the gap in mortality between Aboriginal and Torres Strait Islander peoples and other Australians.

Better Cardiac Care for Aboriginal and Torres Strait Islander Peoples (Better Cardiac Care) is a national initiative supported by the Australian Health Ministers' Advisory Council (AHMAC) as part of the Australian Government's commitment to closing the gap in life expectancy for Aboriginal and Torres Strait Islander peoples.

Better Cardiac Care aims to reduce mortality and morbidity from cardiac conditions by increasing access to services, better managing risk factors, and by improving the coordination of care.
The program includes five priority areas for intervention and associated measures to monitor progress.

More information

Get in touch:

For further information please contact the Better Cardiac Care Team.

1300 668 936
gchhsatsibettercardiaccare@health.qld.gov.au

Clinical Nurse Consultant:
(07) 5635 6284

Pharmacist:
(07) 5635 3286

Working together to achieve First Nations Health Equity.

1. CULTURAL SAFETY
2. ACCESS
3. DETERMINANTS
4. SERVICE AND DATA
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goldcoast.health.qld.gov.au

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Better Cardiac Care for Aboriginal and Torres Strait Islander Peoples

How does the program work?

The Better Cardiac Care program MDT consists of a clinical nurse consultant, pharmacist, hospital liaison officer and administration officer. The program is responsive to Aboriginal and Torres Strait Islander people's cultural needs as well as their clinical needs and it supports their journey from hospital to home.

The Better Cardiac Care multidisciplinary team conduct hospital rounds, visit inpatients and supports outpatients by attending appointments, ensuring medication adherence and arranging GP follow up.

During a patient's stay, the team help to coordinate care and ensure patients clearly understand what their treatment plan is. A major part in improving patient health literacy has been the use of the document 'My Heart Wellness Plan Booklet'. The team sit with each patient and write down in their own words what's happened to them while they have been in hospital, so that it improves their understanding of the care they receive and any further follow up that may be required.

The program involves ensuring patients are registered for the Closing the Gap and First Nations Medication Subsidy. The Better Cardiac Care Pharmacist coordinates with community Pharmacy's to arrange Webster packs and provide inpatient medication education with patients and families. The team will then follow up with patients in the community to ensure medication compliance.

Building connections back to community is vitally important for a patient's health to ensure better quality community follow-up and to lower the rates of readmission to hospital. The team have been working hard, partnering with GCHHS A&TSI services, GCUH Cardiology Team and community engagement, providing direct patient cardiac education via Kalwun (AMS) as part of the Strong and Deadly Wellness Programs.

Five key priorities

PRIORITY 1
Early cardiovascular risk assessment and management

PRIORITY 2
Timely diagnosis of heart disease and heart failure

PRIORITY 3
Guideline based therapy for acute coronary syndrome

PRIORITY 4
Optimisation of health status and provision of ongoing preventative care

PRIORITY 5
Strengthen the diagnosis, notification and follow up of rheumatic heart disease (RHD)

The Better Cardiac Care program commenced within GCHHS in October 2022 and so far, the feedback is remarkable. Patients state they feel they are well supported in the hospital system and have a clearer understanding of their health conditions, treatment options and medications.

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Improvements in cardiac care for Aboriginal and Torres Strait Islander peoples at PAH

- **Significant reduction in FTA to OPD appointments**;
- **Significant increase in uptake of GP follow up** after discharge from hospital;
- Significant reduction in hospital readmission rates (QHEALTH)
- Significant reduction in bed days for patients who do readmit to hospital
- **Significant reduction in repeat MI within 90 days** of discharge for ACS
- Significant reduction in invasive investigation for troponin negative ACS with no increase in MI, death, or unplanned revascularization
- CTG medication supplied on discharge in line with community standard at reasonably low cost to hospital

Mungulli Program- RHP

- The Mungulli program offers a holistic approach to managing chronic disease conditions. The program is run by a multidisciplinary team and facilitates group education, physical activity and an MDT Clinic for A&TSI clients.
- Service locations- RHP, home visits, community AMS.
- The program assists clients to understand their health conditions and find ways to stay well:
- Recognising signs, symptoms and changes in health
- Building confidence to work with health professionals
- Developing health care plans with specific client centred goals
- The program offers community education on a range of conditions including:

Diabetes chronic chest conditions such as COPD and emphysema asthma chronic kidney conditions heart conditions such as coronary heart disease and heart failure social and emotional wellbeing.

Mungulli programs are designed for A&TSI people aged 18 years or over.

Mungulli Program MDT

- **IHW-** All client interactions are culturally safe supported by our IHW's. IHW advocate for clients, link community AMS services, point of contact for clients and arrange supports- transport etc.
- **Clinical Nurses-** Once referred clients are seen by the Mungulli CN for a care plan- identify specific client goals, referrals to other MDT if needed.
- **Physiotherapist-** PT consults with all referred clients- 1:1 assessment: 6MWT, sit to stands, grip strength. Weekly Mungulli gym and HEP. Supported 1:1 exercise/ strengthening sessions if required. Yarn and Walk program commencing soon.
- **Pharmacist-** Better Cardiac Care Pharmacist consults with clients- medication reviews and education- smoking cessation programs.
- **Dietician-** Mungulli Dietician offers 1:1 appointments, group education, cooking classes, family focussed nutrition and meal planning advice.
- **A&TSI Nurse Navigator:** Offer support navigating the wider health system- link in with AMS, connection with community services and supports, provide support, advocacy and coordination for clients health journey.

