3.3 STRATEGIC DIRECTION 3: ENSURING INTEGRATED PLANNING AND SERVICE DELIVERY

Providing continuous, coordinated and high quality healthcare contributes to improved health in Aboriginal people. Strategic Direction 3 focuses on providing integrated planning and service delivery for Aboriginal people. Key actions are:

- improving the coordination and integration of programs and services across providers, governments and funding bodies
- ensuring the needs of Aboriginal communities are addressed in the strategic plans of state health organisations
- collaborating with ACCHSs in developing LHD healthcare plans to achieve a shared, coordinated and joined up approach to service delivery
- addressing the needs of Aboriginal communities through specific planning processes for priority health issues, in partnership with the AH&MRC
- ensuring that relevant NSW Health initiatives consider Aboriginal people a priority population and reflect the needs of Aboriginal communities
- strengthening the role of NSW Health in addressing the social determinants of Aboriginal health.

KEY FINDINGS

- **NSW Health is implementing whole-of-system initiatives aiming to improve healthcare integration, however, some of these could have a stronger emphasis on improving the health and healthcare experiences of Aboriginal people.**
- **Performance frameworks and clinical networks have been established; these enable integrated planning and service delivery for Aboriginal people.**
- **NSW Health is also implementing many (n=120) clinical redesign and integrated care projects aiming to improve the health and healthcare experiences of Aboriginal people.**
- **Through the Bilateral Agreement, the MoH is collaborating with the Australian Government Department of Health to support joint planning and service delivery.**
- **In the last seven years in NSW, rates of unplanned hospital readmissions, emergency department re-presentations and mental health readmissions in Aboriginal people have been stable (6%, 6–7% and 17–18%, respectively).**
- **Encouragingly, there is no gap in rates of unplanned hospital readmissions between Aboriginal and non-Aboriginal people.**
- **Almost all (98%) Aboriginal elective surgery patients are treated on time in NSW, up from 91% in 2010–11.**
- **ACCHSs reported a need for better collaboration between LHDs and ACCHSs in planning and delivering services, especially in the context of supporting Aboriginal people who have complex healthcare needs and/or are leaving hospital.**
- **NSW Health is influencing the social determinants of Aboriginal health through various inter-sectoral initiatives.**

3.3.1 NSW HEALTH ACTIVITIES

NSW Integrated Care Strategy

The integration of healthcare is a strategic direction of the *NSW State Health Plan: Towards 2021*. Integrated care is seamless, effective, efficient and patient-centred care. It requires effective communication and connectivity among health staff across primary, secondary and tertiary care settings, and the delivery of physically and culturally accessible health services. The *NSW Integrated Care Strategy* aims to improve patient health and reduce costs arising from fragmented care in NSW. The Strategy invests in innovative models of integrated care and particularly focuses on people with complex, chronic conditions, which are disproportionately common in Aboriginal people. The Strategy has three components:

1. Three LHDs are implementing large-scale integrated care initiatives in partnership with other health organisations to join up services for local populations.
2. The remaining LHDs and SHNs are implementing smaller scale, innovative integrated care initiatives with the potential to be scaled up.

3. State health organisations are supporting LHDs and SHNs to implement their integrated care projects by establishing: information technology, like HealtheNet, to enable sharing of patient data among providers; resources to support integrated care, such as risk stratification and patient-reported measures; and networks of NSW Health staff to facilitate the diffusion of innovations and lessons learned.

Under the Strategy, some LHDs are working with ACCHSs to improve the healthcare experiences of Aboriginal people. For example, Western NSW LHD has implemented a model of care for the management of chronic conditions in Aboriginal adults in collaboration with Wellington Aboriginal Corporation Health Service. Central Coast LHD has also implemented a service redesign project to provide culturally safe and clinically appropriate maternal and child healthcare for Aboriginal families in partnership with Yerin Aboriginal Health Service Inc. Building on the achievements of the *NSW Integrated Care Strategy*, the NSW Ministry of Health is developing a strategy aiming to support a consistent and evidence-informed approach to healthcare integration in NSW, and the integration of health and social services.

Whole of Health Program

The Whole of Health Program aims to improve the coordination and integration of primary health and hospital care in NSW. LHDs and SHNs are supported to implement patient flow improvement projects through a suite of strategies, including: providing centrally

CASE STUDY

BETTER CARDIAC CARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Cardiovascular disease is a major cause of ill-health in Aboriginal people. Better Cardiac Care is a national initiative that aims to reduce mortality and morbidity from cardiac conditions by increasing access to services, better managing risk factors, and improving the coordination of care. The five priority areas are:

1. Early cardiovascular risk assessment and management
2. Timely diagnosis of heart disease and heart failure
3. Guideline-based therapy for acute coronary syndrome
4. Optimisation of health status and provision of ongoing preventative care
5. Strengthen the diagnosis, notification and follow up of rheumatic heart disease (RHD).

