WAPHA
WA Primary Health Alliance

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PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

Integrated Team Care
Country to City: Improving Patient Transitions

Acronyms and abbreviations

AHCWA	Aboriginal Health Council of Western Australia
AHLO/ALO	Aboriginal Hospital Liaison Officer or Aboriginal Liaison Officer
AHP	Aboriginal Health Practitioner
ACCHS	Aboriginal Community Controlled Health Service
CCSS	Care Coordination and Supplementary Services
CHC	Country Health Connect
CtG	Closing the Gap
DAMA	Discharged Against Medical Advice
DMMR	Domiciliary Medication Management Review
DNA	Did Not Attend
GP	General Practitioner
GPMP	GP Management Plan
HCC	Health Consumer's Council
IIAPMC	Indigenous Access to Mainstream Primary Care
ITC	Integrated Team Care
MBS	Medicare Benefits Schedule
NACS	Notification and Clinical Summaries
PATS	Patient Assisted Travel Scheme
RFDS	Royal Flying Doctor Service
WACHS	WA Country Health Service
WAPHA	WA Primary Health Alliance

Note: Throughout this document the word Aboriginal is used to denote both Aboriginal and Torres Strait Islander peoples.

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Message from the CEO

WA Primary Health Alliance (WAPHA) has a vision to improve health equity, with a key focus on the health status of Aboriginal people in Western Australia (WA).

I am pleased to present the Integrated Team Care (ITC) Country to City: Improving Patient Transitions Project Report (The Project). This Report aims to build knowledge and understanding of the issues impacting on Aboriginal people who travel between regions for health care.

In late 2017, WAPHA met with a range of stakeholders across WA to better understand the issues that can impact on the health outcomes of Aboriginal people who are already registered with or eligible for the ITC program.

Currently the ITC program supports over 1,000 Aboriginal clients across Western Australia, from Albany in the south to Kununurra in the north, with a number of ITC clients travelling away from home for health care.

The Project was initiated in response to feedback relating to the challenges of supporting Aboriginal people who were travelling for treatment from regional and remote communities. Consultation identified that the patient journey may be fragmented, inconsistent and can result in poor health and wellbeing.

It is important to note that the patient journey encompasses more than just chronic disease and includes travel for other reasons such as trauma, mental health and pregnancy. However, the focus of the Project is to make significant improvements to the ITC patient journey for Aboriginal people with a chronic disease, which should see positive flow on effects to other areas.

I would like to thank the WA ITC service providers for their participation and support of ITC clients and service partners. Thank you for participating in the consultations that informed this report.

As we move ahead into 2018, we will continue to work with members of the Project Steering Committee and other stakeholders to implement the 14 recommendations presented in the report.

Those who have shared their stories and experiences with us have been an integral part of this project. It is vital that people who access health services continue to provide feedback of their experiences, as the patient story is important to the work we do here at WAPHA.

We will continue to support ITC providers and their partners to ensure the ITC program makes a tangible difference to the health of Aboriginal people travelling away from home for health care.

Learne Durrington

CEO, WA Primary Health Alliance

Executive summary

The Integrated Team Care (ITC) Country to City: Improving Patient Transitions Project (the Project) was initiated in response to feedback relating to the difficulties of supporting Aboriginal patients who were off-Country and staying in metropolitan areas for health treatment. The feedback identified that the patient journey for Aboriginal people from country to Perth can be fragmented, inconsistent and may result in poor health and well-being.

The objectives of the Project are to:

1. Understand the extent of the issues and concerns regarding the transition of ITC clients, and those eligible for ITC, across WA. In addition, to understand the good practice happening and to share relevant learnings on a state-wide basis.
2. Work with the health sector to develop solutions that will improve the experience and care of Aboriginal people with chronic conditions, promoting integrated, seamless care and optimal health outcomes for Aboriginal people.

It is important to note that the patient journey encompasses more than just chronic disease, and includes travel for other reasons such as trauma, mental health and pregnancy. However, the intention of this Project is to make significant improvements to the ITC patient journey for Aboriginal people with a chronic disease, which should have flow on effects to other patient cohorts.

It is also important to note that many people travelling for health care have a positive experience. Throughout the consultations WAPHA heard many stories that detailed good experiences for a variety of reasons, such as being accompanied by someone to explain and advocate for them, being met by a person at the airport, being provided with social and cultural support, or using telehealth to overcome the tyranny of distance.

However, the consultations identified that the health system still has several gaps and inconsistencies, which exposes people to falling through the cracks in accessing and receiving health care. For this vulnerable group, the effects of falling through the cracks can be, and are, severe. This report focuses on practical solutions that can be implemented across WA to improve processes, promote consistency and increase integration between organisations.

The recommendations were developed with input from approximately 70 stakeholders in a two-day workshop.

Recommendation 1: Establish and implement a standardised intake, allocation, transfer and discharge process for ITC.

Recommendation 2: Develop resources to support clients in preparing for travel, such as a checklist for journey planning, patient stories and videos. Promote and educate patients, community and health professionals on the availability and use of the resources.

Recommendation 3: Work with health service providers to explore ways of using digital health services to avoid unnecessary travel and facilitate care between regions.

Recommendation 4: Provide templates and frameworks to support providers to undertake stakeholder mapping.

Recommendation 5: Regularly circulate a contact list of key ITC staff.

Recommendation 6: During January to June 2018, develop a service model for the provision of primary health and social services support for patients in Perth for treatment. Trial the service model over July 2018 to June 2019 and develop a business case for recurrent funding.

Recommendation 7: Continue to fund the hostel-based Aboriginal Health Practitioner until the service model from Recommendation 6 is ready for trial.

Recommendation 8: Access to a funding pool for ITC providers to support out of region ITC clients.

Recommendation 9: Develop a flowchart on CtG eligibility and enrolment process to support eligible ITC clients to be enrolled for CtG scripts.

Recommendation 10: Advocate for improved discharge processes and continuity of care.

Recommendation 11: Hold regular forums for ITC providers and key stakeholders to network, facilitate consistency, share innovation and jointly problem solve.

Recommendation 12: Promote uptake of My Health Record by ITC providers and the Aboriginal community.

Recommendation 13: Embed use of My Health Record into ITC workflows.

Recommendation 14: Offer Patient Opinion licenses to ITC providers as a mechanism for continuous improvement amongst all organisations involved in the ITC client journey.

1. Introduction

This section outlines the background and objectives of the Integrated Team Care (ITC) Country to City: Improving Patient Transitions Project (the Project).

Background and overview of Integrated Team Care

ITC is an Australian Government initiative delivered across Australia. It provides care coordination for Aboriginal people with a chronic condition according to a patient's GP Management Plan (GPMP) prioritising patients with complex care needs. ITC also provides access to services or medical equipment that would not otherwise be accessible or available in a clinically acceptable timeframe.

ITC commenced as a service in WA from 1 January 2017. ITC is an amalgamation of the previous Care Coordination and Supplementary Services (CCSS) and Improving Indigenous Access to Mainstream Primary Care (IIAMPC) services.

WA Primary Health Alliance (WAPHA) funds the ITC service across WA. Ten organisations are contracted by WAPHA to deliver ITC across nine ITC country regions and five ITC metropolitan regions, either directly or through subcontracting arrangements.

The aims of ITC are to:

- Contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care; and
- Contribute to closing the gap in life expectancy by improved access to culturally appropriate mainstream primary care services (including but not limited to general practice, allied health and specialists) for Aboriginal and Torres Strait Islander people.[1]

Objectives of the Project

Through engagement with ITC providers and other key stakeholders, WAPHA received feedback relating to the difficulties faced in supporting patients who were off-Country staying in metropolitan areas for health treatment. The feedback identified that the patient journey for Aboriginal people from country to Perth can be fragmented, inconsistent and results in poor health and well-being outcomes.

WAPHA received innovation funding from the Australian Government to undertake this Project and investigate the issues further. The Project's primary focus is on Aboriginal people with a chronic condition, namely to improve the transitions when they move between regions for health care, through improvements to ITC. The objectives of the Project are to:

1. Understand the extent of the issues and concerns regarding the transition of ITC clients, and those eligible for ITC, across WA. In addition, to understand the good practice happening in patient transitions to then share relevant learnings on a state-wide basis.
2. Work with the health sector to develop solutions that will improve the experience and care of Aboriginal people with chronic conditions, promoting integrated, seamless care and optimal health outcomes for Aboriginal people.

Methodology

The Project utilised three main methods to understand the current state of the journey for Aboriginal and Torres Strait Islander people when travelling away from home for treatment. Significant stakeholder consultation was undertaken across WA, speaking to ITC providers, ITC clients, hospitals, Aboriginal Community Controlled Health Services (ACCHSs), government bodies and non-government organisations. The full list of stakeholders is provided in Appendix B. Data was obtained from WA Health to understand the number of patients travelling between regions for inpatient separations and outpatient appointments. A desktop scan was undertaken to identify key themes from the literature.

