Australian Government
Department of Health

phn
An Australian Government Initiative

Updated Activity Work Plan 2016-2018: Integrated Team Care Funding

Western NSW PHN 107

Overview

This updated Activity Work Plan covers the period from 1 July 2016 to 30 June 2018. New activity nominated in this work plan is proposed for a period of 12 months. A new or updated Activity Work Plan for 2018-19 will be submitted at a later date.

The aims of the ITC Activity 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.

The objectives are to:

1. achieve better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people, through better access to the required services and better care coordination and provision of supplementary services;
2. foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors;
3. improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people;
4. 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;
5. support mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify; and
6. increase awareness understanding of measures relevant to mainstream primary care.

1. (a) Strategic Vision for Integrated Team Care Funding

Western Health Alliance Limited (WHAL) which operates Western NSW Primary Health Network (WNSW PHN) is committed to the vision that sees Integrated Team Care (ITC) being premised under a Consortium model grounded in the context of unique Aboriginal Health partnerships that focus on improving poor health. The concept proposes that solutions to lift Aboriginal Health will be driven through Aboriginal-owned General Practice clinics and services, and through the spread of integrated health, social and cultural capacity across mainstream General Practice and primary care networks.

A key strategic priority for the WNSW PHN is to**:**
Work in partnership to improve Aboriginal and Torres Strait Islander health outcomes

This will be achieved by:

i. Strengthening partnerships and working in collaboration across the Aboriginal health sector
   - Working in collaboration with Aboriginal health partners, which are the foundations of the WNSW PHN, through the Aboriginal Health Council.

ii. Working in partnership with the Aboriginal health sector and primary care services to improve health outcomes and access for Aboriginal and Torres Strait Islander people with Chronic Disease.
   - Supporting Aboriginal Community Health Services spread the delivery of innovative, high performing Aboriginal health services across all communities in our WNSW PHN region.

iii. Supporting culturally safe models of care and programs
   - Supporting Aboriginal communities and service providers in those communities to increase Aboriginal ownership of health services, empower and self-navigate toward improved health outcomes.

The WNSW PHN's proposed approach to Integrated Team Care will focus working in collaboration with the Aboriginal Community Controlled Health Organisations (ACCHOs) in the region to improve health outcomes for Aboriginal and Torres Strait Islander people. This approach aligns with what has been identified at both a state and national level, in regard to the significance of Aboriginal and Torres Strait Islander peoples (ATSI) participation in and control of primary health care services as an effective action to improve health outcomes for ATSI people.

The vision of collaboration with ACCHOs closely compliments the ITC objectives specifically improving the treatment and management for Aboriginal and Torres Strait Islander people with chronic disease conditions. It also extends to fostering collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors.

WNSW PHN through the establishment of its Aboriginal Health Council guarantees ATSI community involvement in the planning, management and delivery of local primary health care services, in this case the ITC program. The WNSW PHN therefore embeds a committed imprint toward closing the gap in health outcomes between ATSI people and other Australians and also shaping dedicated links with the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.

Using ACCHOs to provide the chronic disease brokerage service permits the practical benefit of decreasing the overhead costs associated with the ITC program through a more effective sharing of resources resulting in an increase in the investment in frontline services.

A key outcome of the Single Provider or Most Capable Provider (MCP) Approach, based on goals and outcomes agreed between WNSW PHN and ACCHOs, will be closer collaboration and support between mainstream primary care providers and the ATSI Islander health sectors. Additionally, there will be a requirement for

linkages with the two Local Health Districts (LHDs) in the region, particularly through the Integrated Care Strategy demonstrator sites.

1. (b) Planned activities funded by the IAHP Schedule for Integrated Team Care Funding

Outline of proposed activities funded under the IAHP Schedule for Integrated Team Care to be undertaken within the period 2016-18.