NSW Health is implementing a range of activities under each priority area. Examples include:

- implementing a data linkage study using Medicare, hospital and deaths data to better understand patterns of care in Aboriginal people with cardiovascular disease in NSW, identify intervention points and guide integration of services (priorities 1 and 4)
- supporting ACCHSs to provide high-quality cardiovascular disease prevention and management through educational teleconferences and webinars on the Medicare Benefits Schedule (MBS) 715 health check, smoking cessation and assessing and managing heart disease (priorities 1, 2, 4 and 5)
- creating and implementing a suite of educational videos designed to improve the health literacy of Aboriginal people regarding cardiovascular health (priority 2)
- establishing a state-wide electronic chest pain pathway in the electronic Medical Record (eMR) to better equip clinical services to deliver seamless and high quality care (priority 3)
- establishing acute rheumatic fever and RHD in people aged <35 years as a notifiable condition, and implementing a state-based register aiming to improve surveillance, inform public health action and improve patient management (priority 5).

The program has contributed to the following outcomes in NSW:

- the proportion of Aboriginal people who received a 715 health check has steadily increased year-on-year, from 10% in 2010–11 to 27% in 2016–17
- the rate of coronary heart disease hospitalisations in Aboriginal people decreased from 1,099 per 100,000 persons in 2010–11 to 1,000 per 100,000 persons in 2015–16
- the rate of coronary revascularisation procedures in Aboriginal people increased from 234 per 100,000 persons in 2010–11 to 258 per 100,000 persons in 2015–16
- since establishment of the register in 2015, there have been 98 notifications for acute rheumatic fever and RHD in NSW.

In NSW, Better Cardiac Care has been led by an Aboriginal advisory group, which includes representatives of stakeholders including the AH&MRC, ACCHSs, the Heart Foundation, the Agency for Clinical Innovation, NSW Ambulance, LHDs and the MoH.

coordinated technical advice; establishing program leads and clinical champions to drive change in LHDs/SHNs, including for Aboriginal people; providing tools to support redesign—like the Patient Flow Portal, Electronic Journey Boards and the Medical Engagement Scale tool—through the program website; including indicators of timely care in Service Agreements between the MoH and LHDs/SHNs, like Aboriginal elective surgery patients treated on time; establishing inter-agency partnerships to share lessons learned and support scaling up of effective interventions; and delivering training to develop local capability, like master classes in readmissions management for Aboriginal people.

HealthOne NSW

HealthOne NSW aims to create a stronger and more efficient primary healthcare system in NSW by bringing federally-funded general practice and state-funded primary and community health services together. In the model, general practices co-locate or virtually integrate with community and allied health centres to create 'one-stop shops'. The core elements of HealthOne NSW services are: integrated and patient-centred care; multidisciplinary care provided across a spectrum, from prevention to ongoing condition management; data sharing among clinicians; and community involvement in service planning.

Guidelines are in place to support LHDs and their partners to establish HealthOne services. There are currently 25 HealthOne NSW services in 11 LHDs in NSW. Several of these services are focused on providing culturally safe, seamless and comprehensive primary care to Aboriginal people, by embedding the role of AHWs and establishing links with ACCHSs and Aboriginal-specific services like the NSW Aboriginal Maternal and Infant Health Service.

NSW clinical networks and the Centre for Healthcare Redesign

The NSW Agency for Clinical Innovation has established 39 clinical networks, taskforces and institutes in health areas such as respiratory care, pain management, diabetes care, alcohol and other drugs misuse, paediatrics and palliative care. These groups include consumers, health managers and administrators, non-government partners and clinicians and provide a forum to: discuss healthcare innovations; share knowledge and experiences to improve healthcare; collaborate across service boundaries; and work with others to develop initiatives designed to improve the delivery and patient experiences of care.

Some of these groups focus on improving Aboriginal health. For example, the Aboriginal Chronic Conditions Network supports evidence-based reform and healthcare integration by identifying and enabling broad uptake of effective initiatives, frameworks and models of care. Some initiatives of the Network include: establishing the Chronic Care for Aboriginal People Model of Care; delivering the 1 Deadly Step program, which aims to improve the management of chronic disease in Aboriginal people through community-based screening and follow up; and delivering the 2017 Innovations in Aboriginal Chronic Conditions Forum. Further, the Cardiac Network has a focus on improving Aboriginal cardiac health and supports the implementation of the Better Cardiac Care program in NSW, which aims to reduce sickness and death caused by cardiac conditions in Aboriginal people by increasing access to services and improving risk factor management and care coordination.