The development of recommendations was driven by stakeholders. As part of the consultations, stakeholders identified what they would like to see changed. This feedback formed the basis of the recommendations that were developed into action plans by stakeholders in a two-day workshop in November 2017.

The action plans have informed the final recommendations in this report, and will be trialled over January to June 2018 in line with the Australian Government innovation funding timeframes.

Structure of the report

The report firstly provides data around the numbers of admissions and outpatient appointments in Perth for the population residing in WACHS regions. The remainder of the report is structured into the key parts of the ITC client journey:

- Referral
- Arranging travel
- Arrival into Perth or regional centre
- Receiving treatment in Perth or regional centre
- Discharge and travel home
- System wide

The current state challenges, examples of good practice and recommendations for improvement are discussed for each part of the ITC client journey.

1 Australian Government Department of Health 2018. Integrated Team Care Activity Implementation Guidelines 2016-2017 to 2017-2018.

2. Data on patients travelling between regions for health care

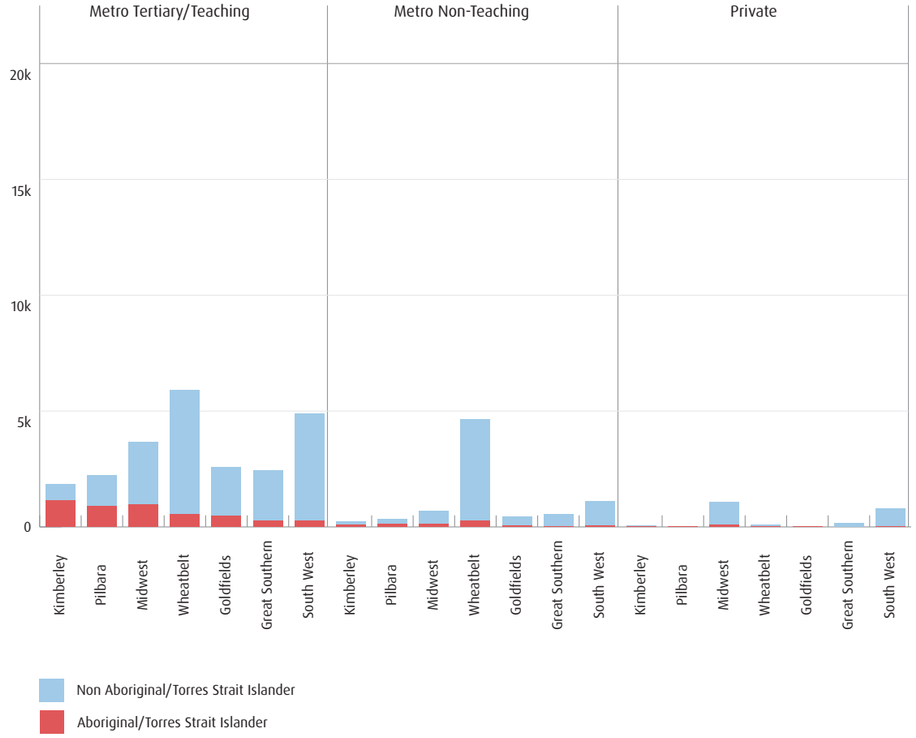
This section outlines data on the number of inpatient admissions and outpatient appointments for the population residing in WACHS regions.

Inpatient admissions

To provide context about the number of Aboriginal people travelling to Perth, the next two graphs show the number of hospitalisations of the population residing in WACHS regions in metropolitan public hospitals (Figure 1), country public hospitals (Figure 2), and public patients in private hospitals [2] (Figures 1 and 2). The scales for Figure 1 and Figure 2 are the same to enable comparison across metropolitan and country regions. The same set of private hospitalisation data is also shown in both figures for comparison.

Most hospitalisations are in country regions, however Figure 1 shows there is a significant patient flow into Perth. The Kimberley region had the most metropolitan public hospital hospitalisations of its Aboriginal population with 1,226 hospitalisations in 2016. This was followed by the Midwest (1,087), Pilbara (1,019), Wheatbelt (778), Goldfields (510), South West (296) and Great Southern (290).

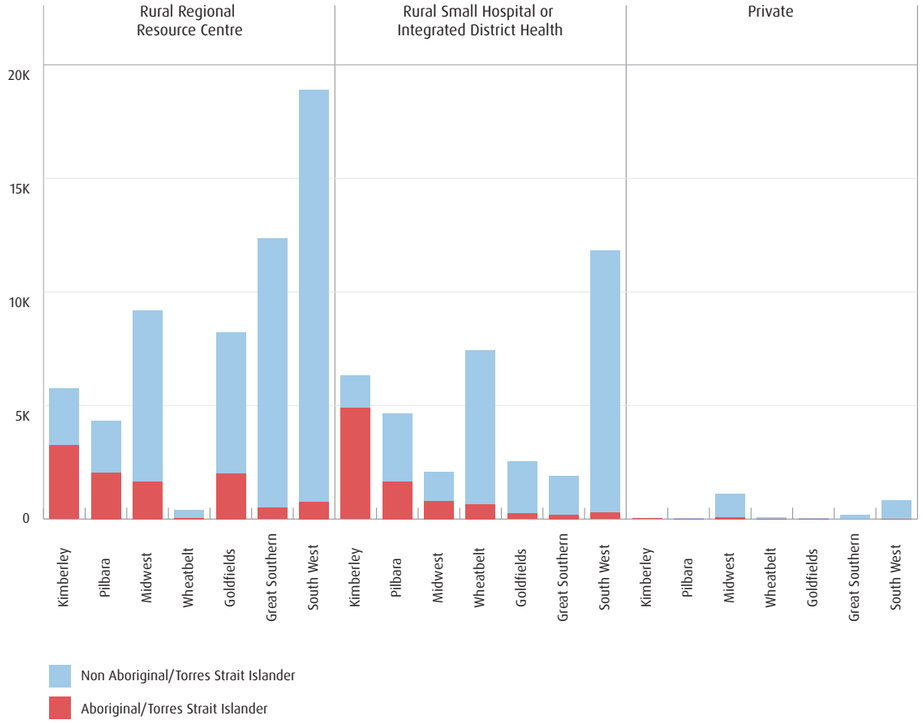
Figure 1: Number of metropolitan public hospital and private hospital[3] hospitalisations in 2016 by residential region, Indigenous type and admitted hospital group (excluding dialysis and chemotherapy)[3]



2 Private hospital data only includes public patients in metropolitan and country private hospitals, except for Joondalup Health Campus, Peel Health Campus and St John of God Midland. These three hospitals have been grouped to 'Metro Non-Teaching'.

3 Data obtained from the WA Department of Health, Hospital Morbidity Data Collection.

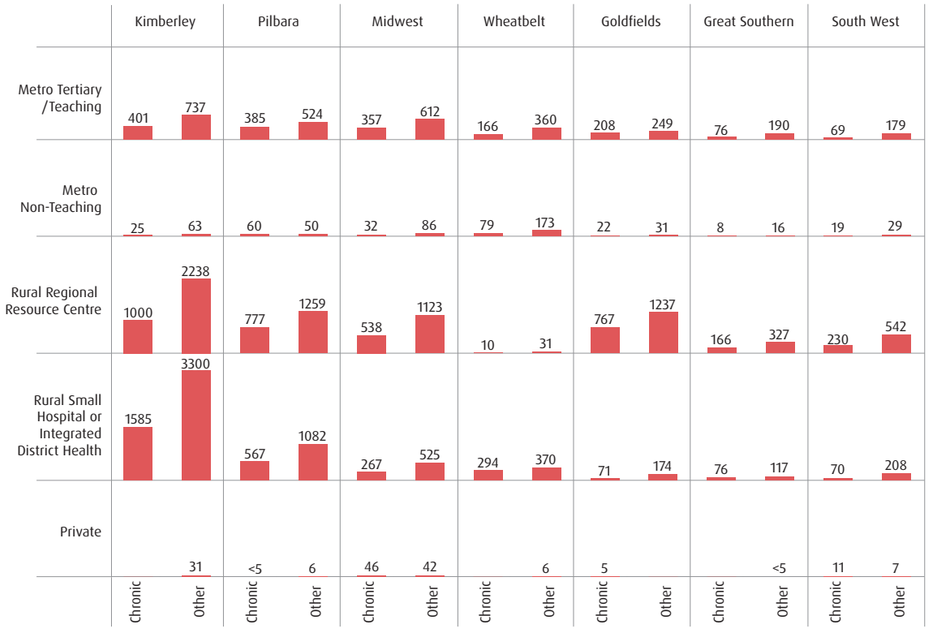
Figure 2: Number of country public hospital and private hospital[4] hospitalisations in 2016 by residential region, Indigenous type and admitted hospital group (excluding dialysis and chemotherapy)[4]



4 Data obtained from the WA Department of Health, Hospital Morbidity Data Collection.

Figure 3 shows the separation of hospitalisations into those for selected potentially preventable chronic conditions[5], and hospitalisations not related to the selected potentially preventable chronic conditions, or 'other'. These figures exclude dialysis and chemotherapy. Overall, metropolitan hospitalisations for the selected potentially preventable chronic conditions represent 37 per cent of all metropolitan hospitalisations.

