

Department of Health

*Review of Care Coordination within the
Integrated Team Care Program*

Summary report

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Introduction

Health Policy Analysis was commissioned by the Commonwealth Department of Health's Indigenous Health Division to review Care Coordination as part of the Integrated Team Care (ITC) Program¹. The review was conducted to investigate the impact that the ITC Program has had on health outcomes for Aboriginal and Torres Strait Islander people with a chronic disease enrolled on the program.

Aboriginal and Torres Strait Islander people have higher rates of chronic illness compared with other Australians. Access to comprehensive, affordable and culturally appropriate primary health care is critical for closing this gap (Australian Institute of Health and Welfare, 2016). In tandem with increasing the access to and use of health services by Aboriginal and Torres Strait Islander people, steps are required to improve the services themselves so they are coordinated, well-run and culturally appropriate, and effectively engage the community (The Hon Malcolm Turnbull 2016).

The ITC Program is part of a suite of programs encompassed in the Indigenous Australians' Health Programme, which commenced on 1 July 2014. Specifically, the ITC Program combined the former Care Coordination and Supplementary Services (CCSS) Program with the Improving Indigenous Access to Mainstream Primary Care (IIAMPC) Program. Funding for the ITC Program is directed through Primary Health Networks (PHNs), who are charged with commissioning organisations to provide services under the Program.

The ITC recognises and builds on the success of the CCSS and IIAMPC programs. It aims to strengthen a team-based approach for the provision of coordinated, multidisciplinary care. This requires collaborative working relationships between patients, general practices, AMSS and other service providers.

The ITC Program has two principal aims:

- 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.
- To contribute to closing the gap in life expectancy by improved access to culturally appropriate mainstream primary care for Aboriginal and Torres Strait Islander people.

This review focused on the impact care coordination has had as part of the ITC Program, and, in turn, its impact on the first of these principal aims.

There are no quantitative data available on patient outcomes resulting from the ITC Program, and it was not possible to collect data directly from ITC clients for the review. Therefore, the approach used to obtain information about outcomes was to interview the ITC workforce and other key stakeholders about patients' uptake and experiences of the Program. Interviews were conducted within 15 PHNs, including 34 commissioned ITC service providers, and 77 members of the ITC workforce².

¹ The ITC Program is formally known as the *Integrated Team Care (ITC) Activity*, in reference to it being an activity of the Indigenous Australians' Health Program. In this document, 'ITC Program' is used.

² Including Indigenous Health Project Officers (IHPOs), Aboriginal and Torres Strait Islander Outreach Workers (Outreach Workers), and Care Coordinators.

In addition, the review drew on the following sources of information:

- Program documentation including implementation guidelines
- six-monthly activity and funding reports submitted by PHNs to the Commonwealth
- a survey of PHNs conducted by the Department of Health in June 2017.

This report is a summary report of the findings of the review. The report uses quotes from interviewees to illustrate views on the Program and patient outcomes.

We keep people alive navigating a complex health system that can cause people to give up

I think an intensive support system that journeys with them through some very complex health issues. By doing that we keep people alive, we really do. There are clients who would not be still around if we weren't here. It's as simple as that. If it's really complex, just navigating the healthcare system can be really difficult for people, and that can cause them to just give up straightaway.

- Care Coordinator

Identified outcomes

Relationship building and the trust is huge

We have had a remarkable result with one of our clients who wouldn't engage wouldn't attend. She had two ICU admissions within a month apart and on the second they were going to turn off her life support.

She was morbidly obese. Over seven months we worked with her and worked with her and worked with her. Building her trust, supporting her decisions, attending appointments. We explained what the doctors had told her, and we did what we said we were going to do, because if you don't, there goes your trust.

After two ICU admissions a month apart, life support about to be turned off, seven months later she's no longer even needs blood pressure medication. She has lost 28 kilos, her sugars are normal, she's self-managing and the improvement in her quality of life is just amazing.

- Care Coordinator

Improved capacity of mainstream primary care and uptake of Aboriginal and Torres Strait islander-specific MBS items

The ITC workforce and PHNs reported increased uptake of Indigenous-specific MBS items, including Health Assessment for Aboriginal and Torres Strait Islander People (MBS item 715). Therefore, the ITC has continued the progress that was made under its predecessor programs (CCSS and IIAMPC) in encouraging Indigenous people to undertake health assessments.

