Australian Government
Department of Health

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An Australian Government Initiative

Activity Work Plan 2019-2021:

Integrated Team Care Funding

Western NSW PHN

When submitting this Activity Work Plan to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Activity Work Plan has been endorsed by the CEO.

1. (a) Planned activities funded by the Indigenous Australians' Health Program Schedule for Integrated Team Care Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2021. These activities will be funded under the IAHP Schedule for Integrated Team Care.

Proposed Activity 1	
ACTIVITY TITLE	ITC-01 – Care coordination and supplementary services
Program Key Priority Area	Indigenous Health
Needs Assessment Priority	*Priority Area* - Aboriginal Health (inc. Chronic Disease) (page 53-67) *Opportunities, Priorities and Options* – Aboriginal Health (inc. Chronic Disease) • Support transport needs and access to affordable transport for medical appointments (page 139) • Assistance to navigate and coordinate care for people with complex and chronic conditions, particularly support for specialist services and arranging travel (page 140) • Improve access to chronic disease management services in areas of poorest health outcomes (page 127)
Aim of Activity	Improve health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to care coordination, multidisciplinary care, and support for self-management.
Description of Activity	<u>Background</u> The service delivery model for ITC across Western NSWPHN region was developed in partnership with peak Aboriginal consortium groups in the WNSW PHN region. The Indigenous Health Support Service (IHSS) program is known as 'Marrabinya' which comes from the Wiradjuri language and means 'hand outstretch thee'. The program commenced on 1 November 2016 using a single/most capable provider (MCP) approach contracted to Maari Ma Health in Broken Hill. The approach extended the reach of that ACCHO to provide health services for Aboriginal people beyond the local communities in the far west region of NSW to cover the whole of the WNSWPHN region. Under the auspice of Maari Ma Health, IHSS delivers ITC services through an Aboriginal consortium led brokerage service model. This permits the ACCHO the practical benefit of decreasing overhead costs associated with the ITC program through a more effective sharing of resources resulting in an increase in the investment in patient services, i.e. savings through co-locating staff within various consortium member Aboriginal Medical Services and related organisations, sharing office space, administrative support and other workforce assets, and diverting those savings to service provision. <u>Key factors that underpin the IHSS service delivery model objective in WNSW:</u> 1) GP and Aboriginal Patient centred ITC health services 2) General practice and patient led chronic disease care

	3) Empowerment of Aboriginal persons through strengthened GP and Patient engagement, and 4) Reduced service duplication. Care coordination (CC) in the Marrabinya model • One-to-one Patient CC isn't provided through the Marrabinya model. Instead, CC undertaken by the patient's referring general practice (health care home) *in alignment to WNSW PHN IHSS service delivery model objective. • Patient CC activities have been replaced by coordination of supplementary service. Some examples include engaging with general practice, AMSs and referring GPs to: o educate and promote the brokerage service model o assist with cultural safety and competency advice and education o support activities that focus on strengthening practice-led patient health care coordination and activities which increase the capacity of Aboriginal patients to self-manage their own chronic health care. Referral process in the Marrabinya model Indigenous patients must be enrolled for chronic disease management in a general practice or an ACCHO. **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 Marrabinya (IHSS) to arrange / purchase the extra services. (A central phone number and direct email contact has been communicated to all mainstream health providers and AMSs). **Step 4** IHSS reviews the referral. If accepted, an Outreach Worker (Local Chronic Care Link Worker) is assigned to follow-up with the patient and referring doctor. What happens if the patient does not receive the GP coordinated care? Since January 2018 a new and more detailed reporting regime has been in place. This includes general practice feedback and patient / client feedback. We expect that this will inform us of the care co-ordination aspects of the model and where the outcome shows a care co-ordination gap both the provider and Western NSW PHN will be able to address this. Marrabinya receives a referral from a client's GP, requesting the components of care that are required to support that person and their chronic disease management: specialist appoint, webster pack, etc. By preparing and sending the referral with a GPMP in place, the practice is demonstrating that care coordination is underway. Marrabinya's role is to be the conduit to make those components happen and for the information to go back to the GP for the ongoing coordination. The model is safer than care coordination being outsourced to a third party and separated from the patients home based practice. The usual treating GP (and patient) is in the driver's seat and the referring practice takes on the responsibility for coordinating care as outlined in the GPMP.