Figure 3: Number of selected potentially preventable 'chronic' versus 'other' hospitalisations in 2016 by residential region and admitted hospital group for the Aboriginal population [6]



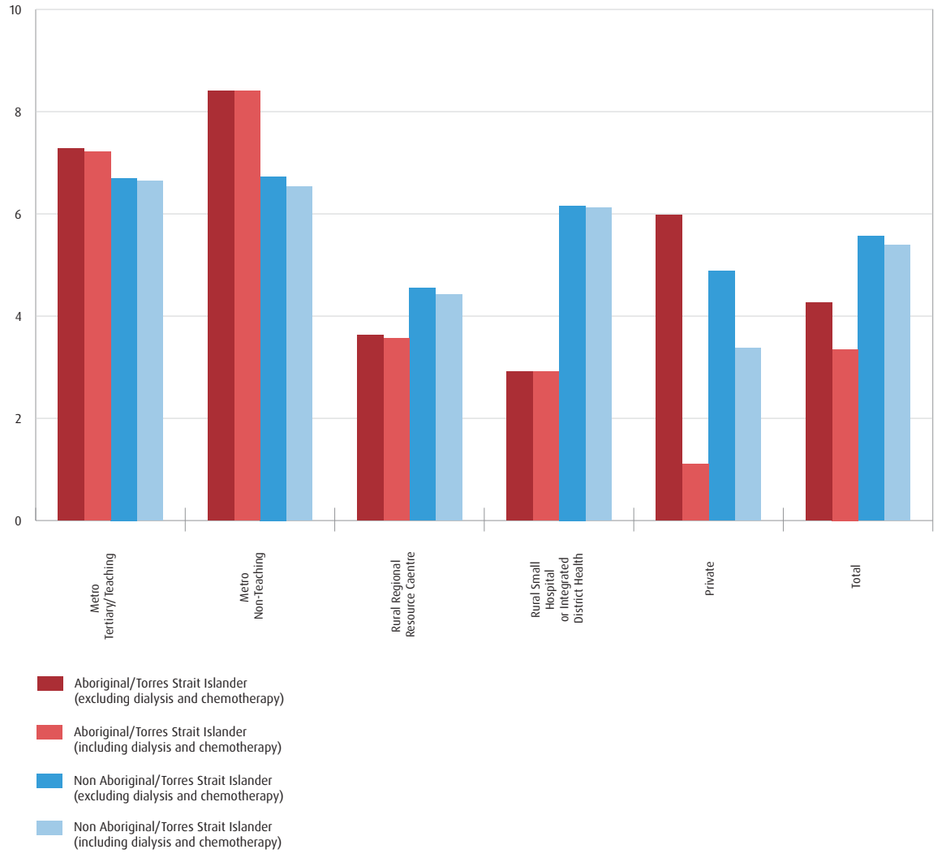
5 The list of selected potentially preventable chronic conditions are asthma, congestive cardiac failure, diabetes complications, chronic obstructive pulmonary disease, bronchiectasis, angina, iron deficiency anaemia, hypertension, nutritional deficiencies and rheumatic heart disease, as defined by National Healthcare Agreement PI 18 at http://meteor.aihw.gov.au/content/index.phtml/itemId/598746, where the diagnosis was the principal or an additional diagnosis.

6 Data obtained from the WA Department of Health, Hospital Morbidity Data Collection.

Length of stay

Figure 4 shows the average length of stay for Aboriginal people in metropolitan and country regions, compared to the non-Aboriginal population for the selected potentially preventable chronic conditions. Aboriginal people have a longer length of stay compared to the non-Aboriginal population when staying in metropolitan hospitals. This is reversed in regional hospitals.

Figure 4: Average length of stay for 2016 hospitalisations for selected potentially preventable chronic conditions by admitted hospital group, Indigenous status and dialysis and chemotherapy[7]

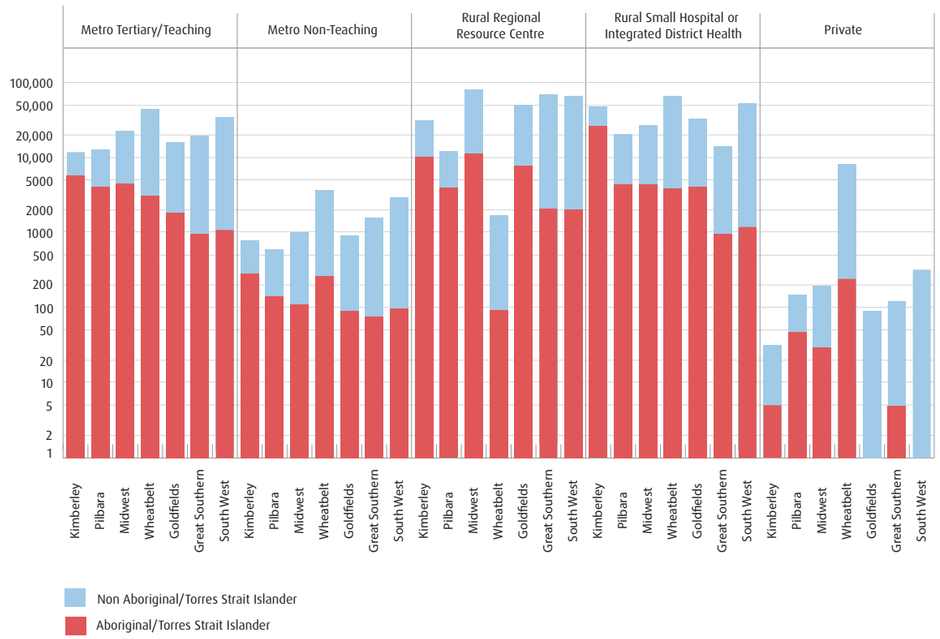


7 Data obtained from the WA Department of Health, Hospital Morbidity Data Collection.

Outpatient appointments

Figure 5 shows the number of outpatient appointments attended by the population residing in WACHS regions. Similar to inpatient admissions, the findings show that most appointments are in country regions. However, there are relatively large numbers of Perth appointments, particularly for the Wheatbelt and South West regions. Please note that Figure 5 uses a logarithmic scale on the y-axis to enable the different volumes for each hospital group to be shown on the same graph.

Figure 5: Number of attended appointments in 2016 by residential region, Indigenous type and hospital group[8]



8 Data obtained from the WA Department of Health, Non Admitted Patient Activity and Waitlist Data Collection.

Percentage of patients that did not attend outpatient appointments

The percentage of patients recorded as Did Not Attend, Did Not Wait, or Other varied considerably across regions, but was consistently higher for the Aboriginal population compared to the non-Aboriginal population. The Kimberley and Pilbara regions appear to have consistently higher rates across all hospital groups.

Non-admitted data does not contain diagnostic information and it was therefore not possible to identify appointments for dialysis or chemotherapy.

Figure 6: Percentage of patients recorded as Did Not Attend, Did Not Wait, or Other for 2016 by residential region, Indigenous status and hospital group [9]

Health region of residence	Indigenous status	Metro Tertiary/ Teaching	Metro Non-Teaching	Private	Rural Regional Resource Centre	Rural Integrated District Health Service or Rural Small Hospital	Total
Kimberley	Aboriginal	35%	38%	n/a	36%	30%	32%
	Non-Aboriginal	18%	16%	38%	21%	17%	19%
Pilbara	Aboriginal	36%	24%	n/a	39%	31%	35%
	Non-Aboriginal	18%	16%	32%	23%	14%	17%
Midwest	Aboriginal	34%	36%	37%	24%	20%	25%
	Non-Aboriginal	18%	11%	54%	16%	11%	15%
Wheatbelt	Aboriginal	39%	29%	31%	25%	18%	29%
	Non-Aboriginal	20%	13%	26%	9%	9%	15%
Goldfields	Aboriginal	35%	35%	n/a	19%	8%	18%
	Non-Aboriginal	20%	12%	48%	11%	10%	12%
Great Southern	Aboriginal	30%	27%	n/a	35%	18%	28%
	Non-Aboriginal	19%	15%	50%	18%	8%	16%
South West	Aboriginal	34%	37%	n/a	12%	19%	20%
	Non-Aboriginal	16%	16%	36%	12%	12%	13%

9 Data obtained from the WA Department of Health, Non Admitted Patient Activity and Waitlist Data Collection.

3. Referral

The typical referral pathway into the ITC program is through the client's regular GP with a GPMP for chronic condition/s. Of the 1,182 new referrals received between 1 January to 30 June 2017, 1,016 were GP referrals, 67 were self-referrals, seven were from other ITC providers and 92 were from other sources (likely to include referrals from health programs and hospitals).[10]

Current state challenges

Limited awareness of ITC amongst community and service providers

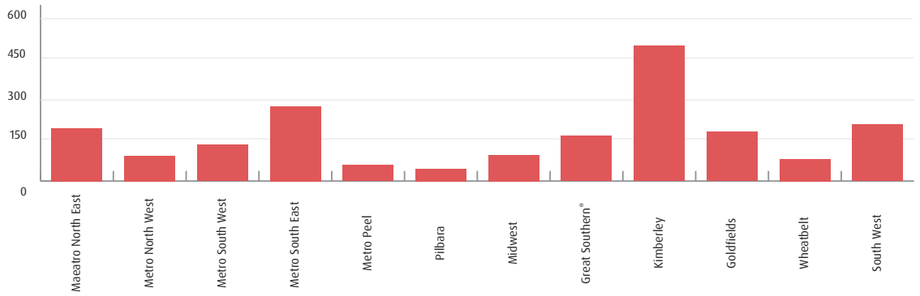
There can be limited awareness of ITC and how to access it amongst the community and service providers which is the first barrier in accessing the service. ITC in WA in its current form commenced on 1 January 2017 after an extensive tendering process. Some successful applicants had previously been providers of CCSS and IIAPMC, and in such instances the transition to ITC was relatively smooth and occurred 'behind the scenes' from the clients' and referrers' point of view. However, in regions where a new provider was appointed additional time was required for the service to be fully operational due to recruitment and promotion. Transition information and support also varied across regions.

