REMOTE
Integrated & Collaborative Health Initiative

A CHARITABLE INITIATIVE OF THE
HEALTHY COMMUNITIES FOUNDATION AUSTRALIA

THE HEALTHY COMMUNITIES FOUNDATION AUSTRALIA

Acknowledgement of Country

We live and work on the lands of the First Australians. We pay our respects to Elders past, present and emerging.

Gamilaraay
Dhayn ngiyani winangaylanha NSWga ganunga-waanda yanaylanha, dhaymaarr ganugu-waanda nhama ngarrangarranmaldanhi

Wiradjuri
Ngiyani Yindyamali Aboriginal Mayiny Murrubandhda Mayinny galangga NSW Ngangaagi

Dharawal
Nijunaliin ngaralanga dharawalwulawala nguradhanhay ngaliya

Dhurga
Ngayaga bundj nguumbun muladha gumara muruul yuwinj wanggan njin dhugandha

Gumbaynggirr
Ngiyaala junga-ngarraanga Girrwaanbi-biin gungnagulam wajaarrgundi gilinggal-wanggaan-wiil

English
We respect Aboriginal peoples as the First Peoples and custodians of NSW.

Partners

Provider Partners
Rural and Remote Medical Services Ltd
InterHealthCare Pty Ltd/PhyzX2U
Kinephonics Pty Ltd
eHealth Pty Ltd
The Dental Station

Research Partners
University of Sydney
Australian National University

Funding Partners
Newcastle Permanent Charitable Foundation
Commonwealth Department of Agriculture, Water & Environment
Murray Darling Basin Authority

Corporate Partners
Studiosity

THE HEALTHY COMMUNITIES FOUNDATION AUSTRALIA

Our Vision

Health and wellbeing for every person regardless of where they live.

Our Mission

Our mission is to transform the way health care and community services are delivered in partnership with communities.

What does this mean?

Children have the best possible start in life.

Young people get the knowledge and skills they need to realise their potential and live a healthy and authentic life.

Communities are safe and inclusive places to live and work, and provide the social and economic opportunities people need to live well and raise the next generation.

People can easily access help and care that reflects their needs locally when they need it.

People with special needs can participate in the social and economic life of the community to achieve their full potential.

Person-Centred Integrated & Collaborative Model of Care

Introduction

The Foundation has adopted the World Health Organization's integrated people-centred health services (IPCHS) framework as part of the Remote Integrated and Collaborative Health (RICH) initiative.

The aim of RICH is to provide collaborative, seamless, effective and efficient care that addresses a person's complete physical and mental health needs across their life in their own community.

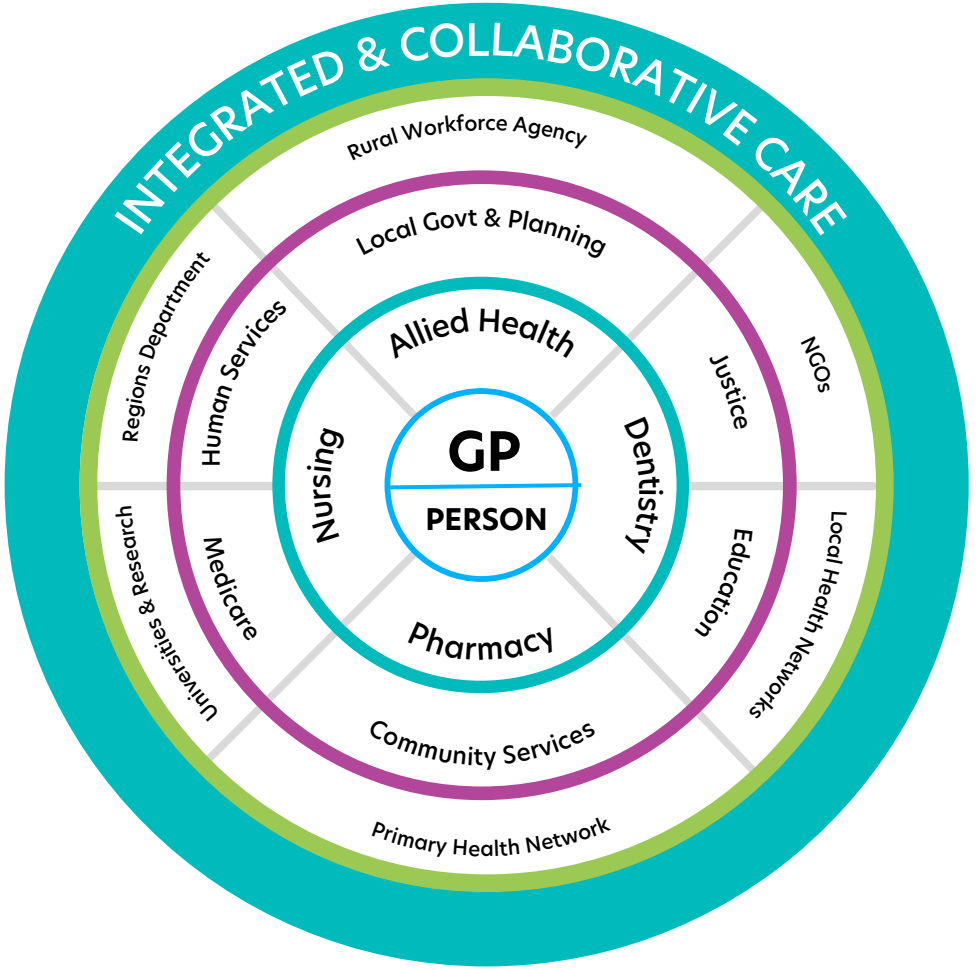
It embraces place-based, community-specific strategies and planning, addressing not just the biomedical dimensions of care, but the social determinants of health at an individual, family and community level.