The Centre for Healthcare Redesign aims to build the capability of NSW Health staff to redesign and improve healthcare delivery across all aspects of the patient journey. The Centre has three functions: providing training in redesign, accelerated implementation method and project management; supporting a state-wide network of redesign and innovation leaders; and supporting redesign projects in LHDs/SHNs. Several of these projects aim to ensure that services meet the needs of Aboriginal people, like the Sugar S.N.A.P Supporting the Needs of Aboriginal People project, a multi-organisation project designed to improve diabetes care in Aboriginal people. Redesign project summaries are on the Innovation Exchange website, a space for sharing local innovations and resources.

Service Agreements

Service Agreements between the MoH and NSW Health services provide a mechanism for monitoring and managing the performance of LHDs and SHNs against various indirect indicators of integrated care, including three indicators that are specifically monitored among Aboriginal patients: unplanned hospital readmissions; unplanned and emergency re-presentations to the same emergency department; and elective surgery patients treated on time. Unplanned mental health readmissions are also monitored, although without a specific focus on Aboriginal patients. An objective of these Agreements is to develop effective partnerships with ACCHSs and ensure the health needs of Aboriginal people are considered in all health plans and programs developed by LHDs and SHNs.

Summary of initiatives implemented across NSW Health

The document review and survey of NSW Health organisations identified a large number (n=120) of initiatives aiming to ensure integrated planning and service delivery for Aboriginal people (see the Appendix for a complete list of initiatives). Table 3 describes a selection of current or recent initiatives.

The MoH has established several frameworks that support the delivery of high quality, integrated and continuous care to Aboriginal people in NSW, like the *NSW State Health Plan: Towards 2021*; the *NSW Cancer Plan 2016–2020*; and the *NSW Hepatitis C Strategy 2014–2020*. Further, some LHDs have established integrated care plans or health service plans that focus on providing integrated care to Aboriginal people.

Policies and guidelines aiming to ensure seamless patient care have also been developed. These include specific supports for Aboriginal people, like: the *Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals* manual; the *Transfer of Care from Mental Health Inpatient Services* policy; and the *Guide to the Role Delineation of Clinical Services*.

Many initiatives being implemented aim to improve the coordination of primary, secondary and tertiary care for Aboriginal people with a chronic condition, like the Leading Better Value Care program, the Aboriginal Transfer of Care project, and the NSW Ambulance and ACCHSs Collaborative Referral program. Some of these initiatives have been rigorously evaluated and are producing good outcomes, like the 48 Hour Follow Up program (see Table 3 and Appendix).

Given the over-representation of Aboriginal people in custody, the Justice Health and Forensic Mental Health Network is implementing programs to provide joined up, holistic care for Aboriginal people who come in and out of contact with the criminal justice system, like the Community Integration program and the Aboriginal Chronic Care program.

There are several examples of NSW Health organisations collaborating with ACCHSs in delivering care to Aboriginal people, like the Bila Muuji Tele Home Monitoring project, the Building Brighter Grins program, and the Mehi Integrated Care program. Further, most LHDs provide outreach services in Aboriginal communities collaboratively with ACCHSs. Examples of outreach services provided include: dental clinics; specialist drug and alcohol services; diabetes care; renal clinics; mental health services; ear, nose and throat services; cardiology services; and paediatric healthcare.

LHDs have co-located services to provide seamless care for Aboriginal people. Some examples include the Gadhu Family Health Centre, the Bungee Bidgel Aboriginal Health Clinic, Bugalwena Aboriginal Health Service and the Nunyara Aboriginal Health Clinic.

Through the Bilateral Agreement, the MoH is collaborating with the Australian Government Department of Health to support joint planning and service delivery and reduce avoidable demand for health services. NSW Health is influencing the social determinants of Aboriginal health through various inter-sectoral initiatives. Focus areas include: preventing disease associated with poor housing; building cohesive and resilient communities; improving child safety and development; supporting access to essential social services; and increasing employment opportunities.