Improved navigation of the health care system

Interviewees described a variety of ways in which Care Coordination assisted patients in navigating the health system. Coordinators described working on relationships with referring GPs, often starting with input into the general practice management plan (GPMP). Examples

were given of GPs in both AMS and mainstream settings collaborating with ITC staff in developing GPMPs, as ITC staff often had a better understanding of a patient's living arrangements, social support structures and access to community programs. This more personalised approach meant a patient's health goals were more likely to be linked with their personal goals.

The Care Coordinator and patient relationship was one that was frequently reported to improve a patient's engagement with the health system. Often the Care Coordinator helped patients better articulate their concerns to health services providers. A care coordinator's understanding of common treatments meant they could also help inform providers of personal, social and environmental circumstances that could impact a patient's ability to follow treatments as recommended.

Building systems with integrity and authenticity

You might think this program is just transport and health information, helping people understand their issues, but it's a lot more than that. It works because it is a lot more than that. It works because service providers are trusted by Aboriginal People and they have built up a trust, trust the person they're dealing with on a personal level. Trust that you're not one of those people that's going to let them down, because they've been let down so many times. Building systems that have integrity, that have authenticity, is the most important part.

- Aboriginal Health Programs Manager

Reduced barriers to accessing services and medical/ health aids

An important feature of the ITC Program is that it helps reduce barriers to accessing services and provides medical/ health aids that are important for chronic illness management. The review found that the ITC has enabled:

- Approximately **56,119 allied health services** and **19,712 specialist services** over the **first 6 months of 2016-17**. This was partly through the purchase of services via supplementary service funding, brokerage of inhouse services, and/or the arrangement of bulked-billed services from external providers.
- **Day to day reduction in health barriers** through medication **dose administration aids** (which make up around 80% of supplementary support through medical aids), **blood glucose monitoring equipment** (1% of medical aids), assisted breathing equipment such as **CPAP machines** (approx. 7% of aids), **medical footwear** (~4% of aids), and **mobility aids**.
- **Coordinated hospital intake and discharge pathways** for ITC patients to help prevent readmission.
- Around 38,000 instances of **patient transport support** in **the first six months of 2016-17**.

Improved continuity and communication between providers and patient

It's like having family look after them

In the past, patients were just visiting their doctor, they felt a bit isolated. But now, we're finding where there is a good relationship between patient and the doctor, there is also a good relationship with the health worker or coordinator and the patient.

If the health worker's got that community relationship, that knowing of the family and things like that, bringing the doctor in is easier. Patients have said they feel like they're having family look after them.

- Care Coordinator

Care Coordinators provide a consistent link, and a single point of contact with the health system for many patients. This was viewed by those consulted as vital in streamlining patients' interactions with the health system, helping patients to navigate the system.

More generally, ITC workforce members provided continuity and familiarity for patients, and helped build trust, respect and rapport between patients and health care providers. This in turn helped to reduce some of the apprehension patients commonly experienced when being introduced to a new doctor or specialist, and improved cultural safety.

Acknowledge and respect me

The client's relationship with our Care Coordinators and outreach workers means they can come along and trust and be themselves. Clients don't have to perform or do other things, because this person actually knows 'me' and my personality, what I've been through, and how important it is to treat me in certain ways and acknowledge and respect me.

- Aboriginal Health Programs Manager

Improved patient self-efficacy and self-management

Interviewees articulated that the Program aimed to empower patients to take greater control of their circumstances. Coordinators noted that many patients, once clear on what they should expect from the system and from their health care professionals, became more independent, allowing coordinators to reduce the intensity of their case management. Additionally, many of the aids sought through the supplementary service funding were aimed at boosting patient independence, for example 'Webster' packs or dose administration aids. Simply portioning pills removed a daily anxiety for many patients, and was reported to improve medication compliance significantly.

When you come from a positive place it has to be a positive outcome

We want to be able to help our people to get well and you know manage whether they're coming to us or whether they're going to a private GP, they just want to know that whoever's looking after them is doing it to the best of that person's need. And you know I think when you come from that premise then I believe that if you get enough of that good will and that positiveness coming particularly from that alliance and if it builds then I think that has to be a positive outcome.