Figure 7 and Figure 8 represent data from ITC provider reports from the period 1 January to 30 June 2017 to show the number of ITC clients per region. This data needs to be interpreted with caution as the reporting templates are new. As these provider reports were the first submitted for ITC, providers are likely to have counted the number of clients differently. However, the data does provide an indication of variation between regions.

Figure 7 shows the number of ITC clients per region as at 30 June 2017. There is wide variation in client numbers across regions, which is to be expected as the population of Aboriginal people varies across regions. However, there is a general trend that client numbers are lower in regions where a new ITC provider was appointed. These regions are the Perth North West, Perth North East, Pilbara, Midwest and Goldfields.

10 Data taken from ITC provider reports for the period 1 January to 30 June 2017.

Figure 7: Number of ITC clients per region as at 30 June 2017



* *Includes some clients from the southern Wheatbelt region*

Figure 8 shows the percentage of the Aboriginal population that accessed ITC as at 30 June 2017. The percentage of the Aboriginal population accessing ITC appears low, indicating the potential for significant improvement in uptake. This needs to be balanced against the capacity of ITC providers.

Figure 8: Percentage of Aboriginal population accessing ITC

Region	Number of ITC clients	Estimated Aboriginal population[11]	Percentage of population accessing ITC
Great Southern*	166*	2,577	6.4%
South West	208	4,178	5.0%
Kimberley	500	17,022	2.9%
Goldfields	181	6,851	2.6%
Metro South	468	18,902	2.5%
Wheatbelt	81	4,260	1.9%
Metro North	288	16,082	1.8%
Midwest	98	8,472	1.2%
Pilbara[12]	45	9,926	0.5%

* ***Includes some clients from the southern Wheatbelt region***

Of the 1,182 referrals into ITC, 1,016 are from GPs (representing 86 per cent of referrals). The 1,016 GP referrals are from 440 individual GPs across 108 practices. There are approximately 650 GP practices in WA, indicating that about one sixth of all practices are aware of and refer into ITC. A common theme across the stakeholder consultations was the desire of all providers to raise awareness of ITC in GP practices and the Aboriginal community,[13] which is further detailed in the next paragraph.

11 Data taken from Holman CDJ, Joyce SJ, A Promising Future: WA Aboriginal Health Programs. *Review of performance with recommendations for consolidation and advance. December 2014.* Perth: Department of Health Western Australia, 2014.

12 The current ITC program in the Pilbara is focussed on the lower population areas to ensure equity in access to care coordination services. This focus will naturally mean lower ITC client numbers. All three ACCHSs have a care coordinator each (funded by WAPHA, but not through ITC) and thus there is less need to enrol chronic disease patients in the ITC program.

13 This recommendation was also supported by the findings from the Davis, J.D., Toll, K., Robinson, S. 2017, Can better access to coordinated, *multidisciplinary care really close the gap in life expectancy for Indigenous people with complex chronic conditions? Evaluation of the Integrated Team Care Program. Results from Qualitative Analysis (Stage 1).*

Access to a regular GP

Access to ITC is dependent on the person seeing a GP and having a GPMP. Stakeholders identified that Aboriginal people may not see a GP and do not know the full extent of their health status. This means their chronic condition may not be identified and managed, in some cases leading to emergency treatment as the condition has progressed in severity. Some stakeholders also identified that a person may not even know a GPMP has been completed, who their GP is, or that they are an ITC client. The provider can identify through Medicare that a GPMP has been completed as the MBS item has been claimed, but the client is unable to say, or is unaware, that this has occurred and by which GP.

ITC is intended to be a primary care service and it is appropriate that most referrals are from GPs. However, acknowledging that access to a regular GP can be a barrier, especially in remote areas where clinics are provided by WACHS or the Royal Flying Doctor Service (RFDS), increased knowledge of ITC amongst the community can help to ensure the service is more readily available to those in need. Some providers also identified the desire to increase hospital staff knowledge of ITC as another way of improving access. Hospitals appeared to have limited knowledge of ITC in the consultations.

Variations in ITC between regions

The stakeholder consultations identified that in practice ITC differed between regions. While there are Australian Government guidelines, these are in some areas very broad and can be applied very differently. Examples include time spent in the ITC service, skill mix and tasks of staff, how care coordination is undertaken, approval for purchase of medical aids, intake processes including eligibility criteria and triaging, access to alternatively funded services in the provider region and discharging processes.

Examples of good practice

Some providers use their knowledge of local community members to follow up individuals to check whether they have had an annual health assessment *(MBS item 715 Medicare Health Assessment for Aboriginal and Torres Strait Islander People)* or review completed. They will then support the person to see a GP and have the assessment completed. This can be an effective method to address the challenge of people not accessing a GP.

Some GPs will have discussions with their patients about advanced care decisions if the condition has progressed to a terminal stage. The patient can then make an informed choice as to whether they want to travel for treatment in the final stages of their life.

Recommendations for improvement

Recommendation 1

Establish and implement a standardised intake, allocation, transfer and discharge process for ITC.

The purpose of implementing a standardised intake, allocation, transfer and discharge process is to ensure Aboriginal people receive consistent ITC access and service across WA, regardless of provider or location. The terms are defined as follows:

- 'Intake' refers to initial entry into ITC, including triage, assessment and prioritisation.
- 'Allocation' is the type of service received (i.e. short-term, long-term, care coordination and/or supplementary services) and ensuring care is client centred.
- 'Transfer' is when a client moves to a different ITC provider.
- 'Discharge' is when a client exits ITC.

Implementing a standardised intake, allocation, transfer and discharge process would involve understanding the current referral pathways in place for each provider and how this is supported by the clinical software used.[14] WAPHA will work with providers to:

- Understand what parts of the referral pathways can be standardised (e.g. eligibility criteria, service model for care coordination, approval process for supplementary services, referral form, transfer form, communication between providers when client travel occurs);
- Encourage community providers to enrol eligible patients in ITC prior to travel to Perth and have advanced care directives in place for appropriate patients;
- Provide a framework for consistent promotion and messaging of ITC throughout WA while allowing for local variation; and
- Ensure ITC information remains current on the HealthPathways WA portal.

14 The most common patient management software systems for ITC are MMEX and Communicare.

4. Arranging travel

This section is about how travel is arranged and coordinated for clients.

The common practice is for the client to receive a referral letter and contact an organisation (such as their GP, ITC provider or ACCHS) for assistance. The client and/or the organisation will liaise with the local PATS office if the client is eligible for PATS.

Current state challenges

Fear of travel

The most common theme of the stakeholder consultations was that people do not want to travel for treatment. There is a fear of Perth as a scary, unfamiliar location without family, and a fear of planes from the perception that others have gotten on *"the big white bird and never returned"*. This is particularly exacerbated for people from remote communities where English is not their first language, there is minimal health education, and/or a more traditional lifestyle is followed.

Problems in coordination and communication between organisations

The responsibility and accountability for preparing patients for travel varied between regions. Where the patient was an ITC client, ITC providers took the lead but this was dependent on the provider knowing that travel was required. There were instances where the provider was unaware the client had travelled to Perth until the journey had been completed and the client had returned to the community. Without an allocated lead to prepare patients for travel, the following challenges were encountered:

- The patient may not realise the importance of the treatment or appointment, and therefore may not show up for the bus, train or plane to Perth or the regional centre.
- Appointments were booked without consideration to the proximity of accommodation, other appointments, or travel requirements.
- Patients did not have essential necessities for the trip such as clothing, toiletries and ID.

Another challenge identified through the stakeholder consultations was poor communication between organisations, particularly with the local PATS offices. One organisation may know that a patient needs to travel, but does not communicate this to other relevant organisations. The key reason for this was not knowing what the relevant organisations were. For example, PATS offices and hospitals are unlikely to know whether someone is an ITC client. Country ITC providers may not know the appropriate metropolitan ITC provider. In some instances, the RFDS had not advised PATS that a patient had been evacuated.