	An independent evaluation of WNSW PHN's commissioned ITC program will be conducted in 2020/21 to review the outcomes of the program, and the service model. This evaluation will apply best-practice methodology and focus on quadruple aim outcomes. An independent evaluator with relevant experience will be engaged as consultants for this work. The independent evaluation budget is $50,000. <u>Operational components in the Marrabinya model</u> 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 into the program via direct referral to the 1800 number that connects them to program intake. The Coordination Manager (IHPO) then assesses patient support service requirements and allocates the service request to the Chronic Care Link workers (Outreach Workers). The focus of the Marrabinya model is on organising scheduled planned care in advance and requires a minimum of 48 hours' notice 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 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 is intended to be seen in the first instance as a program for last resort after all alternative programs have been exhausted, avoiding undue service duplication and patient expenditure. In practice, IHSS liaise between the client's primary care provider (e.g. GP or AMS), the client and the service provider, as per the patient care plan. 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 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 promotes better integrated and patient centred-care. IHSS provides support to both mainstream health providers and ACCHOs to ensure patient access to a comprehensive range of services. For example; Gap fees associated with health appointments such as diagnostic tests, specialist appointments; travel and accommodation to attend health appointments; webster packs for patients with poly pharmacy; assisted breathing equipment; oxygen; medical footwear prescribed and fitted by a podiatrist. Services provided are documented in the patient's GPMP and are not available under other programs. IHSS regularly consults with Aboriginal community groups and is supported by consortium group partners and presents and workshops the brokerage model to Aboriginal health staff, Aboriginal community groups, mainstream and AMS general practice, patients as well as to related sector partners.

External ITC Workforce

1FTE Program Manager (IHPO) *with offices at Brewarrina and Dubbo - works across the region in each of the Cluster areas.*

Key functions:

- Program coordination
- Aboriginal Health planning and engagement
- Oversees the delivery of ITC services
- Manages intake referrals
- Liaises closely with WNSW PHN's IHPO through program reporting and monitoring
- Builds relationships between ACCHOs and mainstream primary health care services
- Colleague support and staff development
- Program and service data input
- Aboriginal Health planning and engagement activities
- Presents and workshops the brokerage model to Aboriginal Health staff
- Aboriginal community groups, mainstream and AMS general practice, patients as well as to related sector partners

8.6 FTE Program Chronic Care Link Workers CCLW *(outreach workers)- *works across the region in allocated cluster areas and located/based at an AMS and associated Aboriginal sector/partner organisations* - Bathurst, Bourke, Brewarrina, Condobolin, Coonamble, Cowra, Dubbo, Broken Hill (please note 0.6FTE CCLW at Balranald is currently vacant), Regional CNS is located at Dubbo.

Key functions:

- Liaise between the client's primary care provider (e.g. GP or AMS), the client and the service, as per the patient care plan.
- Provides feedback to the GP or AMS who continues to be the primary manager responsible for direct client/patient care.

The brokerage service that IHSS provides 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, promoting better integrated and patient centred-care.

Coordination of Supplementary Services activities include as a minimum:

- Engaging with general practice, AMSs and referring GPs to educate and promote the brokerage service model
- Assistance with cultural safety and competency advice and education
- Support activities that focus on strengthening Practice led Patient health care coordination and increase the capacity of Aboriginal patients to self-manage their own Chronic health care.
- The brokerage service provided by Care Link Workers involves assessing the referral and putting in place the non-clinical aspects of the referral that may include arrangements to pay for fees, gap payments, travel and accommodation associated with the patient accessing the services.
- The Care Link Worker provides feedback to the referring GP on the outcomes of the referral and GP management plan.

0.4 FTE Clinical Nurse Specialist works from Dubbo and provides service for all clusters in the program. This part-time role offers day to day operational support and guidance for Chronic Care Link Workers including the important role of clinical advice to inform the purchase of services required (such as medical aids/equipment).

Internal ITC Workforce

1FTE Project Officer (identified role) located within the WNSW PHN office, works across the region.
Key functions include:

- Oversight responsibility for the delivery of ITC program
- Monitors provider service performance and evaluation reporting
- stakeholder engagement
- maintaining and extending relationships with mainstream health services
- Supports the implementation of the ITC Activity with the aim of:
    - contributing to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care; and
    - contributing 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 people.

ITC Workforce

Workforce Type	TOTAL FTE	AMS*	MPC	PHN
Indigenous Health Project Officers	1.0	1.0		
Outreach Workers	8.6	8.6		
Clinical Nurse Specialist (CNS)	0.4	0.4		
Indigenous Health Project Officers	1.0			1.0
Other: specify				

*AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services

Workforce development provided for staff under this activity.

