Country WA PHN Activity Work Plan

Integrated Team Care

Summary View
2021/2022 – 2024/25

Presented to the Australian Government Department of Health

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Contents

ITC 1000 - Integrated Team Care Program

Activity Title

Integrated Team Care Program

Activity Number

1000

Existing, Modified or New Activity

Modified

PHN Program Key Priority Area

Aboriginal and Torres Strait Islander Health

Aim of Activity

To grow the Integrated Team Care (ITC) programs' integration, effectiveness, and outcome focused service model to meet the aims and objectives of the ITC Program.

The ITC program will be made up of a team including Care Coordinator, Outreach Worker and Indigenous Health Project Officer.

The ITC team will work together to:

- Contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to care coordination, and multidisciplinary care, and to support self-management.

Improve 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.

Description of Activity

ITC program objectives include:

- Contribute to better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people enrolled in the program.
- Improve access to appropriate health care through care coordination and provision of supplementary services for eligible for Aboriginal and Torres Strait Islander people with chronic disease.

- Foster collaboration and support between mainstream primary care and the Aboriginal and Torres Strait Islander health sector.
- Improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait islander people.
- Increase the uptake of Aboriginal and Torres strait Islander specific Medicare Benefits Schedule (MBS) items, including Health Assessments for Aboriginal and Torres Strait Islander people and follow up items.

The PHN will contract appropriate organisations to deliver the ITC program across the Country WA PHN regions of South West, Great Southern, Midwest, Goldfields, Wheatbelt, Pilbara, Kimberley. The PHN will support ITC teams by:

- Strengthening links and program integration across WA PHNs (Primary Health Networks) to improve patient outcomes.
- Encouraging commissioned services to enhance and continuously improve the capacity of their ITC workforce to support a client's ability to self-manage complex chronic care needs.
- Developing program improvement initiatives and communities of practice within the ITC sector.
- Ongoing support with data collection and outcomes focused reporting.
- Improving program reporting with the aim to improve patient experience, health outcomes, cost efficiency, provider experience and health equity.

Commissioned ITC service providers will implement two ITC activities.

1. Care Coordination and Supplementary Services – will be delivered by the Care Coordinator and Outreach Worker and supported by the Indigenous Health Project Officer.
2. Culturally competent mainstream services – will be led by the Indigenous Health Project and supported by the Outreach Worker and Care Coordinator.

Care Coordination and Supplementary Services – Enhancing Care

WAPHA developed the WA ITC Program Model of Care from the Flinders Chronic Condition Management Framework and the Department of Health ITC Program Guidelines. The Flinders Chronic Condition Management framework supports the objective of the ITC Program as a short-term care coordination activity designed to support people with chronic conditions, to collaborate in care planning with a view to self-management. The ITC Model of Care supports delivery of the program and management of chronic health conditions, with a view to self-management.

The ITC Model of Care includes seven (7) stages:

1. GP (General Practitioners) referral and client screening
2. Intake assessment/Registration and Consent
3. Care Coordination Planning
4. Care Management
5. Monitoring and Review
6. Discharge Planning
7. Client discharged back to their GP

To achieve the desired objectives, the Care Coordinator will lead the following activities, with support from the outreach worker:

- Develop and maintain a close working relationship with the clients GP and practice.
- Arrange the required services outlined in the client's GP Management Plan.
- Provide one-on-one care coordination to assist clients to manage complex chronic care needs.
- Support the client to access a range of services such as appointments with specialist and allied health providers. Enabling access may include arranging transport, completing forms, coordinating appointments, or arranging payment of services.
- Assist clients to understand and manage their chronic health conditions, and if appropriate, involve the client's family and carer.
- Utilise care planning to assist patients to become self-managing.
- Implement the WAPHA ITC Standardised Processes.
- Encourage clients to register for [and utilise] a My Health Record.

Whilst all Aboriginal and Torres Strait Islander people with a chronic condition are eligible for ITC support, priority will be given to people:

- Who require more intensive care coordination that is currently able to be provided by general practice and/or Aboriginal Medical Service.
- Who are unable to manage a mix of multidisciplinary services.
- Who are at greater risk of experiencing otherwise voidable hospital admissions.
- Who are at risk of inappropriate use of services, such as hospital emergency presentations.
- Who are not using community-based services appropriately or at all.
- Who need help to overcome barriers to access services.

Culturally competent mainstream services

WAPHA will continue to work with the primary health care network to improve cultural competence by:

- Developing the WAPHA cultural competency framework, which will enable the PHN to assess and make improvements to the management of ITC, to ensure people receive high quality and culturally appropriate care.
- Assisting primary health care providers to adopt culturally appropriate models of care for Aboriginal people.
- Supporting increased uptake of Aboriginal specific chronic disease packages including PIP (Practice Incentive Program) IHI and relevant MBS items.
- Supporting increased access to cultural awareness training that meets PIP IHI requirements.
- Promoting the ITC program as a culturally safe resource for primary care providers to partner with, in their care of Aboriginal people with complex chronic disease management needs.

Indigenous Health Project Officers (IHPO) will work to increase capacity of mainstream health service providers to deliver culturally appropriate primary care services and improve integration with other service providers (mainstream and Aboriginal Community Controlled Health Service).

The IHPO role, supported by the Outreach Worker will:

- Promote local credible cultural awareness training providers to mainstream primary care providers and services.
- Encourage the uptake of Indigenous MBS items such as 715 health checks and follow up services, to both general practice, Aboriginal Medical Services and Aboriginal and Torres Strait Islander community members.
- Assist practices to create a more welcoming environment for Aboriginal and Torres Strait Islander people i.e.: Indigenous Artwork, posters, Indigenous flags, flyers relevant to Indigenous people.
- Support, as required, primary health care providers to recognise significant days in the Indigenous calendar.
- Develop and disseminate resources for Aboriginal and Torres Strait Islander people about accessing services and managing chronic disease.

Country WA PHN Needs Assessment Priorities

Priorities	Page reference
Support Aboriginal people to navigate the primary care system and access appropriate services.	34

Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal populations and build capacity for patient self-management.	38
Support primary healthcare providers to manage chronic disease populations and build capacity for patient self-management (Goldfields, Midwest, Wheatbelt, South West)	15

Target Population

Aboriginal and Torres Strait Islander people with an existing chronic condition.
Mainstream general practice, Aboriginal Medical Services, allied health providers and specialists.

Coverage

Country WA PHN region

Activity Duration

Activity Start Date	Activity End Date
1 July 2019	30 June 2024

Activity Planned Expenditure

FY 21 22	FY 22 23	FY 23 24	FY 24 25	Total
$4,803,195.00	$4,864,378.00	$4,937,344.00	$0.00	$14,604,917.00