Travel that could be avoided

Stakeholders identified the issue of unnecessary travel for appointments and/or treatment that may have been delivered in region or via telehealth. The most common reason for this appeared to be lack of knowledge about telehealth criteria or the services available in region (including visiting specialists) by locum doctors unfamiliar with the region, or by metropolitan based health professionals who may not realise the challenges of the travel required for country patients.

Application and knowledge of PATS policy

ITC providers had different experiences with PATS between regions in relation to taxi vouchers, mode of transport, carers/escorts, accommodation, upfront payment versus reimbursement and eligibility if there was a visiting specialist. The PATS policy has guidelines for these aspects, but the application and understanding of the policy varied between regions, particularly if there had been turnover in PATS staff. There are also regional business rules that can impact the application of the PATS policy. There is flexibility in the guidelines if the GP provides a clinical justification for an exception, however this was often not provided, particularly if the region had new or locum doctors.

Examples of good practice

Where an organisation took responsibility to prepare the patient for travel, this often resulted in a positive experience for the patient. The organisation could be the ITC provider, the ACCHS, WACHS inter-hospital liaison or WACHS Community Health. The organisation would undertake tasks such as communication with the patient and family to ensure they understood the need for travel, arrangement of transport and ID, and ensuring the travel itinerary made best use of time (such as sufficient time for travel between locations and that multiple appointments with different specialties were booked for the same trip).

Another example is where a provider is listed on the Outpatient Direct List which means they have access to the details of their clients' next clinical appointment. The provider contacts the Outpatient Direct List on a regular basis to obtain details of any scheduled outpatient appointments for ITC clients. The provider will then offer support to the client for travel.

Some ITC providers prepared a pack of information for the client to take with them for travel. This included the itinerary, referral form, PATS form, contact information and clinical information.

Some stakeholders used the Rural Health West Outreach Health Services Map available online to identify when a medical specialist or allied health professional was visiting the region. This helped to minimise travel and ensure the person received care closer to home.

Use of interpreter services

Interpreter services were utilised in hospital settings to support Aboriginal patients where English is the second, third or even fourth language. The Kimberly Interpreter Service is utilised across metropolitan, regional and remote hospital settings. It was established that in hospital settings interpreter services are utilised to support the clinician when speaking with the patient and their family about the diagnosis and the treatment being offered. Stakeholder consultations identified the potential for interpreter services to be used for more social conversation with patients and their families i.e. conversation not necessarily related to the person's condition or treatment.

Recommendations for improvement

Recommendation 2

Develop resources to support clients in preparing for travel, such as a checklist for journey planning, patient stories and videos. Promote and educate patients, community and health professionals on the availability and use of the resources.

WAPHA will work with stakeholders to develop resources to support clients preparing for travel. The work will build on existing resources (such as the PATS travel booklet) and could include a common checklist for journey planning and a library of resources for clients (such as patient stories, information on treatment, hospital virtual tours and information on accommodation, flights and public transport). The checklist will include things such as the GPMP, itinerary, medical list, contact details, clinical history and referral forms.

A Steering Committee will guide development, promotion and training of the travel resources. The resources will be developed in print, video, or audio, be culturally appropriate, and locally tailored for different regions and language groups. Training and education will be provided on use of the resources. The resources will be located on websites accessible to patients, community, service providers and health professionals.

One platform is HealthPathways WA, a web-based portal with condition-specific 'pathways' localised across WA. Each pathway supports clinicians with assessment, management and local referral information. The HealthPathways WA site is designed for GPs but is also available to hospital specialists, nurses and other health professionals. HealthPathways WA is regularly updated as clinical information and services change.

In addition, HealthPathways WA has recently published travel assistance pathways. Health professionals can access information in one place on travel assistance services, eligibility criteria and referral information. Furthermore, travel assistance is indicated and linked throughout other pathways where it may be required as shown in Figure 9. HealthPathways WA also contains visiting specialists' rosters and information on telehealth services.

Figure 9: Example of linked travel assistance pathway on HealthPathways WA

Pilbara

1. Refer the patient to a Perth metropolitan hospital via the Central Referral Service.
2. Discuss travel assistance.

Recommendation 3

Work with health service providers to explore ways of using digital health services to avoid unnecessary travel and facilitate care between regions.

WAPHA will work with WACHS State-wide Telehealth Services, Area Health Services and Rural Health West to explore ways of using digital health services to avoid unnecessary travel, facilitate multidisciplinary care between regions and ensure connection back to family at home.

Section 6 Receiving treatment in Perth or regional centre outlines an example of good practice where telehealth was used for a patient in Perth to speak to family back home. This demonstrates that telehealth can be used not just for clinical services, but also social services to support recovery.

Recommendation 4

Provide templates and frameworks to support providers to undertake stakeholder mapping.

WAPHA will provide templates and frameworks to support providers to undertake stakeholder mapping. The purpose is to improve communications and relationships between key stakeholders both intra-regionally and inter-regionally. The regional Aboriginal Health Planning Forums are a key means of engagement for Aboriginal health, and WAPHA will also broker relationships through the WAPHA regional teams' networks. This approach recognises that regions will be at different stages of stakeholder engagement, and differing levels of support will be required. The templates will help providers to:

- Identify key stakeholders in the region, such as PATS, AHLOs, WACHS, the local ACCHS, service providers and Rural Health West;
- Understand the role of each stakeholder, their remit and what they are funded for.
- Establish service agreements and/or MoUs (where relevant) to formalise how organisations will work together.

The improvement of communications and relationships between regions is addressed in Recommendation 11.

5. Arrival into Perth or regional centre

This section is about the client's arrival into Perth or a regional centre.

Clients may travel via car, plane, train or bus. Sometimes the client will head first to their accommodation at an Aboriginal hostel, hotel, friend or family's house; or they may go straight to an appointment (or be admitted to hospital if it is an emergency evacuation or inter-hospital transfer).

Current state challenges

Cultural shock in Perth

Stakeholders discussed the cultural shock that Aboriginal people can experience once they arrive in Perth, particularly if they are unaccompanied, if it is their first visit from a remote community or if English is not their first language. Perth is perceived as confusing, scary and difficult to navigate for such people. Even the colder temperature can be a challenge for someone accustomed to hot weather and therefore may be without appropriate warm clothing in Perth.

Issues with transport and arrival times

Arrival times in Perth or the regional centre can be after hours, particularly if remote travel is required. This presents the challenge of lack of transport to the accommodation or appointment. Taxi vouchers can be made available but some challenges associated with their use are that taxis may not be available in the region, patients may not know how to use taxis, and the limited budget available for vouchers.

Metropolitan providers unaware of arrival of country ITC clients

Metropolitan ITC providers are often unaware that an ITC client will be arriving in Perth. This means they cannot provide any support for the client if required. An additional challenge is that metropolitan providers will encounter patients off-Country who are not ITC clients, but are eligible for the service. In such instances, they will link the person into ITC but this can be complicated if the person does not have a regular GP, or if a GPMP has already been completed but the person cannot identify by which GP.

Examples of good practice

A number of ITC providers will accompany their clients to Perth and act as their guide and advocate. The provider offers social and cultural support, takes the lead in organising or providing transport and ensures the client understands what the health professional is saying. This is often the difference between a poor experience where the client refuses to travel again, and a positive experience that *"becomes an opportunity for a yarn"*.

Another example of good practice is a country ACCHS ITC provider with a Perth-based care coordinator who meets clients at the airport and supports them in transport to appointments and accommodation, and advocacy in appointments. This position is not funded through ITC, but the role does support ITC clients. The provider does not enrol all chronic disease clients travelling to Perth in ITC, as they already have a role there to support care coordination. Clients are only enrolled in ITC if there is a need to access supplementary services funding as other funding is not available.

The Perth-based care coordinator has advance notice of patients travelling to Perth as well as documentation such as the itinerary, referral forms, and clinical information. This facilitates an effective journey as the Perth-based care coordinator ensures the patient gets to appointments, has cultural, social and emotional support, and accesses required services. The role works across more than one part of the patient journey, with significant components being patient advocacy, patient understanding of treatment and condition management. A key factor in the position's success is that they are from the region and has existing relationships with the Aboriginal community. Patients therefore know and trust them.

Recommendations for improvement

Refer to Recommendation 6 for the development of a service model that encompasses transport, health and support services, and advocacy.

Recommendation 5

Regularly circulate a contact list of key ITC staff.

WAPHA will develop and circulate a contact list of key ITC staff. The purpose of the contact list is so providers have the details of who to contact if a client needs to travel.

The contact list will include names, positions, direct phone numbers and emails. Each provider will be able to nominate one person for contact, but will be asked to also provide details for other key staff members for information and backup if the lead person is unavailable.

The contact list will provide details for the expanded Meet and Greet Service for after-hours support.

6. Receiving treatment in Perth or regional centre

This section addresses the time clients spend in Perth or a regional centre receiving treatment.