Maari Ma engage their Marrabinya staff in a quarterly meeting held in locations across the region which includes Professional Development and Cultural Safety training components. The meetings include invitations to organisations to offer education and explain their services, these include workshops from IPTAAS, WNSW PHN Mental Health programs, Local elders delivering education to build on cultural competence and recently have completed a TAFE certificate in Professional Email and Letter Writing.

Training currently undertaken by CCLW's is 1x CCLW currently undertaking Enrolled Nurse Training, 1x CCLW completed Certificate 3 in Aboriginal Health

	March 2019, 2x CCLW Certificate 3 in Aboriginal Health commencing April 2019 and 2x CCLW attended Great Leaders are Made (GLAM) 2019. The IHPO working within Marrabinya will develop Individual Performance and Development Plans with each staff member for the period 06/2019 – 07/2020.
Target population cohort	Aboriginal and Torres Strait Islander people with a diagnosed chronic condition
Indigenous specific	Yes
Coverage	Whole of Western NSW PHN Region
Consultation	The WNSW PHN works with many organisations in delivering this unique ITC Program and a key feature is strong Indigenous partnership alliances. Some core relationships for consultation include: • WNSW PHN Aboriginal Health Council • All ACCHOs across the WNSW PHN region • Western NSW Local Health District (NSW Health) integrated care strategy program staff • Far West NSW Local Health District • Local Health District Aboriginal health workers (WNSWLHD AND FWLHD) • Bila Muuji Aboriginal Health Services Incorporated (regional peak ACCHO/AMS consortium group). • Regional Assemblies: o The Murdi Paaki Regional Assembly (MPRA) (represents 16 Aboriginal communities in Western NSW. They are Broken Hill, Wentworth/Dareton, Ivanhoe, Menindee, Wilcannia, Cobar, Bourke, Enngonnia, Brewarrina, Goodooga, Weilmoringle, Lightning Ridge, Walgett, Coonamble, Gulargambone, Collarenebri). o The Three Rivers Regional Assembly (region extends from Lithgow in the east of NSW through to Nyngan in the west, representing the interests of Aboriginal people across the communities of Bathurst, Dubbo, Gilgandra, Mudgee, Narromine, Nyngan, Orange, Parkes, Peak Hill, Trangie, Warren and Wellington). • Aboriginal Lands Council groups. Consultation and maintaining these relationships include regular meetings, regular provider and program updates (to the WNSW PHN Aboriginal Health Council) and Project monitoring i.e. PHN reporting and evaluation, stakeholder, patient and GP feedback and program governance.
Collaboration	Collaboration with stakeholders is vital for the ongoing success of this program and involves maintaining relationships with the organisations listed under the Consultation section above. The Marrabinya Governance Group, a sub-committee of Maari Ma Health and the Bila Muuji consortia membership is another important input to the ITC program. This group provides strategic level advice to inform: • Provider engagement linked to the model, program outcomes and planning beyond the 2017/18 contract. • Strategies to engage ACCHO and mainstream general practice

	• Community engagement strategies to ensure Aboriginal people eligible for services under the program are accessing the service. • Managing community expectations. The Marrabinya Governance Group reviews bi-monthly progress reports, including outputs, risks and key issues that have the potential to impact on the Maari Ma / Bila Muuji Alliance and Marrabinya reputation with regards to delivering on the ITC contract. The WNSW PHN will work with stakeholders on the development of a Regional Plan for Chronic Disease to strengthen alignment and integration of programs in the region.
Activity milestone details	Service continuity effective 1 July 2019. Activity is valid for full duration of AWP
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	N/A

