

KEY MESSAGES

Partnerships in Care: Attributes of successful care coordination models which improve health care networks for people with intellectual disability

September 2013

Assoc. Prof Lucie Walters, Dr Jane Tracy, Assoc. Prof Linda Sweet, Assoc. Prof Robert Davis, Dr Rachael McDonald, Ms Lucy Atkinson, Ms Heather Burton.

Policy context

People with intellectual disability make up 2-3% of the population and have a higher morbidity and reduced life expectancy when compared with the general population. They encounter a range of physical, attitudinal, communication and systemic barriers to accessing mainstream health services which contribute to and compound their disadvantage. Additionally, rural health and disability services are limited by resources, distances and workforce shortages which lead to a double disadvantage for people with intellectual disability living in rural Australia.

Care coordination is a mechanism that facilitates the Health and Disability sectors working together to ensure people with intellectual disabilities receive appropriate and timely healthcare, and experience optimal health and wellbeing. There is no current gold standard care coordination model. This study sought to identify key attributes of successful care coordination models to improve health outcomes for people with intellectual disability that live in rural areas.

Key messages

Three distinct care coordination programs in rural sites across Victoria and South Australia were studied using Realist Evaluation methods. The results demonstrated that there were four primary ways that the Care Coordinators were able to effect change in the health system to improve health outcomes for people with intellectual disability. These included 1) joining the care network 2) facilitating navigation of the health care system, 3) linkage and knowledge exchange between stakeholders, and 4) building knowledge and improving quality of care.

Our findings demonstrate that in order to improve health outcomes for people with intellectual disability in rural areas, the Australian Government must implement sustainable, long-term models of care coordination and:

- > Situate care coordinators in local primary health care organisations which have effective working relationships with General Practice to leverage engagement
- > Ensure care coordinators act as 'trusted navigators' supporting: clients to access and benefit from complex health systems; and service providers to meet the needs of these people, including supporting GPs to provide a mandated standardized comprehensive annual health assessment
- > Implement benchmarking of health outcomes for people with intellectual disability against local population data
- > Enforce health service accountability through measures focused on system linkages and collaboration between health and disability services

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health and Ageing.