Staying in Perth or regional centre may be only a few days for an outpatient appointment or standard procedure, or alternatively may be several weeks or months if the client is very unwell, requires dialysis or needs medical clearance to return home.

Current state challenges

Limited availability of appropriate accommodation

One of the challenges identified by stakeholders was the limited availability of appropriate accommodation for Aboriginal people in Perth. There are two Aboriginal hostels run by Aboriginal Hostels Limited, Allawah Grove and Derbal Bidjar. These are the preferred places of accommodation as the fees are covered by the PATS accommodation subsidy. The hostels provide three meals per day and are serviced by the WACHS Country Health Connect (CHC) transport service. However, these hostels may be full or culturally inappropriate if several language groups are staying there at the same time, or because of avoidance rules, or having to share rooms with strangers.

The hostels only provide accommodation and meals, and do not provide health care, cultural, social or emotional support. This presents a challenge as Aboriginal people staying at the hostels are often there for treatment and can be very unwell, and report social and cultural isolation being so far away from family and home.

There are alternatives to staying at Allawah Grove and Derbal Bidjar, but each has its own set of challenges. Alternative accommodation options include:

- Family or friends, but this may lead to overcrowding and is not covered by CHC.
- Hotel, but this may not be affordable, does not have health care or cultural support, and is not covered by CHC.
- Private hostel, but this does not include meals, does not have health care or cultural support, and is not covered by CHC.

Limited financial resources

Stakeholders identified the limited financial resources of some Aboriginal people as a key challenge. They may not be able to afford necessities in Perth (food, public transport, taxis, toiletries), particularly if they are also covering household expenses at home (rent, utilities, food and dependents). For those people on Centrelink payments, the alternate week between fortnightly payments can be difficult to pay for necessities. The status of temporary residency in Perth means the person may be unable to access financial assistance, emergency housing, Housing Authority and rent assistance. The PATS accommodation subsidy is only payable for six consecutive months.

Missed appointments

Unfamiliarity with Perth, long waiting times, miscommunication, culturally unsafe waiting rooms and lack of cultural understanding on the part of health professionals can all contribute to the patient missing appointments (recorded as 'Did Not Attend', or DNA), or leaving hospital without medical consent (recorded as 'Discharged Against Medical Advice', or DAMA). This means the patient has not received the treatment required, but it also means they may be unable to access PATS for the return journey home and can become 'lost' in Perth.

Country clients accessing metropolitan resources

The metropolitan ITC providers will support country ITC clients. If a country patient is not an ITC client but is eligible, the metropolitan provider will support the person to access ITC (i.e. taking the person to see a bulk-billing GP and having a GPMP completed). There are two key issues with this:

- ITC is funded on a population basis and the support that metropolitan providers offer to country clients (in the form of staff time, transport and supplementary services) impacts metropolitan clients; and
- Metropolitan ITC providers have identified that having a GPMP completed in Perth is not ideal as the GP will not be the person's regular GP responsible for continuity of care.

Examples of good practice

A provider is funded for an Aboriginal Health Practitioner (AHP) based in Derbal Bidjar and Allawah Grove hostels to assist with medication management, GP follow up, health literacy and linkage of eligible patients into ITC. The AHP works with all patients staying in the hostel regardless of region or ITC status. The AHP helps to ensure patients are compliant with medication and are linked into primary health care. The AHP also provides some advocacy such as support with Centrelink.

In another example, telehealth was used to link a patient back into community and family. The opportunity to see and speak to family provided cultural, emotional and social support, and was beneficial for physical recovery. There is also the additional benefit that the patient becomes familiar with telehealth and associates it with a positive experience. The patient is therefore more amenable to using telehealth in the future for follow-up appointments and minimises the need for travel.

Recommendations for improvement

Recommendation 6

During January to June 2018, develop a service model for the provision of primary health and social services support for patients in Perth for treatment. Trial the service model over July 2018 to June 2019 and develop a business case for recurrent funding.

WAPHA will develop a potential service model for the provision of primary health and social services support for off-Country Aboriginal patients in Perth for treatment. The purpose of the service model is to ensure all available evidence and options are considered in determining the most effective and cost-efficient method to provide primary health and social services support. A Steering Committee of key stakeholders will provide strategic direction.

Developing the service model will include the following steps:

- Needs analysis to identify demand, evidence base and current models;
- Identification of key stakeholders and interactions with existing services (such as ITC, CHC, PATS, AHLOs, Silver Chain and GP Links) to minimise duplication;
- Identification of broader service models for patient travel, such as Ronald McDonald House and Crawford House;
- Development of different service model options, skills mix (such as an AHP and Aboriginal Community Liaison Officer), operating hours and associated funding;
- Trial over a six to 12 month period; and
- Develop a business case for recurrent funding.

Recommendation 7

Continue to fund the hostel-based Aboriginal Health Practitioner until the service model from Recommendation 6 is ready for trial.

WAPHA will continue to fund the AHP that supports Allawah Grove and Derbal Bidjar hostels until the service model from Recommendation 6 is ready to be trialled. The purpose of continuing funding is to ensure continuity of service. WAPHA will investigate the feasibility of expanding the service to support Fiona Stanley Hospital patients.

Recommendation 8

Access to a funding pool for ITC providers to support out of region ITC clients.

WAPHA will make available a funding pool for ITC providers to support out of region ITC clients. The purpose of the funding pool is to ensure the ITC funds allocated to each provider are used on that region's Aboriginal population.

The funding pool will be administered by one organisation and access will be based on the supplementary services guidelines to ensure consistency. WAPHA will develop a policy and procedure that outlines how providers will access the funding pool, including invoicing, required documentation and timeframes. The funding pool will be trialled over January to June 2018 and will provide data on the number, dollar amount and types of services accessed by out of region ITC clients. This will be used to inform whether the funding pool will be ongoing post June 2018.

7. Discharge and travel home

This section is about handover from tertiary care to primary care and the client's journey home.

Discharge summaries for inpatient admissions are sent to the client's regular GP. If the client is eligible for PATS the appropriate clinical permissions need to be provided for the return trip. Discharge summaries are not provided for outpatient and emergency department visits.

Current state challenges

Inadequate discharge from hospital

Where the patient has travelled to Perth or a regional centre due to an acute hospital admission, stakeholders identified several challenges with discharge:

- Discharge planning may not consistently occur with enough notice to implement or refer to services such as ITC.
- Discharge summaries may not be sent to ITC providers, particularly if they are not part of an ACCHS.
- ITC providers may not be aware their client has been hospitalised and are not involved in discharge planning.

The lack of handover from hospitals to primary care and a regular GP is a significant issue as there is no clinical follow up, monitoring of the condition and medication. The ITC provider is limited in the support they can provide if they do not know what treatment occurred.

CHC often receive requests for transport for clients returning home only a few hours before the flight. Demand for transport means that CHC cannot always assist.

Difficulties in affordability and access to medication

Medication management was identified as a key challenge. Hospitals cannot write CtG scripts, which means the patient needs to pay up front when having their scripts filled; or see a GP who can provide them with CtG scripts or wait for the hospital to dispense and arrange Webster packs. This can take more than five hours and is a service that is only available during business hours on weekdays. Where a community pharmacy is involved patients will incur a co-payment cost until the scripts are annotated with 'CtG'. If the patient chooses to wait for their medications to be dispensed by the hospital, they are often moved to the transit lounge to wait which is a busy and open environment without privacy. In addition, by the time medications are ready the patient may need to travel to the hostel after dark, which is particularly confronting if it is their first visit to Perth. Many patients leave without receiving medications for these reasons.

Hospitals provide medication for varied lengths of time (some hospitals provide medication for two days, others for two weeks) but this is not always Webster packed which can lead to non-compliance with a complicated and confusing medication regime. Sometimes there is insufficient medication for the return trip home, or to last until the next script can be filled. This is particularly an issue in rural locations which do not have an extended on-hand supply of medication.

As detailed in the previous section for *'Receiving treatment in Perth or regional centre'*, patients may be unable to return home if they have been recorded as a DNA or DAMA.

Examples of good practice

GPs signed up for electronic discharge summaries can access these as soon as they are available from the hospital. This facilitates follow up from the patient's regular GP once they return home. Some ITC providers are ACCHSs which means they can have access to electronic discharge summaries.

One metropolitan hospital identified they had formal arrangements with a community pharmacy to provide Webster packed medication that can be delivered straight to the patient.

Recommendations for improvement

Recommendation 9

Develop a flowchart on CtG eligibility and enrolment process to support eligible ITC clients to be enrolled for CtG scripts.

WAPHA will develop a flowchart on CtG eligibility and enrolment process for distribution to ITC providers. The purpose of the flowchart is to provide clarification and a standard process to enable ITC providers to support enrolment of CtG eligible clients.

Recommendation 10

Advocate for improved discharge processes and continuity of care.

WAPHA will advocate to the Area Health Services for improved discharge processes and continuity of care in line with the National Safety and Quality Health Service (NSQHS) Standard 6 on Clinical Handover (first edition), and with the second edition[15] which will include six Aboriginal and Torres Strait Islander specific requirements for improving care for Aboriginal patients.[16] WAPHA will aim to work with hospitals and Area Health Services to develop and support the implementation of protocols which ensure continuity of care.