Our Integrated Care Partners have a shared vision to improve the health and wellbeing of people living in rural and remote communities.

To realise this Vision, the partners understand the need to change the way we deliver primary health care and to leverage the benefits that technology can bring to improve access and continuity of care.

The Partners aim to design, trial and evaluate models of care that reflect the needs of rural and remote people. They aim to work collaboratively to improve the coordination and integration of general practice, allied health, dental and social care services and the effective use of technology to enhance continuity of care.

The aim of this trial is to explore how it may be possible to make continuity of care with a regular health care team financially sustainable and attractive to health services providers to address poor access to healthcare services in rural and remote communities.



WHO Integrated People-Centred Health Services Framework

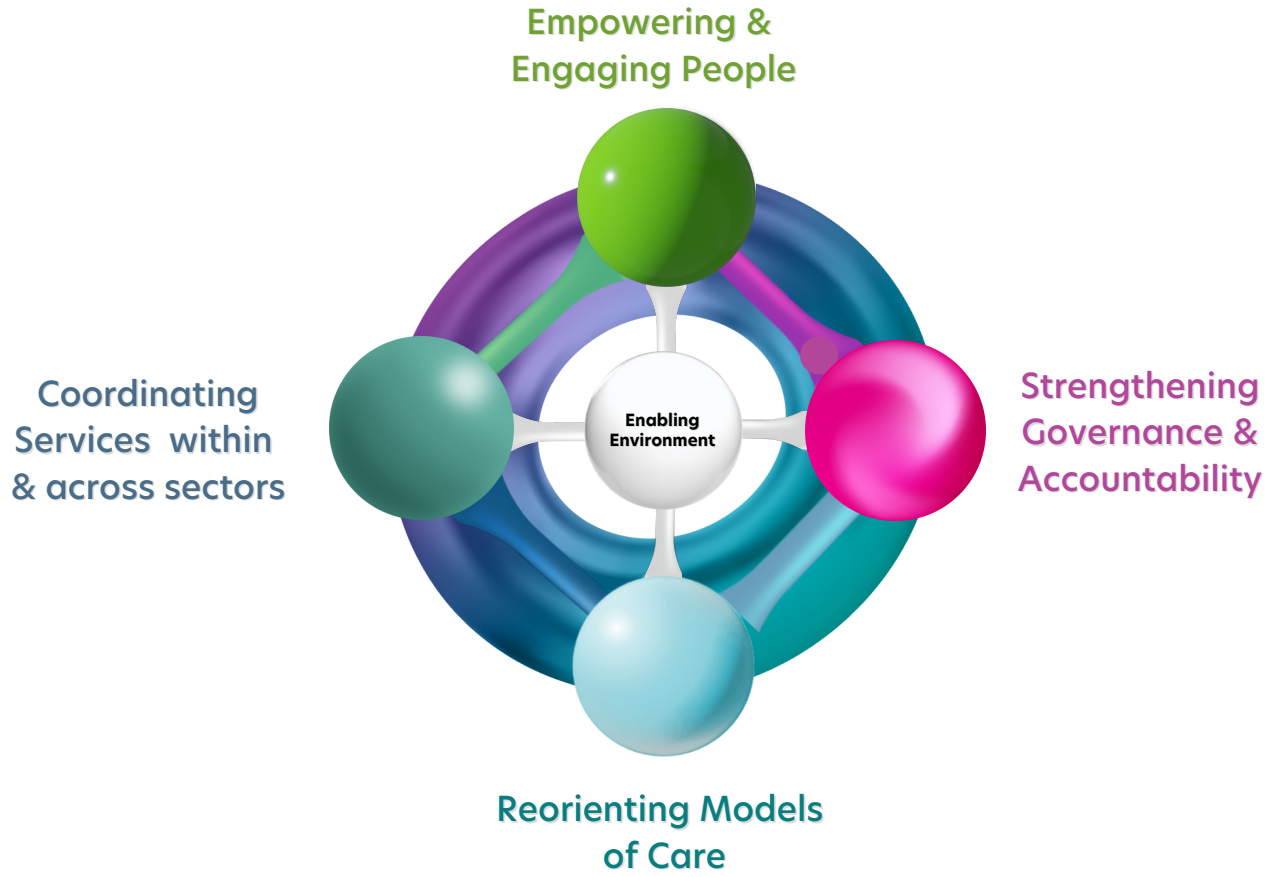
Integrated People-Centred Health Services
IPCHS