TABLE 3. EXAMPLES OF KEY INITIATIVES ALIGNING WITH STRATEGIC DIRECTION 3: ENSURING INTEGRATED PLANNING AND SERVICE DELIVERY*

	Program name	Program description	Lead agency(ies)	Scale and outcomes
Integrated care plans, policies and agreements				
1	State-wide strategies in health priority areas	NSW Health has strategies for specific health priority areas that have a focus on providing integrated care to Aboriginal people, like the *NSW Cancer Plan 2016–2020* and the *NSW Hepatitis C Strategy 2014–2020*. Improving Aboriginal health is a priority in whole-of-system strategies like the *NSW State Health Plan: Towards 2021* and in operational plans of State health organisations like the Agency for Clinical Innovation and NSW Ministry of Health.	Various NSW Health organisations	State-wide implementation. Strategic frameworks encouraging and guiding efforts to improve service delivery for Aboriginal people in NSW.
2	LHD integrated care plans	Most LHDs have established integrated care plans or healthcare service plans—and associated programs of work—that focus on providing seamless and high quality care for Aboriginal people. These plans were typically developed with ACCHSs. For example, the *Northern NSW LHD Integrated Aboriginal Health and Wellbeing Plan 2015–2020* aims to improve Aboriginal health through collaborative service planning and delivery within the district and across multiple organisations. It is underpinned by partnerships with Aboriginal communities and ACCHSs.	Various LHDs	Implemented in multiple LHDs. Service redesign and integrated care initiatives being implemented in multiple LHDs.
3	*Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals* policy directive and manual	Policy directive aims to support patient flow systems in acute services in NSW public hospitals. It outlines five mandated steps in coordinating patient care: pre-admission/admission; multidisciplinary team review and care; preparing for discharge; referrals and liaison; and care transfer. A manual has been developed to support its implementation and provide guidance on the coordination of care for Aboriginal people. The policy directive and manual require a patient discharge summary be sent to a primary care provider within two days of hospital discharge.	MoH	State-wide implementation.
4	*Transfer of Care from Mental Health Inpatient Services* policy directive	Promotes safe and effective transition of all mental health clients between inpatient treatment settings, and from the hospital to the community. Outlines specific requirements for Aboriginal patients when planning for transfer of care, including that staff liaise with specialist Aboriginal health staff, like Aboriginal Health Workers (AHWs), to ensure that transfer of care planning starts early and is consistent with the needs of the patient and local community.	MoH	State-wide implementation.
5	*Guide to the Role Delineation of Clinical Services* (2016)	Planning tool used by LHDs and SHNs in health service and capital developments. Describes the minimum support services, workforce and other requirements for the safe delivery of clinical services. Three service models for Aboriginal health are described, which recommend strong referral pathways and joint service planning and delivery with a range of partners, including ACCHSs.	MoH	State-wide implementation.
6	Bilateral Agreement	Aims to improve patient health outcomes, the delivery of care for people with or at risk of chronic and complex conditions, and reduce avoidable demand for health services. Focuses on: data collection and analysis; information integration; care coordination services; multidisciplinary team care; palliative and end of life care; age-related issues; rural and remote services and mental health.	Australian Government Department of Health/MoH	State-wide implementation. Project plans have been drafted, and include a focus on Aboriginal health.

* In identifying activities for inclusion in this table, large-scale initiatives were prioritised over programs of smaller scale, as the former have greater potential to influence population health. A few small-scale innovations *with good potential for scaling up* are also included. Initiatives in this table are informed by evidence.

