Perth North PHN Activity Work Plan

Integrated Team Care

Summary View
2023/2024 – 2026/2027

Presented to the Australian Government Department of Health and Aged Care

T 08 6272 4900 F 08 9277 5304 E info@wapha.org.au A level 2, 1 Hood Street Subiaco 6008 PO Box 883 Subiaco 6904 ABN 11 602 416 697

/waphaphns /wapha_phns /wapha_phns www.wapha.org.au

Contents

ITC 1000 – Integrated Team Care Program

Activity Title

Integrated Team Care Program

Activity Number

1000

Activity Status

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 Primary Health Network (PHN) will contract appropriate organisations to deliver the ITC program across the PHN Perth North East and Perth North West. The PHN will support ITC teams by:

- Strengthening links and program integration across WA PHNs 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

WA Primary Health Alliance (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.

The PHN developed a set of ITC Standardised Processes to support a consistent approach to care coordination and continues to work with providers to support and achieve the desired objectives of the program.

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 have complex needs, and require multidisciplinary coordinated care for their chronic disease/s. This includes, but is not limited to, clients with diabetes, eye health conditions associated with diabetes, mental health conditions, cancer, cardiovascular disease, chronic respiratory disease, and chronic kidney disease.
- Who require more intensive care coordination than is currently able to be provided by general practice and/or Aboriginal Community Controlled Health Service staff.
- Who are unable to manage a mix of multidisciplinary services.
- Who are at greatest risk of experiencing otherwise avoidable 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:

- Implementing 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.

The PHN has developed an ITC Brochure and Service Provider Mapping that is readily available on the PHN website and promotes the ITC program through various networks and community engagement events.

Alignment of activities to the National agreement on Closing the Gap and its priority reforms.

The PHN will:

- Work in partnership with stakeholders to prioritise local activities (commissioning and general practice support) that address the leading causes of mortality for Aboriginal people. This includes coronary heart disease, diabetes, chronic respiratory conditions, cancer, and as it relates to Target 1 of the National Agreement on Closing the Gap – Everyone enjoys long and healthy lives.
- Enhance focus of WAPHA's population health initiatives that address improving immunisation and cancer screening rates for Aboriginal people. Further work with primary care providers to focus on activity that relates to Target 2 of the National Agreement on Closing the Gap – Children are born healthy and strong.
- Undertake preliminary transition planning to support potential action associated with Priority Reform 2 – Building the Community Controlled Sector and Clause 55 from the National Agreement on Closing the Gap.
- Implement the WAPHA Cultural Competency Framework to improve the PHNs cultural competency and contribute to Priority Reform 3 – Transforming Government Organisations (and their funded agencies).

Collaboration

WAPHA will continue to collaborate with the Aboriginal Health Council of WA to support Aboriginal Health Initiatives and to improve access to primary health care services and improve health and wellbeing outcomes for Aboriginal people.

Consultation

In December 2021, WAPHA engaged IPS Management Consultants to review the ITC program's delivery and measure the extent to which service providers were delivering the program in alignment with the implementation guidelines. Engagement with ITC clients was out of scope for the review and, as such, claims relating to the client experience, value and success of the program are subjective, and further engagement is required to substantiate some of these claims.

The aims of the review were to assess:

- Alignment of contractual obligations to the Department of Health and Aged Care ITC Program Implementation Guidelines.
- Program fidelity to the ITC Program Implementation Guidelines.
- Role of Indigenous Health Project Officers (IHPO)
    - Alignment to ITC Program Implementation Guidelines
    - Best positioning for IHPOs.

The recommendations were based on findings and intended to provide guidance to improve alignment to the implementation guidelines, improve service delivery, and

ensure the program is best placed to meet future needs. A copy of the executive summary and recommendations can be located at https://www.wapha.org.au/about-us/our-priorities/aboriginal-health/

Activity Milestones	Due Date
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Needs Assessment	15 November 2024
Twelve-month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025

Perth North PHN Needs Assessment

Priorities	Page reference
Support Aboriginal people to navigate the primary care system and access appropriate services.	37
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal populations and build capacity for patient self-management.	37

Target Population Cohort

- Care Coordination and Supplementary Services – Aboriginal and Torres Strait Islander people with an existing chronic condition
- Culturally competent mainstream services – Mainstream general practice, Aboriginal Medical Services, Allied Health providers and specialists.

Activity Reporting Requirements

Type of organisations engaging in the ITC workforce.	Total number of patients assisted by outreach worker.
Care coordination patients by gender.	Total number of occasions of assistance provided by outreach.
Number of new patients in the reporting period.	List the 3 types of assistance provided by outreach worker.
Number of patients discharge from the program completely.	Number of transport services accessed by supplementary services.

Number of patients now self-managing, but still receiving SS assistance (i.e., ITC client who no longer needs assistance from a care coordinator).	Describe some of the activities undertaken in the PHN region to meet the needs of the ATSI people receiving care coordination.
Number of patients on care coordination waiting list as of 30 June.	Describe the referral, intake, and discharge processes of the program. (Referral-the process to identify possible patients); Intake- the process to accept and assess patients of the program; Discharge-the process by which patients leave the care of the program).
Number of unique supplementary services.	Describe the activities undertaken to improve cultural competency of mainstream primary health care services.
Number of unique clinical services.	Supply a good news story regarding the ITC Program.
Total number of allied health supplementary services.	List the top 3 allied health services purchased.
Total number of specialist supplementary services.	List the top 3 specialist services purchased.
Number of unique care coordination services.	

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Integrated Team Care Funding	$1,791,221.17	$1,853,913.40	$0.00

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

Activity Title

ITC Country to City – Improving Patient Transitions Project

Activity Number

3000

Activity Status

Modified

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 Integrated Team Care Country to City: Improving Patient Transitions Report (2018) published by the 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 continue to be addressed, prioritised and enhanced during this period include (but are 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.

It is envisioned that several of the recommendations will be transferred to business-as-usual activities for the PHN as part of ongoing plans in Regional Integration and with Quality Improvement Initiatives in partnership ITC service providers and Local Health Networks.

Funding for service delivery of the Country to City Service will cease on 30 June 2024. The PHN will continue discussions with WA Country Health Service and the service provider to ensure Aboriginal clients who are coming off-country for treatment are supported in their care whilst in the city and when returning home.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
There is a need for alternative options to Emergency Department for Aboriginal people presenting with socioeconomic and psychosocial circumstances. (Metro)	34

Target Population Cohort

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

Consultation

The PHN will engage with the following organisations in communicating changes to this activity:

- Aboriginal Health Council of WA
- Local Health Networks
- ITC service providers

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities will be undertaken in accordance with the approved activity Work Plan as amended and agreed by the Department	100%

Activity Milestone	Due Date
Activity Work Plan and Budget	30 April 2024
Twelve-month performance report	30 September 2024
Twelve month audited income and expenditure statements	30 September 2024

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2020	30 June 2024

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Integrated Team Care Funding	$59,737.83	$0.00	$0.00

END