At the World Health Assembly in May 2016, the WHO Framework on integrated people-centred health services was adopted by Member States. The Framework acknowledges that our health systems are at a breaking point and doing business as usual is no longer an option. WHO recommended five strategies to implement integrated people-centred health services that require local adaptation.

1. Engage and empower people and communities to take an active role in their health and health services.
2. Strengthen governance and accountability to build legitimacy, transparency and trust, and to achieve results.
3. Reorient the model of care to ensure that care is provided at the right time, in the right place, and in the right way, while striving to keep people healthy and free of illness.
4. Strengthen the coordination of care across providers, organizations, care settings and beyond the health sector to include social services and others.
5. Create an enabling environment to facilitate transformational change through enhanced leadership and management, information systems, financial incentives and reorientation of the health care workforce.

The Framework on IPCHS promotes cross-cutting collaboration and integration across sectors, organizations, health care settings, providers and users.

The Foundation has endorsed the IPCHS Framework and works with communities to implement this Framework to address the social determinants of disadvantage and improve access to care.



Our Behaviours

Person-centred integrated and collaborative care requires health, human and community care professionals to step out of their institutional paradigms ('comfort zone') to place the person, and the community in which people live, at the centre of decision making about care.

This means challenging the "way we do things" when those things do not support improved health for our patients/consumers and communities. When existing systems impede the change we need, we work together to identify change and advocate for our patients/consumers and communities both internally or externally for policy or regulatory reform.

Our focus on the person in their place and context means that we behave in ways that are inclusive and supportive of the paradigm shift in health that we are seeking to achieve including:

- we act with integrity to build confidence among the Partners, and with our patients/consumers and communities, about our intentions.
- we critically analyse our actions and plans to make sure that the person and community remain always at the centre of our model of care.
- we actively recognise and value our different perspectives and views, understanding that we each come to the table with our own philosophies that can enrich our shared understanding and help us to decide collectively the best approaches for our patients/consumers and communities.
- we argue enthusiastically for our patients/consumers, and listen with equal passion, remaining at all times open to new thinking and ways of doings things that benefit our patients/consumers and their health.
- we recognise that the best setting for achieving better health and well-being may not be a GP, Physiotherapist, dentist, speech pathologist or similar health service and the setting for care is where our patients/consumers achieve the best outcomes (e.g. at home, school or the banks of a river).

Steering Committee Terms of Reference

Purpose
The purpose of the Remote Integrated & Collaborative Care (RICH) Steering Committee is to:

1. Oversee the design, implementation, trialling and evaluation of models of integrated care in agreed rural and remote communities that are strategically aligned to the purpose of each of the Partners and that ensures that their combined resources are being used to best effect.
2. Ensure strong clinical governance including patient consent to participate in any evaluation or research, including the implementation of data collection into the project to ensure evaluations can be undertaken consistently and effectively.
3. Develop and update a joint business and financial plans to enable effective evaluation of the sustainability of integrated care including the evaluation of sustainable business models that address the opportunities for, and barriers to, integrated care and continuity of care.
4. Promote collaboration, multi-disciplinary coordination, and person and community-centred care across disciplines in rural and remote communities.
5. Ensure that each integrated care trial is based on a clear program logic and assumptions that can be evaluated.
6. Set the outcomes and performance measures against which the integrated care trials will be evaluated, and monitor and review the outcomes and performance in line with the program logic and goals identifying areas for improvement and areas of good practice, taking action where outcomes and performance fall short of requirements
7. Ensure the engagement of stakeholder groups, including users, patients and carers, partners and community organisations, in the formulation of the integrated care trials.
8. Identify, mitigate and manage risks associated with integrated care.
9. Oversight performance and finances and ensure, if required, appropriate actions are taken to ensure delivery of expected performance targets within permitted budget.

Principles
The following principles will guide the integrated care steering committee:

1. Strategic - trials will be strategic and outcomes-based rather than activity-based.
2. Multi-disciplinary and holistic - place patients/consumers at the centre of the model of care by bringing together those with interests in all aspects of rural and remote integrated care research, education, policy and practice.
3. Independent – partners act independent and not in the interests of any profession, institution, service sector or interest group.
4. Collaborative – bring together all fields of primary health, human and community care to improve the experience of integrated care and improved continuity of care.
5. Outcome focussed - define and measure outcomes to inform professional practice and policy.
6. Fair – promote equity of access and outcomes for rural and remote people.