Proposed Activities	
ITC transition phase	Services delivered through the Care Coordination and Supplementary Services (CCSS) and the Improving Indigenous Access to Mainstream Primary Care (IIAMPC) providers during 2015/16, under an extension approval for transition (four months to 31 October 2016) is now complete and ITC in its remodelled format is now active. Maari Ma through Indigenous Health Support Service (IHSS) as the current provider of ITC has provided a minimum of 20 episodes of care per day under the new brokerage service model since its commencement on November 1, 2016. ITC is delivered to clients/patients where services are documented as a need in the patient's GP Management Plan (GPMP) and where they are not available under other programs.
Start date of ITC activity as fully commissioned	The WHAL authority master agreement for ITC was signed 15 October 2016 and ITC Provider assistance to clients/patients under the brokerage service model commenced rollout on November 1, 2016.
Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?	An important feature of ITC in our WNSW PHN area that encompasses 53% of NSW, is the strong Indigenous partnership links through affiliation with our Aboriginal Health Council and the ACCHOs located across the WNSW PHN ITC service areas. Another internal feature of ITC activity yet to be operationalised includes WNSW PHN Health Planning and System Improvement activity in the form of data collection and practice support initiatives as well as evaluation activity incorporating Integrated care stakeholder organisations in the two Local Health Districts that sit within the WNSW PHN boundary. Significant to ITC is collaboration and stakeholder partnerships with Bila Muuji Aboriginal Health Services Incorporated, the consortium that comprises all of the Aboriginal Community Controlled Medical Services located within the WNSW PHN geographical area covering Brewarrina, Bourke, Coomealla, Coonamble, Dubbo, Forbes, Orange, Wellington and Walgett. Management of this alliance since the roll out of ITC comprises collaboration and Project updates via the WNSW PHN Aboriginal Health Council and an agreement that has seen the WNSW PHN Aboriginal Health Manager commence monthly tabled attendance at Bila Muuji Aboriginal Health Services Incorporated consortium meetings.

	Under the auspice of Maari Ma, IHSS as the new ITC provider maintains its own relationship with Bila Muuji and its consortium based partners. An agreement between these parties sees IHSS utilising consortium partnership resources in the form of shared office space to locate ITC care co-ordinators, tapping into existing ACCHOs administrative support and workforce assets and also connecting with current colleague support for ITC staff as well.
Service delivery and commissioning arrangements	ITC was commissioned using a Single/Most Capable Provider (MCP) Approach to Maari Ma Aboriginal Corporation in Broken Hill which has extended the reach of that ACCHOs to provide health services for Aboriginal people beyond the communities in the far west region of NSW to the 53% of NSW area that the WNSW PHN covers. Under the auspice of Maari Ma, the IHSS delivers ITC services through a brokerage service model which permits them the practical benefit of decreasing the overhead costs associated with the ITC program through a more effective sharing of resources resulting in an increase in the investment in frontline services. Since inception, IHSS has worked to introduce its new brokerage service model to General Practices in Western NSW most particularly those who once cared for Aboriginal people under CCSS and IIAMPC. The new central phone number and direct email contact for IHSS Care Coordinators has been communicated to all mainstream health providers and Aboriginal Medical Services (AMSs). Working collectively to improve patient outcomes, GPs with an Aboriginal patient eligible for the ITC program who have a current GPMP or patients themselves, link via direct referral to a 1800 number to an ITC Care Coordinator who manages various types of ITC patient support services. The focus of IHSS is on organising schedule planned care in advance. A minimum of 48 hours' notice is required for IHSS to review, assess, respond to referrals and arrange/purchase agreed services. IHSS is not set up to address crisis/acute issues and GPs should utilise Enhanced Primary Care (EPC) items in the first instance to refer patients for allied health services and refer to IHSS only after exhausting EPC appointments. The emphasis of the new IHSS brokerage service model supports the patient care provided by the patient's GP in both General Practices and Aboriginal Medical Services. The IHSS brokerage service is not a parallel clinical service and should be seen in the first instance as a program for last resort after all alternative programs have been exhausted so as to avoid undue duplication service and patient expenditure. In practice, IHSS liaise between the client's primary care provider (e.g. GP or AMS), the client and also the service, as per the patient care plan that the clients need. Feedback is then provided to the GP or AMS who continues to be the primary manager responsible for direct client/patient care. The brokerage service that IHSS