15 The second edition of the NSQHS Standards was released in November 2017. Assessments to the second edition will commence from 1 January 2019.

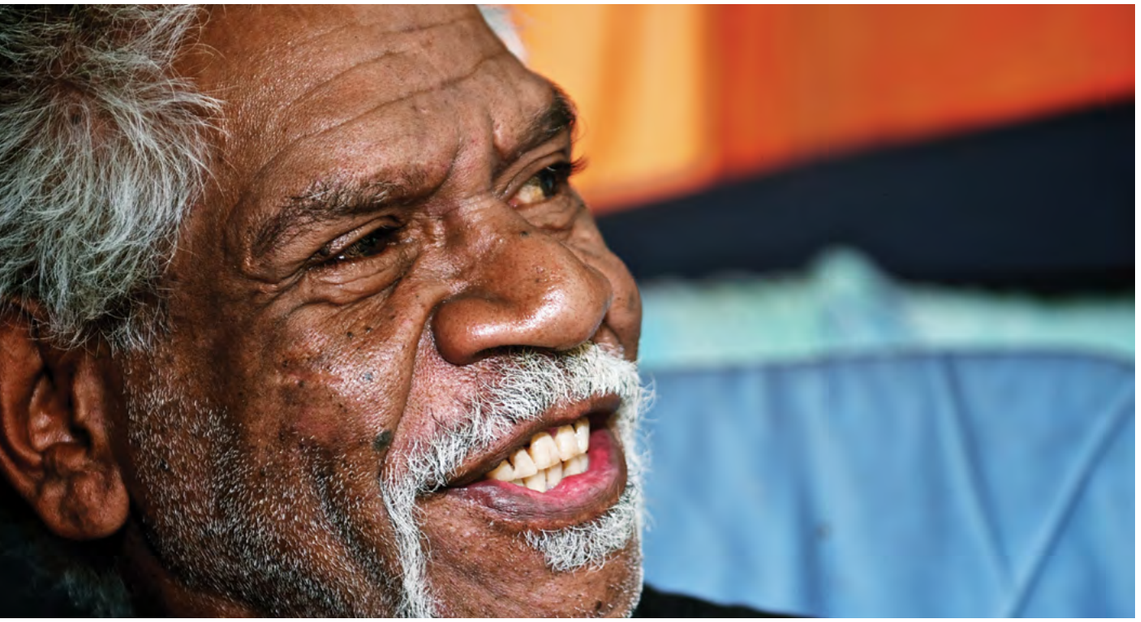
16 Australian Commission on Safety and Quality in Health Care, May 2017, *National Safety and Quality Health Service Standards (second edition) user guide for Aboriginal and Torres Strait Islander health – Draft*, https://www.safetyandquality.gov.au/wp-content/uploads/2017/05/NSQHS-Standards-second-edition-user-guide-for-Aboriginal-and-Torres-Strait-Islander-health.pdf

Improvements to discharge processes may include:

- Adequate notice of discharge (i.e. more than 24 hours' notice).
- Better identification of Aboriginal inpatients so they can be supported appropriately by AHLOs and hospital staff.
- Public hospitals develop a policy regarding the supply of discharge medications for Aboriginal patients to ensure consistency across sites.
- Inclusion of the ITC Care Coordinator in discharge planning and communication for admitted ITC clients.
- Consideration of listing ITC providers as recognised providers on the Notification and Clinical Summaries (NaCS) system, enabling ITC providers to be sent discharge summaries with appropriate client consent.
- Identification and promotion of online resources to increase knowledge of available services, providers, and catchment areas upon discharge from hospital into the community (i.e. HealthPathways WA, National Health Services Directory, My Community Directory).

WAPHA will work with ITC providers to identify best practice to support ITC clients with medication compliance, with a focus on supporting those recently discharged from hospital. A potential activity may include increasing ITC provider knowledge and access of Domiciliary Medication Management Reviews (DMMR).

WAPHA will continue to advocate for hospital prescribers and specialists to issue CtG prescriptions, and community pharmacies to annotate scripts if patients are known to be eligible.[17]



17 The Pharmacy Guild of Australia, media release 31 October 2017, *Pharmacy Guild and NACCHO working together to improve Aboriginal and Torres Strait Islander Health*, https://www.guild.org.au/news-events/news/2017/pharmacy-guild-and-naccho-working-together-to-improve-aboriginal-and-torres-strait-islander-health

8. System wide

This section is about the challenges that impact across all the patient transitions from initial referral, travel, treatment, and returning home.

The *Managing Two Worlds Together Project* by Dwyer et al[18] was a comprehensive research project that explored complex patient journeys to add to the existing knowledge of what works well in the system and what could be improved. Many of the findings across the *Managing Two Worlds Together Project* and ITC Country to City: Improving Patient Transitions Project were similar, both highlighting:

- Lack of access to services such as transport, accommodation, financial support, interpreter services and regional services;
- Journeys are made more complicated by lack of flexibility in policies and procedures;
- Lack of operational policy and templates to support providers and facilitate consistency;
- Lack of coordination among providers across geographical and sector boundaries; and
- Challenges in building good communication, trust and rapport between Aboriginal people and health care staff.

These last two points are explored further in the next section.

Current state challenges

Systemic discrimination against Aboriginal people

Stakeholders identified the systemic discrimination experienced by Aboriginal people, with feedback suggesting that some hospital staff may possess a limited understanding of cultural factors such as avoidance, and men's and women's business.

Lack of communication and handover between organisations

There was a general lack of communication and handover between organisations along the entire ITC client journey. There are many organisations involved in the ITC client journey, from the client's regular GP in region, the regional hospital, PATS, country ITC provider, metropolitan ITC provider, metropolitan hospital and metropolitan GP. There are many transition points where a client can fall through the gaps due to lack of communication and information passed between organisations.

18 Dwyer, J., Kelly, J., Willis, E., Glover, J., Mackean, T., Pekarsky, B. & Battersby, M. 2011, *Managing Two Worlds Together: City Hospital Care for Country Aboriginal People – Project Report*, The Lowitja Institute, Melbourne.

One key relationship highlighted was between ITC providers and Aboriginal Hospital Liaison Officers (AHLOs). Often country AHLOs do not know their counterparts in metropolitan hospitals. AHLOs may also not know their regional ITC providers. This link between ITC providers and country and metropolitan AHLOs is critical as AHLOs are a key link into hospitals and can provide advocacy, cultural, social and emotional support for Aboriginal patients.

Lack of feedback mechanism

There was a lack of feedback mechanisms for the ITC client journey. Where a client has had a poor experience, there is no readily identifiable place to provide that feedback and obtain a response. Likewise, where a patient has had a positive experience there is no place to provide a compliment. This means there is limited opportunity for organisations to continuously improve services based on consumer feedback.

Examples of good practice

Some hospitals have conducted cultural competency training that has improved ward staff knowledge of cultural factors such as avoidance, and men's and women's business which was facilitated through the Lighthouse Project.

Stakeholders identified that regular ITC provider meetings provide the opportunity for networking, sharing of good practice and joint problem solving.

Recommendations for improvement

Recommendation 11

Hold regular forums for ITC providers and key stakeholders to network, facilitate consistency, share innovation and jointly problem solve.

WAPHA will hold regular forums for ITC providers to network, facilitate consistency, share innovation and jointly problem solve. The forums will also be an opportunity for training and development. The purpose of the forums is to improve communication and collaboration between ITC providers and key stakeholders.

The forums will be a combination of face to face meetings and videoconferences. The face to face meetings will be held twice a year in Perth and the videoconferences will be held bi-monthly. Key stakeholders such as GPs, CHC, PATS, State-wide Telehealth Services, tertiary hospitals, AHCWA, and Aboriginal hostels will be invited to attend the face to face forums. A working group chaired by WAPHA will be appointed to organise the face to face forums.

Recommendation 12

Promote uptake of My Health Record by ITC providers and the Aboriginal community.

WAPHA will promote the uptake and use of My Health Record by ITC providers and the Aboriginal community. The purpose of My Health Record is to promote shared, continuous care amongst providers by allowing important health information to be stored and accessed by health professionals.

My Health Record will become an opt out system by the end of 2018. The aim is that all Australians (except those who opt out) will have a My Health Record by December 2018. WAPHA will promote the uptake of My Health Record by:

- Conducting regional training workshops for providers, communicating the benefits and dispelling the myths of My Health Record;
- Ensuring all ITC providers are registered as a 'Healthcare Provider Organisation' so they can view and add to clients' My Health Record;
- Working with the Australian Digital Health Agency to develop an Aboriginal specific brochure to promote the benefits of My Health Record amongst community and address commonly held concerns regarding confidentiality of information; and
- Working with ITC providers to hold community yarning sessions about My Health Record.

Recommendation 13

Embed use of My Health Record into ITC workflows.