Membership
1. Angela Hubbard, Director, PhyzX2u (Chair)
2. Julia Faulkner, RICH Program Manager, Foundation
3. Mark Burdack, CEO, Foundation
4. Michael Johnson, CEO, First Australians Health
5. Phoebe Beniac, Kinephonics Pty Ltd
6. Professor Sarah Dennis, University of Sydney
7. Peyton Ramien, Registered Nurse, Collarenebri Community Health and Youth Hub
8. Dr Jalal Khan, CEO, The Dental Station

Meetings
Meetings will be held monthly.

CYCLE OF CARE RECEIPE

1.INVESTIGATE

5.IMPROVE

GP Consultation
Patient History
Investigations
Physical Examination
(BMI,BP)
Medications Review
Immunisations Review
Patient goals

Pathologist
(Hb1Ac, Urine, cholesterol and triglycerides)

Podiatrist
Foot exam

Optometrist
Eye Exam

2.PLAN

Prepare GMP/TCA

Depending on the investigations, the Care Team may involve the following allied health team.

Nurse
Immunisations Update

Podiatrist
Circulation Plan

Physiotherapist/Exercise Physiologist
Exercise Plan

Optometrist
Eye Health Plan

Nutritionist
Diet Plan

Diabetes Nurse Educator
Education Plan

Psychologist
Mental Health Plan
Quit Smoking Plan

Urologist
Kidney Disease

Ophthalmologist
Eye Disease

Cardiologist
Heart Disease

Multidisciplinary Care Review

Care Team participate in quarterly case conference to review patient progress and adjust plans accordingly.

4.REVISE

Patient Review Cycle

3.REVIEW

TECHNOLOGY ENHANCED MODELS OF CARE & LEARNING

Operating Model of Care supporting Student Training

Potential Model of Care supporting Student Training

For development in Stage 2

Nurse Immunisations UpdateS	On-site immunisation by qualified nurse				
Podiatrist Circulation Plan	Monthly Outeach to Location by qualified podiatrist	Diagnosis on Site by qualified Podiatrist or Trainee under Supervision	Electronic Treatment Plan agreed with GP registered into Best Practice	Electronic Recall via HotDoc if required	
Physiotherapist/Exercise Physiologist Exercise Plan	Monthly Outeach to Location	Diagnosis on Site by Final Year Student under on-site Supervision by Qualified Physio/EP	Electronic Treatment Plan agreed with GP registered into Best Practice	Weekly/Fortnightly Telehealth Consultation with Student under Supervision of Physio/EP	Online App downloaded by patient used to guide treatment & measure patient activation
Optometrist Eye Health Plan	Monthly Outeach to Location	Diagnosis on Site by qualified Optometrist or Trainee under Supervision	Electronic Treatment Plan agreed with GP registered into Best Practice	Electronic Recall for fitting/treatment if required	
Nutritionist Diet Plan	Monthly Outeach to Location byTrainees	Draft Diagnosis & Plan developed and reviewed by qualified Nutritionist off-site	Electronic Treatment Plan agreed with GP registered into Best Practice	Weekly/Fortnightly Telehealth Consultation with Student under Supervision of Physio/EP	Online App downloaded by patient used to guide treatment & measure patient activation
Diabetes Nurse Educator Education Plan	Virtual Education Sessions from clinic by Trainees under supervision				
Psychologist Mental Health Plan Quit Smoking Plan	Virtual Consultations with qualified psychologist or Trainees under Supervision				
Dentist Oral Health Treatment	Practice staff take dental photographic scan using iTero to generate 3D image	Image sent electronically to off-site dentist	Electronic Treatment Plan agreed with GP registered into Best Practice	Electronic Appointment made using HotDoc for treatment on-site	Treatment provided on-site via monthly outreach plan using Dental Bus by qualified dentist or trainee under supervision
Speech Pathology Speech & Learning	Monthly Outeach to Location	Treatment Plan Developed	Electronic Treatment Plan agreed with GP registered into Best Practice	Asynchronous Online Speech App for patient learning	Telehealth Consultation with Qualified Speech Pathologist or Student under Supervision
Pathologist (Hb1Ac, Urine, cholesterol and triglycerides)	On-Site Collection by Qualified Nurse	Road transport to Pathology Laboratory	Pathology report developed by Pathologist or Trainee under Supervision	Electronic Results to GP registered into Best Practice	Electronic Recall via HotDoc if required
Specialists	Virtual Consultations with Specialist or Trainee	Off-site appointment booked	Community Transport booked	Electronic Results to GP registered into Best Practice	

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