Proposed Activity 2	
ACTIVITY TITLE	ITC-02 – Culturally competent primary health services
Program Key Priority Area	Indigenous Health
Needs Assessment Priority	*Priority Area* - Aboriginal Health (inc. Chronic Disease) & Service Access (page 53-67) *Opportunities, Priorities and Options – Aboriginal Health & Service Access* • Provide training in cultural safety for health professionals to improve cultural competence to meet the needs of Aboriginal people (page 147). • Continue to require (and support) commissioned services comply with WNSWPHN's cultural safety framework (page 145) • Work with general practice and other care providers to improve their ability to yarn with Aboriginal patients and provide accessible information about their health, delivered in a culturally safe way (Page 140).
Aim of Activity	Cultural safety is increasingly used in organisations representing and or providing services to Aboriginal and Torres Strait Islander peoples. The purpose of WNSW PHN Cultural Safety Framework implementation activities are to drive and influence improvement in health outcomes for Aboriginal people and help prevent systemic racism and discrimination in primary health care. All activities extend on work already undertaken in developing our WNSW PHN Cultural Safety Framework. This activity aims to: • Provide High quality culturally safe, responsive and accessible primary health care for Aboriginal and Torres Strait Islander people • Raise awareness about the barriers to equitable outcomes for Aboriginal people • Strengthen partnerships with the primary health sector • Improve capacity of General Practice and ACCHOs to provide culturally responsive health care for Aboriginal people.
Description of Activity	This activity builds on the Cultural Safety work previously undertaken by WNSW PHN across the region by undertaking the following activities to further develop culturally appropriate primary healthcare services in both AMSs and mainstream health care providers. Activities include the following: • **Extension of WNSWPHN Cultural Safety in Primary Health Services education program.** Program content will be based on WNSWPHN Cultural Safety Framework, provided within local context and will include relevant primary care case studies. The target audience for this training is: Specialists, GPs, Registrars, Nurses, Allied Health Professionals, Dental clinicians, Pharmacists, Reception Staff and other primary care providers working within Specialist Practices, Allied Health Practices, General Practices, Dental Practices and others within the primary care sector. ACCHO/AMS specific regional education sessions will also be delivered, based on feedback from the sector. The education program will be provided by an appropriated trained, qualified, accredited facilitator/training organisation, procured in alignment with WNSW PHN procurement policy. • **Implementation of WNSW PHN Cultural Safety Framework.** Activities include promotion of the framework for use across the primary care sector including commissioned service providers.

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Practice Support Aboriginal Health Initiatives. Activity to continue to incorporate Aboriginal Health Initiatives within Practice Engagement plans for mainstream and AMSs as delivered by the WNSW PHN Practice Support Team. This involves delivering an Aboriginal Health Business Model developed by the Practice Support Team, including a presentation of the ITC program; care tool templates for Aboriginal and Torres Strait Islander patients; Closing the Gap and Practice Incentive Program education; as well as information and resources on Cultural Safety. (This sub-activity is delivered by PHN resources funded from the Health System Improvement activity under Core funding)
Development of an Aboriginal Stakeholder and Community Engagement Process Guide for health care organisations. The process guide will align with the WNSWPHN Cultural Safety Framework and have relevance to a WNSWPHN regional context and will include an education training component. The purpose of this document is to support improved, appropriate engagement and consultation with Aboriginal community and stakeholders for health services, increasing cultural safety and access to services for Aboriginal people.

<u>1.0 FTE Program Officer</u> located within the WNSW PHN to work across the region. Key functions include:

This role has a primary focus on implementing the WNSW PHN cultural safety framework across ACCHO and mainstream general practice, specialist practices and allied health provider practices to improve cultural safety in primary care services and will further support and strengthen the ITC program (Marrabinya) to improve health outcomes for Aboriginal people.

<table>
<tr><th>Workforce Type</th><th>FTE</th><th>AMS</th><th>MPC</th><th>PHN</th></tr>
<tr><td>Indigenous Health Project Officers</td><td>1.0</td><td></td><td></td><td>1.0</td></tr>
<tr><td>Outreach Workers</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Consultants</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Other: specify</td><td></td><td></td><td></td><td></td></tr>
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Workforce development activities provided in-line with WNSW PHN staff training and development program and Aboriginal Employment Strategy.
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<tr><td>Target population cohort</td><td>Aboriginal and Torres Strait Islander people with a diagnosed chronic condition</td></tr>
<tr><td>Indigenous specific</td><td>Yes</td></tr>
<tr><td>Coverage</td><td>Whole PHN region</td></tr>
<tr><td>Consultation</td><td>
Stakeholder engagement and consultation activities will include collaboration and feedback review with the following groups:

WNSW PHN councils:

Aboriginal Health Council,
WNSW and FW Community Councils
WNSW and FW Clinical Councils

Western NSW Local Health District (WNSW LHD)
Far West Local Health District (FW LHD)

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	• Agency of Clinical Innovation network associations • NSW/ACT PHN Aboriginal Health and network partnerships • ACCHOs/AMSs • General practice, Primary health and community healthcare providers.
Collaboration	The WNSW PHN Aboriginal Health Council will be the key collaborators in the development and delivery of this activity.
Activity milestone details	Project commenced in 2018-19 under prior AWP. Service continuity effective 1 July 2019. Activity is valid for full duration of AWP
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known (Education provider) ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) WNSW PHN Internal Project Officer 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	N/A