Client can also be refer on to other CD&PAP's at RHP

Mungulli Education Programs- RHP

- **Elders Strong and Deadly Wellness Program**: Offers a five-week community based program (4-5 times per year) which includes cultural activities, healthy eating, chronic disease and medication education and physical activity for clients- Kalwun wellness centre- Bonogin
- **Deadly Tracks Education:** Half day education session delivered by the Mungulli multidisciplinary team for clients and carers who want to learn more about their health conditions, medications and treatment options- RHP.
- **Yarn and Walk Program (PHN)-** Weekly physical activity and education program for A&TSI clients- Supported by Mungulli & BCC MDT- supervised Physio lead exercise session followed by 'yarning circle' covering different topic each week- cultural activities, nutrition, chronic disease conditions, cardiovascular disease risk factor modification and physical activity and strength.

Mungulli Service - YouTube

CD&PAP (Chronic Disease and Post Acute Programs-RHP)

CD&PAP MDT

- Diabetic Nurse Educators
- Podiatrist
- Occupational Therapists
- Psychologist
- Social Workers
- Exercise Physiologist
- Speech Pathologist

Falls and Balance Clinic:

The Falls and Balance Clinic is a multidisciplinary outpatient diagnostic service targeted to clients who are falling or at risk of falls.

Clients undergo a comprehensive multidisciplinary falls risk assessment aimed at early diagnosis, initial care planning, recommended preventative treatment and timely referral to appropriate services.

Due to the falls-related fracture risk in many clients, bone health is also assessed, and recommendations provided.

MDT: Geriatrician/Rehabilitation Specialist, Clinical Nurse Consultant, Pharmacist and Physiotherapist.

Eligibility criteria:
•Recent recurrent falls or near falls, and/or significant balance or gait instability
•Falls with significant complications (skin tears, extensive soft tissue bruising or fractures)
•Falls with presentations to primary care providers, emergency department or non-government organisations

Referral process:
•Clients require a GP referral.

CD&PAP's MDT (Chronic Disease and Post Acute Programs- RHP)

Cognitive Disorders Service

The Cognitive Disorders Clinic is a diagnostic program, providing a comprehensive multidisciplinary diagnostic and intervention service. Patients with a known diagnosis of Dementia should be referred to the Community Dementia Service.

In conjunction with forming a medical diagnosis, the Clinic provides nursing and allied health input to support the social and psychological care of managing dementia.

Eligibility

This service is for people, 45 years and over experiencing 'cognitive problems' (requiring diagnosis and treatment) characterised by progressive cognitive decline, and/or memory impairment not in relation to personality disorders, illicit drug use, Clinical Disorders, pre-existing brain injury.

Referral accepted from General Practitioners only. Internal referrals are not accepted.

MDT

Specialist Consultant, Clinical Nurse, Neuropsychologist , Speech Pathologist.

Get in touch:

Better Cardiac Care team

Monday – Friday, excluding public holidays

1300 668 936

gchhsatsibettercardiaccare@health.qld.gov.au

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Working together to achieve First Nations Health Equity.

Get in touch:

Advanced Aboriginal & Torres Strait Islander Chronic Disease Health Worker

Monday - Friday

Robina Health Precinct

Robina QLD 4226

1300 668 936

Use the QR code to visit our website

Mungulli Clinic

Supporting the health and wellbeing of Aboriginal and Torres Strait Islander Community.

Mungulli Clinic

The Mungulli Clinic offers a holistic approach to managing chronic conditions. The clinic is run by a multidisciplinary team, depending on need, three times a year in a group setting.

The Mungulli clinic is here to help

We assist clients understand their health conditions and find ways to stay well. This can include:

- Recognising signs, symptoms and changes in health
- Building confidence to work with health professionals
- Developing health care plans and goals

We offer community education on a range of conditions including:

- diabetes
- chronic chest conditions such as COPD and emphysema
- asthma
- chronic kidney conditions
- heart conditions such as coronary heart disease and heart failure
- social and emotional wellbeing.

Mungulli programs are designed for Aboriginal and/or Torres Strait Islander people aged 18 years or over.

Strong and Deadly Wellness

A four week community based program which includes cultural activities, healthy eating and physical activity.

Deadly Tracks Education

An education session delivered by the Mungulli team for clients and carers who want to learn more about their health condition.

Mungulli is the Yugambeh word for the cotton tree. Mungulli was traditionally used for spears, string and boomerangs. Mungulli was the chosen name for this program because like the cotton tree, we aim to provide the community with knowledge and resources.

Get in touch:

Advanced Aboriginal & Torres Strait Islander Chronic Disease Health Worker

Monday - Friday

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Use the QR code to visit our website

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Referrals for CD&PAP's at RHP:

- Further details for all services mentioned can be located on the *Refer your Patient site*
- The preferred referral method to the all CD&PAP's is via the *Referral Intake Hub GCUH Smart Referral Workflow Solution*.
- **Alternatively, referrals can be sent to the Referral Intake Hub**
- **Fax: 56874497**
- **Phone: 1300 668 936-** for information and referral details for all Chronic Disease and Post Acute Programs at RHP.

Thank you