	provides thus facilitates the client receiving the care that is deemed necessary by their GP according to their care plan and promotes clinical care being provided by the GP to prevent disconnected patient information and service delivery, and promote better integrated and patient centred-care. IHSS provides support to both mainstream health providers and Aboriginal community controlled sectors to ensure patient access to a comprehensive array of services. Information about the types of services that are provided are available both on the WNSW PHN and Maari Ma websites. Additionally, IHSS have consulted with various Aboriginal community groups and have workshopped the new brokerage model to Aboriginal Health staff presenting the model at the NSW Western Local Area Health District Aboriginal Health forum in October 2016. At the time of this update IHSS are unable to measure comparatively against the care coordination and supplementary service data based upon the information provided by previous providers but rather, as the provider of a new ITC service model, what is recorded is the uptake of 'episodes of care' as opposed to the actual number of clients that were measured by the previous providers. Current ITC data that measures the number of episodes of active service to clients is seen as most valuable because there is no way to determine the validity of active or inactive client data of previous providers and the current data can both inform future ITC service provision and measure against improvement in health outcomes for Aboriginal patients.
Decommissioning	N/A
Decision framework	The decision framework for the WNSW PHN ITC project is founded in the literature that informs the fact of significant health disadvantage for Aboriginal people. Indigenous Australians experience disproportionate levels of educational, employment and social disadvantage and unacceptably many Indigenous Australians also experience poorer health than other Australians, often dying at much younger ages. Using evidence-based framework, the WNSW PHN aims through ITC to continue to address the pressing social inequality and determinants of health that are so pivotal to long term health improvements most particularly for Aboriginal people in WNSW PHN Aboriginal communities. The following information is outlined in the WNSW PHN Needs Assessment 2016 and accordingly, it informs the WNSW PHN needs assessment outcomes in relation to identifying Aboriginal Health and inclusive and proposed effective partnerships with Aboriginal communities as a key priority. In relation to ITC, this included the re-designed model that is now being rolled out through the WNSW PHN region. • WNSW PHN has the highest Aboriginal population (11.8%) of all NSW PHNs (HealthStats NSW). • For residents of WNSW PHN, 40.7% of respondents aged 15+ yrs. were current daily smokers; 59.5% of participants aged 2 yrs. and over were overweight or obese; and 76.7% have at least one long term health condition. (2012-13 National Aboriginal and Torres Strait Islander Health Survey -ABS).

	Other significant elements linked to the ITC decision framework include the WNSW PHN's Aboriginal Health Council that continues to support and advise the WHAL Board on strategic directions and opportunities to improve the health and wellbeing of Aboriginal people living in Western NSW. The Aboriginal Health Council's role confirms the strategic intent of the WNSW PHN to build innovation and collaboration with the ACCHOs) sector, to assist the development of a locally responsive patient centred system of primary health care that will deliver better outcomes for the communities of the Western region and specifically recognise the needs of Aboriginal people. The WNSW PHN's Aboriginal Health Council involvement in the provision of advice to the WHAL Board and WNSW PHN Management on the future direction of the ITC program is ongoing.
Indigenous sector engagement	An important feature of ITC in our WNSW PHN area is the strong Indigenous partnership links through affiliation with our own WNSW PHN Aboriginal Health Council and the ACCHOs located across the ITC service areas. These partnership links not only guarantee Indigenous sector engagement but also embed Indigenous sector engagement into all ITC activity from patient/client and service provider contact to provision and delivery of ITC services. Another facet of Indigenous sector engagement that is significant to WNSW PHN's ITC project is collaboration and stakeholder partnerships with Bila Muuji Aboriginal Health Services Incorporated, the consortium that comprises all of the ACCHOs located within the WNSW PHN geographical area, equivalent to 53% of NSW covering areas including Brewarrina, Bourke, Coomealla, Coonamble, Dubbo, Forbes, Orange, Wellington and Walgett. As a consortium based partner and member of Bila Muuji under the auspice of Maari Ma, IHSS as the new ITC provider very much maintains its own relationship with Bila Muuji continuing and again guaranteeing the flow of Indigenous sector engagement.
Decision framework documentation	The ITC decision framework adopted by WNSW PHN originates in the successful application to operate the WNSW PHN. Drawing a similar parallel, the founding documents submitted by a consortium in January 2015, proposed that "solutions to lift Aboriginal Health will be driven through Aboriginal-owned General Practice clinics and services, and through the spread of integrated health, social, and cultural capacity across mainstream General Practice and primary care networks". Additional to the founding WNSW PHN documentation, other decision framework documentation for ITC includes; i. WNSW Primary Health Network's Strategic Plan ii. WNSW Primary Health Network Needs Assessment, 2016 iii. WNSW Primary Health Network Mental Health and Drug & Alcohol Needs Assessment, 2016 iv. WNSW PHN Regional Health Profile