- Commissioning PHN and former Care Coordinator

On our drives, we talk a lot

On our drives to and from appointments we talk a lot about how the services are doing, how they are impacting their life. We also talk about things around the home you know, budgeting, relationships... all that sort of stuff gets mentioned as we're driving along.

Quite often after a specialist visit with patients we'll chat about what was said in there we can actually get them to reflect on what was actually said to make sure they understood it all. We'll ask "what did you hear that doctor say?" They then can tell us in their words what they heard. And we can help them with anything they are unsure about.

- Aboriginal Health Worker

Patient education was a common feature across commissioned programs. This included structured education sessions with diabetes educators and other allied health workers as well as informal or ad hoc opportunities, such as between ITC workforce members and patients between appointments or travelling to appointments.

One of the key focus areas of education was in explaining why patients needed to see specific health professionals or adhere to treatment. For example, the link between diabetes and foot and eye health.

Why hasn't anyone ever told me that?

I remember there was a lady she was an easy client; She could drive herself to appointments, she knew where to go, but she just needed some assistance with specialists.

She had diabetes but refused to go to see the podiatrist. I remember speaking to her one day about visiting the podiatrist and she said, 'I'm 70 and my feet are fine.' I said 'do you know why you have to go?' her response was 'because my doctor said so but he never looked at my feet. 'So I explained to her, about diabetes, nerve damage, blood flow and infections. She said she never knew that, 'why hasn't anyone ever told me that?'

- Care Coordinator

All PHNs reported improved patient compliance with medications, care planning and a significant reduction in non-attendance at medical appointments.

Able to gain their own footing

Clients have been able to gain their own footing so to speak, they now feel better about the way they interact with specialists and doctors. They don't need us as much anymore so we're able to kind of wean them off so to speak because they are more self-resilient, self-reliant and understanding of what's going on.

- Care Coordinator

Impact on outcomes and quality of life

Stakeholders consistently reported that the ITC Program was providing better health outcomes for Aboriginal and Torres Strait Islander people. Many of those interviewed had personal stories of how without the Program, many of the people they could now reach would be in far worse health or have passed away.

However, few commissioned organisations systematically collected information on outcomes. Some collected change in clinical measures such as Glycosylated haemoglobin (HbA1c, a measure of blood glucose/diabetes control), which they remarked improved once patients engaged with ITC. Others collected patient experience/ satisfaction, which they mainly used to target service providers for cultural competence training.

There were many anecdotes about how the Program turned the lives of patients around, improving their overall quality of life.

Move with his young family to their own home

Care was coordinated for a 32-year-old man, with complex renal issues, working across several service providers to assist him in becoming compliant with treatment. As a result, his condition has improved significantly and he is now seeking to move with his young family from housing commission accommodation to their own home.

- Commissioned service provider

He's very proud of his garden

We had a client who was 230 kgs. He wasn't moving about or doing anything. Since coming to our programme we've supported him with a dietician through video links with him, a diabetes educator performing home visits along with other Allied Health Services and even the GP. He now gone from 230 kg to 170 and has been able to go off his insulin. Now he's even got a garden.

He's getting his confidence back, now he is jumping in the car and coming down to hospital himself to get weighed and have check-ups. He is continuing on, and he's very proud of his garden.

- Care Coordinator Outreach worker

She would have to be in a nursing home

I have one client that lives miles out of town. She would have to be in a nursing home if we didn't have this sort of arrangement going on with ITC, there's no way she'd be able to live at home, so that's made a big difference to her.

I have another client, a young girl, who we've hired a hospital bed for her recovery. If not for the bed, she'd have to be back in hospital. She's only in her twenties, it's made a big difference to her and her young family.

Other outcomes of the Program

Local implementation of the ITC Program often has strong links with organisations/ groups beyond the health care sector, such as community groups, yarnning circles, community legal services, departments of housing, etc. These links help to further strengthen patient outcomes.