WAPHA will work with ITC providers to embed the use of My Health Record into ITC workflows. The purpose is to ensure that My Health Record is utilised as part of business as usual activity.

Potential uses of My Health Record in ITC are to:

- Assist all ITC clients to register for My Health Record;
- Obtain consent to access a client's My Health Record as part of the referral form;
- Identify a person as an ITC client on the 'event summary' on their My Health Record; and
- Upload key care coordination or supplementary services activity as an 'event summary' on My Health Record.

Recommendation 14

Offer licenses to ITC providers for Patient Opinion as a mechanism for continuous improvement amongst all organisations involved in the ITC client journey.

WAPHA will work with ITC providers and the Health Consumers Council to promote the use of Patient Opinion as a mechanism for consumer driven continuous improvement. The purpose of Patient Opinion is to provide a transparent source of consumer feedback that providers can act upon to improve services.

WAPHA has included in all service provider contracts the requirement for patient driven continuous improvement. To facilitate this WAPHA will provide licenses for Patient Opinion to interested ITC providers. This will allow providers to respond to client feedback posted on the site.

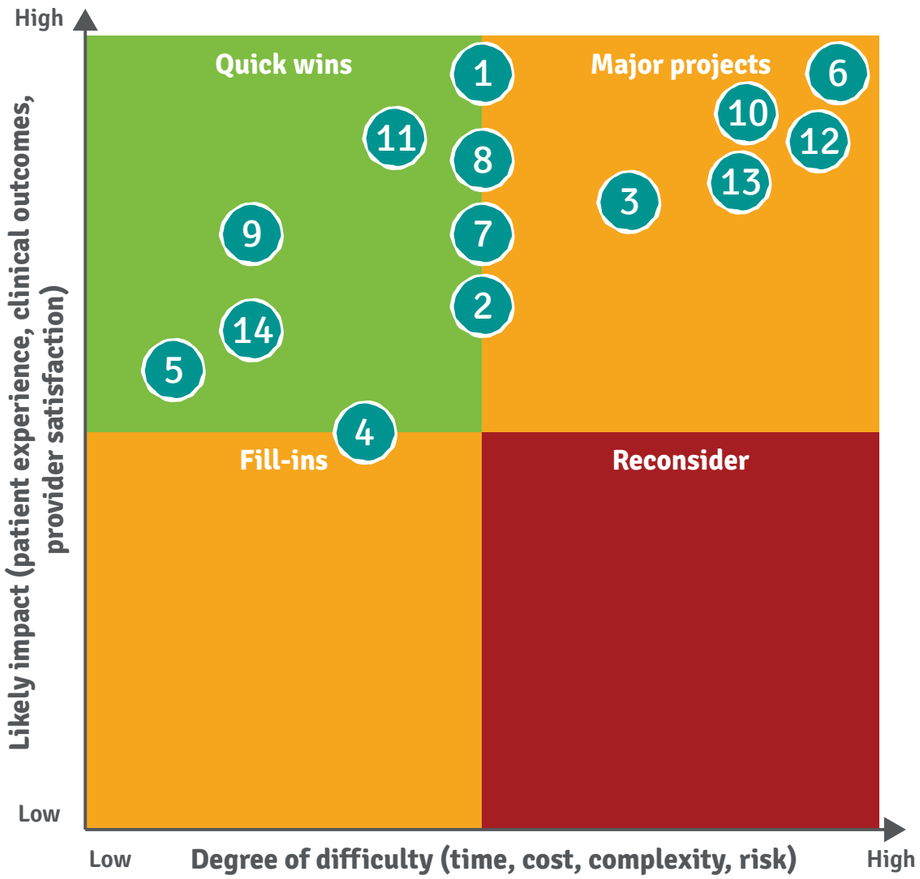
It should be noted that all public hospitals are now required to use Patient Opinion, and it has been widely implemented across country regions.

Appendix A: Summary of recommendations

The following table summarises the recommendations throughout the report. The recommendations have been written from WAPHA's point of view (i.e. the role that WAPHA will play to facilitate change and promote integrated, seamless care). The prioritisation matrix categorises the recommendations based on the degree of difficulty to implement, and the impact.

Recommendation	Partners	Timeframe for completion	Indicative funding from 1 Jan to 30 Jun
1: Establish and implement a standardised intake, allocation, transfer and discharge process for ITC.	ITC providers	March 2018	n/a
2: Develop resources to support clients in preparing for travel, such as a checklist for journey planning, patient stories and videos.	ITC providers and WACHS	June 2018	$20,000
3: Work with health service providers to explore ways of using digital health services to avoid unnecessary travel and facilitate care between regions.	WACHS and AHS	June 2018 and ongoing	n/a
4: Provide templates and frameworks to support providers to undertake stakeholder mapping.	n/a	March 2018	n/a
5: Regularly circulate a contact list of key ITC staff.	n/a	December 2017 and ongoing	n/a
6: During January to June 2018, develop a service model for the provision of primary health and social services support for patients in Perth for treatment. Trial the service model over July 2018 to June 2019 and develop a business case for recurrent funding.	WACHS, AHS and AHCWA	June 2018 for development of service model	$100,000
7: Continue to fund the hostel-based Aboriginal Health Practitioner until the service model from Recommendation 6 is ready for trial.	n/a	June 2018	$63,000
8: Access to a funding pool for ITC providers to support out of region ITC clients.	n/a	January 2018	$50,000
9: WAPHA will develop a flowchart on CtG eligibility and enrolment process to support eligible ITC clients to be enrolled for CtG scripts.	n/a	March 2018	n/a
10: Advocate for improved discharge processes and continuity of care.	n/a	March 2018	n/a
11: Hold regular forums for ITC providers and key stakeholders to network, facilitate consistency, share innovation and jointly problem solve.	WACHS, AHS and AHCWA	June 2018 and ongoing	$35,000
12: Promote uptake of My Health Record by ITC providers and the Aboriginal community.	ITC providers	June 2018 and ongoing	$20,000
13: Embed use of My Health Record into ITC workflows.	ITC providers	June 2018	n/a
14: Offer licenses to ITC providers for Patient Opinion as a mechanism for continuous improvement amongst all organisations involved in the ITC client journey.	ITC providers	June 2018	n/a

Prioritisation matrix



Appendix B: List of stakeholders

The following organisations were consulted as part of the Project.

Kimberley

- Boab Health Services – ITC staff and clients
- Broome Hospital, Derby Hospital and Fitzroy Crossing Hospital – ALOs, PATS officers, medical staff, nursing, Community Health
- Derby Aboriginal Health Service, Broome Regional Aboriginal Medical Service and Emama Nguda Aboriginal Corporation

Pilbara

- Mawarnkarra Health Service – ITC staff and clients, PATS officer, Perth based outreach worker and Senior Medical Officer
- Puntukurnu Aboriginal Medical Service - staff members

Goldfields

- Hope Community Services – ITC staff and clients
- Aboriginal community members in Leonora and Laverton

Midwest

- Carnarvon Medical Service Aboriginal Corporation – ITC staff and clients, CMSAC General Manager
- Geraldton Regional Aboriginal Medical Service – ITC staff and clients
- Geraldton Hospital – ALO and Telehealth Coordinator

Great Southern

- Amity Health – ITC staff and clients
- Katanning Hospital – nursing
- WACHS Great Southern Aboriginal Health
- Pioneer Health Albany GP Practice

South West

- GP Down South – ITC staff and clients
- South West Aboriginal Medical Service – ITC staff and clients
- Breakaway Aboriginal Corporation
- Spencer Street Family Practice
- Bunbury Regional Hospital – Chronic Disease Project Officer

Wheatbelt

- Amity Health – ITC staff and clients
- Wheatbelt Health Network – ITC staff and clients
- Wheatbelt Aboriginal Health Service

Metropolitan

- Arche Health – ITC staff and clients
- Mooditj Koort – ITC staff and clients
- GP Down South – Nidjalla Waagan Mia
- AHCWA
- WACHS – Aboriginal Health Improvement Unit and PATS
- Health Consumer's Council
- GPs – Dr Wood, Dr Krishnan, Dr Dolan and Dr Wozencroft
- Fiona Stanley Hospital – pharmacists, ALOs, complex care coordinators, clinical nurse specialist, cardiologist
- Royal Perth Hospital – pharmacists, ALOs, nurses, specialists
- Sir Charles Gairdner Hospital - pharmacists, ALOs
- Allawah Grove

WAPHA
WA Primary Health Alliance

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PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

This information is available in an alternative format on request
Ph: (08) 6272 4900

Acknowledgements

WAPHA acknowledges and pays respect to the Traditional Owners and Elders of this country and recognise the significant importance of their cultural heritage, values and beliefs and how these contribute to the positive health and wellbeing of the whole community.

Throughout this document the word Aboriginal is used to denote both Aboriginal and Torres Strait Islander peoples.

WAPHA acknowledges the Acting Manager Inpatient Data Collections and Manager Non Admitted Data Collections and their teams from the WA Department of Health for the provision of data and advice on appropriate use of the data.

For more information

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