Description of ITC Activity	ITC Provider assistance to patients by Maari Ma through IHSS as the current provider of ITC under the new brokerage service model commenced rollout on November 1, 2016. A minimum of 20 episodes of care per day under the new brokerage service model has been delivered to clients where services are documented as a need in the patient's GPMP and where they are not available under other programs with access to the ITC program being chiefly via the following steps; **Step 1** GP completes ATSI health check (715). **Step 2** GP completes GP management plan (721) **Step 3** GP assesses the patient's needs for extra services and refers an eligible patient to IHSS to arrange / purchase the extra services **Step 4** IHSS reviews the referral. If accepted, a Local Chronic Care Link Worker is assigned to follow-up with the patient and referring doctor Guiding this process, the ITC Coordination Manager (IHPO) employed by consortium partners has since rolled out, focused on overseeing the delivery of ITC services by the Care Coordinators, liaised closely with WNSW PHN's IHPO through program reporting and monitoring and, has also had considerable involvement in building relationships between ACCHOs and mainstream primary health care services. Another component of provider activity since rollout of ITC on November 1, 2016 has been maintaining and extending relationships with mainstream health services including with Bila Muuji and its consortium based partners. Supported by WNSW PHN involvement, continued and strengthening collaboration between Indigenous Health providers has led to agreement arrangements for IHSS utilise Aboriginal consortium partnership resources in the form shared office space to locate ITC care co-ordinators, tapping into existing ACCHOs administrative support and workforce assets and also connecting with current colleague support for ITC staff as well. IHSS envisages that the new model and the 50/50 split across staff, infrastructure costs and services, is key to facilitating significantly more funds being spent on direct service provision. Additional to direct ITC provider activity to clients and stakeholders, is the continued work being by the WNSW PHN, with advice from its Aboriginal Health Council on the development of a Cultural Safety Framework inclusive of a suite of tools to ensure that the service providers working in mainstream primary care have appropriate competences in place. In the final stages of completion and yet to be endorsed by the WNSW PHN Aboriginal Health Council then approval by the WHAL Board, the WNSW PHN Cultural Safety framework will interlink with the WNSW PHN whole of region Aboriginal Health planning and service development and coordination. Next stage planning has begun in view to rollout both within the WNSW PHN for our own staff and externally to both existing and future providers.

	Delivering the Cultural Safety framework has and will continue to involve ongoing investigation of suitability options for training deliverables and also engagement with ACCHOs and Aboriginal communities; Commonwealth, State and non-government organisations; so as to lead the implementation of the Cultural Safety framework and oversee and monitor the contract relationship with the ACCHOs organisations delivering ITC. In consultation with the WNSW PHN Aboriginal Health Council, this activity will continue to be driven internally by the Indigenous Health Project Officer (IHPO)/ WNSW PHN Aboriginal Health Manager.
ITC Workforce	IHSS delivers ITC in seven cluster areas across the 53% of NSW that the WNSW PHN covers and whilst the new provider had offered temporary positions to the ceasing providers to ensure a smooth transition, a comprehensive recruitment process to fill all ITC positions across the entire region has now been completed. Internally, to assist in its coordination of ITC and Aboriginal Health planning and engagement activities, WNSW PHN has employed one Indigenous Health Project Officer (IHPO) from the funding provided in the 2016/17 and 2017/18 financial years. The justification for this relates to the significant Aboriginal population in the WNSW PHN region and the need for effective PHN coordination of primary health care services for Aboriginal people. The IHPO officer employed as the WNSW Aboriginal Health Manager works closely with the Aboriginal Health Council and with the ITC provider. External ITC workforce particulars include one ITC Coordination Manager based in Broken Hill to cover each of the seven Cluster areas and eight ITC Care link workers based at various AMS's and other associated Aboriginal sector organisations that cover each of the seven cluster areas: Cluster 1 Bourke, Brewarrina, Cobar, Nyngan Cluster 2 Armatree, Walgett, Coonamble, Coonabarabran, Gulargambone, Lightning Ridge, Collarenebri, Goodooga Cluster 3 Dubbo, Gilgandra, Narromine, Trangie, Tullamore, Tottenham, Trundle, Mendooran, Wellington, Mudgee, Kandos, Charbon, Rylstone, Gulgong Cluster 4 Condobolin, Parkes, Forbes, Peak Hill, Alectown Cluster 5 Dareton, Gol Gol, Buronga, Wentworth, Balranald, Cluster 6 Orange, Grenfell, Blayney Cluster 7 Bathurst, Oberon and Kelso Workforce flexibility has been applied in relation to the form the ITC roles will take in individual communities, based on need, whether the roles will be located in a General Practice/ ACCHO, and workforce availability. The consortium based agreement of using ACCHOs to provide the chronic disease brokerage service utilising partners resources e.g. the premises to locate the ITC care link workers, permits the practical benefit of decreasing the overhead costs associated with the ITC program through a more effective sharing of resources resulting in an increase in the investment in frontline services.