The Program was also reported to have much wider benefit than the immediate benefit to patients enrolled in the ITC program. For example, it was commonly reported that patients who had benefited from the Program took what they had learned and educated their families and communities. Also, care coordination often reached further than ITC patients. An example provided in one of the interviews was that in assisting an ITC enrolled patient, the patient's daughter asked for and received information about when and where to go for her child's immunisations and developmental checks.

Service level observations

Engagement with mainstream primary care

The ITC Program provides for PHNs and communities to develop flexible approaches in providing access to health care for Aboriginal and Torres Strait Islander people. A key part of this is ensuring Aboriginal and Torres Strait Islander people have a choice in where they seek their health care.

To facilitate choice for patients, and to recruit more services to help with closing the gap, engagement of mainstream primary care is a key activity of the Program and the work that PHNs and commissioned services undertake.

The ITC Program Guidelines indicate that engaging with mainstream practice and developing referral pathways are key responsibilities of the IHPO role. PHNs also have this responsibility, including more broadly than the ITC Program. Therefore, it was not surprising to observe sharing of the IHPO responsibilities between commissioned organisations and PHNs. Where these relationships were mature, a clear and efficient sharing of responsibilities and working relationship was observed between PHN and commissioned organisations. However, some stakeholders reported a degree of confusion in the delineation of responsibilities between the commissioned organisations and the PHN. This confusion, or lack of clear delineation, could sometimes result in the neglect of one or more of the IHPO responsibilities, including mainstream engagement, especially around developing and implementing strategies to improve the capacity of mainstream primary care providers to deliver culturally appropriate care. Commissioned service providers and PHNs were aware of this confusion and the gaps that were emerging. These PHNs and service providers noted that it was a result of the resourcing being consumed by the early stages of commissioning, and that once

established, PHNs and service providers will be able to devote more attention to these responsibilities.

While not common, gaps in mainstream engagement were observed in situations where the ITC workforce was primarily commissioned within ACCHOs and where there are communities (with significant Indigenous population) that are not within the traditional catchment of these ACCHOs. This may occur where communities are serviced by private general practice, or alternatively, state/territory primary care clinics. In these situations, the responsibility for 'mainstream' engagement remains unclear. This is not only an issue of mainstream engagement, but ITC coverage and patient access in general.

As identified previously, gaps in engagement of mainstream primary care correlate with the relative newness of the commissioned Program in some PHNs. In these early stages, PHNs and service providers noted that their resources were tied up with commissioning services, and that mainstream engagement at this stage was a lower priority. In most instances, PHNs had identified these issues and had commenced planning to address them for the future. For these reasons, it is likely that more mainstream engagement activity will be observed over time as services move beyond their establishment phase. The PHNs and the Commonwealth should continue to monitor this over time to ensure the work is being done.

Stakeholders noted that patients report incidents of culturally inappropriate care, which signifies patients' hope that this can be improved. Several of the commissioned organisations outlined their approaches to follow-up and engagement with service providers following a report. This often included the provision of resources, and an offer for cultural awareness training.

Success in engaging mainstream primary care can be measured by an increased uptake of Aboriginal and Torres Strait Islander-specific Medicare Benefits Schedule (MBS) items (including 715 Aboriginal and Torres Strait Islander Health Assessment), and increases in the number of Aboriginal and Torres Strait Islander people willing to identify as Indigenous within mainstream primary care.

Referral pathways for care coordination

Referrals or requests for patient care coordination come from many different areas. The two most common areas were referrals from GPs located within a commissioned care coordination service and referrals from mainstream GPs (i.e. from outside of the commissioned organisation). Formal referral requires a GPMP. However, service providers are often happy to work with patients to help them establish a GPMP. This meant that services can take informal referrals from a much wider pool, including hospital discharge networks, community services, and even individuals self-referring.

Many commissioned organisations rely on paper-based referral systems. Several were using electronic referrals, and some were considering electronic systems. In many instances, the forms developed by service providers aimed to educate and guide primary care services (mainstream and otherwise) on the nature of support available through the ITC Program, often listing the services and support available on the form.

While formalised referrals were the most common, service providers also indicated they would accept self-referrals in instances where a patient was not eligible for a GPMP. For example, the patient had had a GPMP in that calendar year or their chronic disease did not

strictly meet local criteria. Providers reported, that when they could determine a patient was in clear need, they would do what they could to support them.

