Perth North 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 PHN Perth North East and Perth North West region. 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.

Perth North 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

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

Perth North PHN region

Activity Duration

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

Activity Planned Expenditure

FY 21 22	FY 22 23	FY 23 24	FY 24 25	Total
$1,641,715.00	$1,715,544.00	$1,791,220.00	$0.00	$5,148,480.00

ITC 3000 - ITC Country to City - Improving Patient Transitions Project

Activity Title

ITC Country to City (C2C) - Improving Patient Transitions Project

Activity Number

3000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Aboriginal and Torres Strait Islander Health

Aim of Activity

To improve coordination of health and other care elements and improve the health journey of ITC clients across WA and support providers to apply continuous quality improvement to the Country to City – Improving Patient Transitions Project, including but not limited to the service model, standardised processes and improving communication, information sharing and discharge planning.
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.
2. Understand the good practice happening and to share relevant learnings on a state-wide basis.
3. 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.

Description of Activity

Activities to implement the Project align with recommendations from the ITC Country to City: Improving Patient Transitions (2018) Report published by WAPHA. The report focuses on practical solutions that can be implemented across WA to improve processes, promote consistency, and increase integration between organisations. The report concluded with 14 recommendations.
The Recommendations that will be addressed, prioritised, and enhanced during this period include (but not limited to):

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 6: Develop a service model for the provision of primary health and social services support for patients in Perth for treatment.

Recommendation 10: Advocate for improved discharge processes and continuity of care – where a patient has travelled to Perth or a regional centre due to an acute hospital admission.

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.

The PHN will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Perth North PHN Needs Assessment Priorities

Priorities	**Page reference**
Improve access to coordinated culturally appropriate primary care for Aboriginal people	15
Reduce non-urgent emergency department attendances and improve access to alternative services.	12
There is a need for alternative options to emergency Departments for Aboriginal people presenting with socioeconomic and psychosocial circumstances	34

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

Perth North PHN region

Activity Duration

Activity Start Date	Activity End Date
27 October 2021	31 October 2025

Activity Planned Expenditure

FY 21 22	FY 22 23	FY 23 24	FY 24 25	Total
$162,316.00	$159,295.32	$0.00	$0.00	$321,611.00

ITC 9000 – Increasing Aboriginal health COVID-19 preparedness and response Grants

Activity Title

Increasing Aboriginal health COVID-19 preparedness and response Grants

Activity Number

9000

Existing, Modified or New Activity

New Activity

PHN Program Key Priority Area

Aboriginal and Torres Strait Islander Health

Aim of Activity

To undertake the Increasing Aboriginal health COVID-19 preparedness and response Grants One Off Program.

The intent of the program is to strengthen Aboriginal health service activity that improves Aboriginal people's COVID preparedness and enables the provision of appropriate healthcare of Aboriginal clients who are COVID positive in the community through a range of non-clinical measures.

Description of Activity

WA Primary Health Alliance (WAPHA) has been working with stakeholders to update and develop COVID-19 positive community care pathways. As part of this work the need of additional Aboriginal health activity was identified.

Aboriginal people are at higher risk from COVID-19 due to high incidence of chronic disease, environmental issues, limited access to some health services and the range of known factors impacting on their health generally.

A grant process managed by the Aboriginal Health Council of WA (AHCWA), will assist Aboriginal health services to contribute to achieving the following objectives:

1. Inceased COVID-19 health preparedness of Aboriginal people.
2. To enable the provision of appropriate healthcare of clients who are COVID-19 positive in the community through a range of non-clinical measures.
3. Reduce the avoidable need for more intense and acute health services and enhance appropriate/optimal use of the health system through the

provision of care in the community setting.

Consultation with stakeholders identified that one off time limited funding opportunities to assist with COVID-19 preparedness of Aboriginal people and to support the care of COVID positive Aboriginal people in this community.

Aboriginal health care sector organisations are best placed to provide appropriate, flexible services and supports to their local communities.

Perth North PHN Needs Assessment Priorities

Priorities	**Page reference**
Support Aboriginal people to navigate the primary care system and access appropriate services	34
There is a need for alternative options to Emergency Department for Aboriginal people presenting with socioeconomic and psychosocial circumstances	18

Target Population

Aboriginal and Torres Strait Islander people with an existing chronic condition.

Mainstream general practice, Aboriginal Medical Services, allied health providers and specialists.

Consultation

Consultation occurred with the Australian Government Primary Health Networks, Primary Care and Indigenous Health Divisions and Living with COVID Team to seek advice about the initiative, inform the development of the initiative and use of funds.

The PHN consulted and continues to consult with a range of stakeholders in the planning and commissioning of services, including Aboriginal Health Council of WA at a State level and WA Health.

Local consultation has occurred with ACCHSs, Aboriginal health service providers and Local Governments.

Ongoing consultation with AHCWA, ACCHSs and Aboriginal health services will inform the development of service specifications and deliverables, reporting obligations, appropriate alignment of services and current needs and engagements with consumers and key stakeholders.

Collaboration

The PHN is working with WA Health, ACCHS and AHCWA to support the state's COVID response
AHCWA: In addition, to ongoing collaboration with AHCWA through a Memorandum of Understanding and regular meetings, AHCWA will be engaged to manage the Grant initiative for ACCHSs and Aboriginal Health Services.

ACCHSs/Aboriginal Health Services: Ongoing collaboration with ACCHSs and Aboriginal Health Services to design, deliver and report on the activities.

WA Health: Ongoing collaboration with WA Health to inform the development of relevant COVID-19 response guidelines and processes through regular meetings.

Coverage

Perth North PHN region

Activity Duration

Activity Start Date	Activity End Date
14 March 2022	30 September 2022

Activity Planned Expenditure

FY 21 22	FY 22 23	FY 23 24	FY 24 25	Total
$191,594.00	$0.00	$0.00	$0.00	$191,594.00