Gaps in patient access can occur in situations where commissioned providers had current or historic catchment regions. At times these did not include populations serviced by mainstream GPs or state/territory based primary care services. Where patients reside outside these catchment regions, they have to travel vast distances to receive ITC support. It was noted that PHNs were aware of where this was a problem within their regions. It is accepted that in many instances, especially when considering vast remoteness of much of Australia, perfect coverage is a near impossible task. It is a task though that warrants continued effort and attention of PHNs, services providers, and the Commonwealth.

Triage/assessment

To assist in determining caseloads and patient needs, several providers used a formal 'triaging' tool to determine whether a patient qualified for Care Coordination, and to estimate resources required for their care. Other services used ITC workforce case conferencing on a regular basis to informally assess patient needs.

Both assessments typically considered a range of issues wider than health. These included factors related to social support, and the person's ability to self-manage. Assessments routinely considered:

- patients living arrangements (with family or alone)
- level of assistance of family or friends
- transport needs
- level of literacy, including health literacy.

Often social support factors were given significant weighting in the triage process. Providers did not formally record triage scores for patients, nor any re-assessments, and thus this data is not available. There is significant benefit for service providers in formalising this process and performing regular re-assessments. The greatest benefit is that this ensures no patient is neglected; it also enables resourcing and staff to be prioritised. Additionally, the triage systems put in place may also help service providers track patient progress over time. Again, as the ITC matures as a commissioned program, supported and encouraged by the PHNs, it is expected that commissioned services will develop more formal processes overtime.

Patient discharge from the Program

Figures provided by PHNs in their six-monthly reports to the Department of Health indicated that approximately 10-12% of patients were discharged from the ITC Program over the initial six-months of 2016-17. Patient discharge as a concept may be considered a proxy outcome, indicating that a patient is self-managing to a level in which they no longer need care coordination. However, discharge also captures all other reasons for discharge, including loss of contact with a patient and death.

Gleaning meaningful information from the discharge data is made more complicated as there is no common definition that is applied across all service providers. Many service providers noted that the nature of complex chronic disease is that it is not curable, and therefore patients were unlikely to ever be discharged.

Providers, considering the nature of chronic disease and the likelihood of future relapse and therefore acute need, found it was easier to keep patients enrolled. It was reported that the

process of re-enrolment can be so complex that it can prolong the time a patient is at risk while waiting for care. Providers also noted that while many of their patients were effectively self-managing, they still relied on supplementary services funding to access specialist appointments to maintain their current level of self-management.

A small number of service providers used a system for flagging patients as 'active' or 'inactive.' This indicated a patient's current level of need, and recognised that this may change over time. The system also allowed providers to better manage resources and caseloads.

The overall ITC Program could benefit from collaborative work to develop a set of common concepts and definitions that can be used for reporting. This should include defining discharge, and what discharge sets out to measure or achieve. The development of definitions for 'low support' or 'self-management' with agreed criteria, may help capture information about whether patients are moving to less intensive phases of care over time.

Supplementary services

It was clear from the interviews conducted that the supplementary services component of the ITC had a significant positive impact on patient care and outcomes. In a 2016-17 six-monthly report to the Department of Health, one PHN stated: "*The prioritising of Exceptional Circumstances Supplementary Services funding has resulted in some inspiring outcomes for ITC clients.*" Supplementary services had allowed many patients to attend private sector specialist appointments who would not have had the opportunity otherwise.

How patients or service providers accessed supplementary service funding differed across PHNs. Some PHNs were more involved in the assessment of supplementary service applications, which in some instances led to longer wait times. At times, this process could also seem inconsistent to external providers and patients as they were detached from the decision-making process.

There were several commissioned service providers that were given full responsibility of supplementary service budgets and decision making. In these situations, transparency was improved, funds could be made available more immediately, and allocating across the budget period was made easier. PHNs that were still handling the supplementary services funds stated that they intended to transition this to the commissioned organisations as the commissioned organisations became better established, and PHNs built better mechanisms for allocating funds across their region based on patients' needs.

Transport represented a significant proportion of supplementary service spending across the ITC Program. Several service providers identified expenditure on taxis, petrol vouchers and/or other transport as their biggest by far. They commented that the ability to purchase capital items, such as cars, could reduce the current expenditure on transport³.

Team leadership

The nature of the relationships between IHPOs, Care Coordinators and Outreach Workers was shaped by the model employed by the PHN and commissioned service(s). Typically, the roles and responsibilities of IHPOs, Care Coordinators and Outreach Workers were maintained as intended by the ITC Program Guidelines. In most instances Care Coordinators

³ Purchasing capital items like cars is currently not allowed under the ITC program.

provided the key role in service delivery to patients, with IHPO and Outreach Workers supporting.

In several situations, the roles of IHPO, Care Coordinator and Outreach Worker were shared or combined. That is, a single person was performing all or combinations of these roles. This was typically the case where the available funding for the commissioned organisation was less than a full-time position.

Where the working relationships were strongest between IHPOs and Care Coordinators, Care Coordinators were able to make better use of their time and supplementary service funding. The close working relationships between IHPOs and Care Coordinators allowed information about patients' needs to be used in developing strategies to target service gaps and new referral pathways. It also provides a safe environment for patients to report instances of culturally inappropriate care.

Outreach Workers were instrumental in operationalising care plans. Care Coordinators noted that Outreach Workers were key in getting patients to engage. Outreach Workers having local knowledge and links to community built instant trust, respect and insight into community need. Outreach workers provided valuable information, identifying gaps in cultural competency of service providers. They also routinely identified patients on the Program who required unscheduled follow up due to changed circumstances or exacerbation of their condition.

Care Coordinator caseloads

Stakeholders across all PHNs reported continual growth in demand for care coordination services. The review observed great variation in caseloads of anywhere between 15 patients per Care Coordinator in smaller services, and up to 75 in larger services. A typical caseload was impossible to glean for a few reasons: difference in how services counted patients, how services classified staff (ITC Care Coordinators vs. non-ITC funded Care Coordinators), and the fact that organisations were at very different stages in filling positions.

A successful visit to a culturally appropriate mainstream primary care

While seeking a local general practice to refer a patient, our Indigenous Outreach Worker identified a practice local to the patient that required training and upskilling in culturally appropriate service delivery. The General Practitioner when contacted, admitted not knowing about the Close the Gap - Pharmaceutical Benefits Scheme Co-payment, which enables Indigenous patients to access more affordable medication. The Outreach Worker made further enquiries and identified staff in the practice who would benefit from cultural competency training. Working with the Practice Manager the Outreach Worker helped to organise in-house training.

When the patient returned for their next consult, they were successfully identified as an Aboriginal/Torres Strait Islander patient and registered for Close the Gap PBS Co-payment. The patient had an Indigenous Health Assessment and was provided with a Close the Gap annotated prescription allowing them to access affordable medications.

At the end of this process both patient and Outreach Worker felt they were leaving the practice after a successful visit to a culturally appropriate mainstream primary care provider.

- An example of the Outreach Worker activity as provided by a commissioned service provider through six-monthly ITC reporting.

Collaboration between commissioned services

Collaboration between ITC providers held great benefit for patients. Many PHNs provided opportunities for ITC workforce members from different service providers to interact and share knowledge. In some instances, neighbouring PHNs brought their workforces together in much the same way. These gatherings provide opportunities for the ITC workforce across vast areas to jointly receive updates on the implementation of the Program and related programs/ initiatives (e.g. progress with My Health Record) and professional development training.

In addition, these gatherings provide ITC workforce members a chance to share their experiences, including issues and barriers they had faced. It also provided the opportunity for greater cross-region collaboration, for example, where a patient was required to travel large distances across or into other PHNs for specific treatment. The relationships forged in these meetings often resulted in patients having someone at the other end of a long journey to assist them in settling into their accommodation and getting to their appointments in an unfamiliar place.

Collaboration within PHNs was equally beneficial to patients. Several commissioned service providers instigated case conferencing to discuss patient needs. These were more common in ACCHO-affiliated organisations, where multidisciplinary care team members were employed by the same organisation. Several mainstream commissioned services also engaged in case conferencing, which included external health and community service providers. At their most advanced, Care Coordinators and GPs would be joined by allied health, community services, family members, medical specialists and at times representatives from schools or workplaces at these conferences.

Many PHNs showed some early signs of building care networks. PHNs should encourage, and be encouraged to, support and foster these networks both within their jurisdictions and more widely.

Community collaboration

A single parent family of five had recently moved into the area. One of the children had significant care needs; they were in wheelchair, required assistance with personal care, incontinence, medication, physiotherapy, as well as a number of specialists including, respiratory physician and cardiologist.

A case conference was arranged to discuss what assistance was available to the whole family and specifically the young person. The GP developed a GP management plan in conjunction with the physiotherapist and their treatment plan. Representatives from the school attended to talk about modifications they could and were making to the school as well as discussing arrangements to facilitate physio appointments for the young person in school hours. The Care Coordinator helped organise and discuss specialist appointments cardiologist and the respiratory physician and paediatrician. They were also able to discuss the closing the gap, and what that meant for reducing the cost of care and medications. As a group, we were able to identify and arrange a personal care worker for them as well.

- **Care Coordinator**

Conclusion

This evaluation has found that care coordination plays an integral role in improving access to services for Aboriginal and Torres Strait Islander People with chronic conditions. Given the positive impact on health outcomes that this improved access has achieved, it is recommended that the ITC Program is continued in its current form.

Based on reports and the available data, it was found that the ITC has resulted in:

- **Improved patient self-efficacy and self-management**, contributing to **improved adherence to treatment**, and **better health outcomes**.
- **Improved trust between the patient and the health system** and health professionals as a result of care coordination. Once a trusted relationship had been built with the health system, coordinators could reduce the intensity of care management in many cases, as **patients became more confident in navigating the health system**, secure in the knowledge that they could call on coordinators when needed.
- **Improved continuity of care and communication** between providers and patients due to the work of Care Coordinators and outreach workers, as the trusted links with the health system.
- **Patients being more proactive in meeting their health needs** as Care Coordinators could advocate for the patient and confirm the patient's understanding of their condition,
- **Improved navigation of the health care system by patients.**

- **Improved cultural appropriateness and cultural safety of mainstream primary care services.**
- **Improved access to and uptake of allied health, specialist and tertiary health care by Indigenous people,** with 75,831 allied health and specialist services purchased or brokered for ITC patients in the first half of 2016-17.
- **Reduced barriers, including financial barriers, to accessing services and medical/ health aids.** For example, in the first six months of 2016-17, the ITC provided approximately 38,000 instances of patient transport to and from medical appointments.
- **Improved uptake of Aboriginal and Torres Strait islander-specific Medicare Benefits Schedule (MBS) items.** The latest MBS statistics show 217,678 Indigenous health assessments (MBS 715) were claimed in 2016-17. This is an increase of 11% on the previous year and represents approximately 34% Aboriginal and/or Torres Strait Islander population according to the 2016 Census.

Recommendations

1. The Commonwealth should continue to fund the ITC Program in its current form. ITC is unique in that it takes a community approach to care coordination in supporting and improving the health of Indigenous Australians.
2. The Department of Health should consider options to achieve a longer funding cycle (of at least three years) for the Program, and alignment of the funding cycle with other PHN funding.
3. The Department of Health should restate to PHNs the importance of engaging with mainstream primary health as part of the ITC Program.
4. The Department of Health should emphasise to PHNs and service providers the importance of continuing to work towards improving the geographic reach of ITC services, further improving access for Aboriginal and Torres Strait Islander people with chronic conditions.
5. The Department of Health should review the current Program Guidelines and Frequently Asked Questions (FAQs) related to supplementary services, and identify areas in which FAQs can be incorporated into the Guidelines to improve clarity.
6. The Department of Health should provide PHNs and service providers with a report on feedback data submitted through the Program, to facilitate quality improvement and build capacity for future local benchmarking.
7. The Department of Health should initiate a collaborative process with PHNs and service providers to redesign reporting under the Program, to ensure that data collection is efficient but also informs the outcomes of the Program. The review of reporting should consider developing a minimum data set with clear definitions of items, which could underpin or form part of the reporting requirements.