Coordination of primary, secondary and tertiary healthcare				
7	Leading Better Value Care	Aims to improve patient outcomes, patient and staff experiences of care provision, and the efficiency and effectiveness of care. A main focus is measuring success based on value rather than volume. Eight clinical initiatives are being implemented across NSW Health, including the introduction of a new model of care for Diabetes High Risk Foot Services. Under the program, St Vincent's Health Network is establishing a new targeted Aboriginal position in podiatry and exploring the feasibility of providing services via telehealth to ACCHSs in rural areas.	MoH/Agency for Clinical Innovation/LHDs	State-wide implementation. Evaluation is being built into all clinical initiatives under the program.
8	Aboriginal Transfer of Care Project	Aims to reduce unplanned hospital readmissions within 28 days. Ensures that Aboriginal people have transfer and follow up plans confirmed before discharge or transfer from hospital. Delivers intensive case management, person-centred care coordination and multidisciplinary follow up for Aboriginal people preparing for transfer of care from Campbelltown or Camden hospitals to a community health service.	South Western Sydney LHD	Implemented in South Western Sydney LHD. Contributed to 66 fewer unplanned hospital readmissions in Aboriginal patients in 2016-17 compared to the previous financial year.
9	NSW Ambulance and ACCHS Collaborative Referral Program	Aims to improve engagement with primary healthcare providers among Aboriginal people who use the NSW Ambulance Service for an unplanned health problem. Establishing referral mechanisms between Ambulance paramedics and ACCHSs and sharing of patient information are the main program components.	NSW Ambulance/ ACCHSs	Implemented in multiple LHDs. Statement of collaboration has been signed with one ACCHS. Engagement with other ACCHSs is underway.
10	NSW Aboriginal Ear Health Program	Aims to prevent otitis media in Aboriginal children in NSW. Includes health promotion, screening and early intervention strategies, and emphasises integration of health and other social services. Delivered in public maternity and child and family health services, ACCHSs and other non-government organisations. Guidelines have been established to support its implementation.	MoH	State-wide implementation.
11	48 Hour Follow Up Program	Aims to improve the health of Aboriginal patients with a chronic disease by providing telephone follow up within two days of hospital discharge. The follow-up involves coordination across care teams and supports: adherence to medications; engagement with primary care following hospital discharge; and patient wellbeing.	MoH	State-wide implementation. Exposed patients had significantly lower rates of adverse events post-discharge from hospital than unexposed patients.
12	Community Integration Team	Assists young people with significant mental health and/or drug and alcohol problems to access health services in the community upon release from custody. Addresses access to services by: developing release care plans; providing referrals to local health and support services; and helping clients attend health appointments. Provides care pathways for young Aboriginal people through ongoing collaborative partnerships with ACCHSs and LHDs. About 60% of participants identify as Aboriginal.	JH&FMHN/ Juvenile Justice	State-wide implementation. Number of participants increased from 479 in 2013-14 to 569 in 2015-16. Outcomes have improved for recidivism and several health measures, including completion of care plans.
Joint LHD and ACCHS service delivery				
13	Aboriginal Chronic Care Program: Murr-roo-ma Dhun-barn ('To Make Strong') Program	Aims to prevent and manage chronic conditions in Aboriginal people who come into contact with the criminal justice system in NSW. Services provided include: routine screening and follow up; referral to a Care Navigation Support Program for follow up (while in custody); and patient education and self-management support. Provided in partnership with ACCHSs. Care team consists of nurses and AHWs from ACCHSs.	JH&FMHN	Currently operational in 16 correctional facilities (15 adult and 1 juvenile) in NSW. In 2016-17 there were 1,262 patients who accessed the program.
14	Bila Muuji Tele Home Monitoring Project	Aims to test the acceptability and utility of tele home monitoring (the management of chronic conditions from a distance using information and medical technologies) among staff and patients of ACCHSs in the Bila Muuji alliance. Forms part of a broader trial of the approach in four LHDs in NSW.	Western NSW LHD/ACCHSs	Implemented in Western NSW LHD. In 16 months, 48 patients were enrolled and 89% indicated that they would recommend the approach to others.

15	Building Brighter Grins Program	School-based dental program for children attending Mid North Coast LHD primary schools that have a high Aboriginal population. Consists of an oral health education session delivered by an Aboriginal dental assistant. Dental assessments are then carried out at the school in a classroom, and when needed dental treatment is provided in a mobile van on school grounds. Durri ACCHS and Mid North Coast LHD implement the program jointly, and operate in partnership with the Dunghutti elders who identified a program need.	Mid North Coast LHD/ACCHSs	Implemented in three primary schools in Mid North Coast LHD. Oral health services have incorporated the program into their core business.
16	Mehi Integrated Care Program	Provides antenatal outreach care in isolated rural communities and is particularly aimed at Aboriginal women. Provides patient-centred care in country, allowing patients to stay close to home, family and community. Enables timely referrals to specialist antenatal services and is delivered collaboratively with ACCHSs.	Hunter New England LHD	Implemented in two rural communities in Hunter New England LHD.
17	South Western Sydney LHD specialist and allied health outreach model with ACCHSs	Aims to improve Aboriginal peoples' access to specialist and allied health services by providing integrated outreach clinical services in ACCHSs. Referral pathways have been established between ACCHSs and district services to facilitate ongoing care. Examples of outreach services provided include: cardiology, endocrinology, gastroenterology, paediatrics, mental health, drug health and speech pathology.	South Western Sydney LHD	Implemented in South Western Sydney LHD. A multidisciplinary model of paediatric care and an ear disease surgery pathway have been established.
18	Outreach care	Most LHDs provide outreach health services in Aboriginal communities collaboratively with ACCHSs. Examples of the types of care provided include: dental care; specialist drug and alcohol services; diabetes care; renal care; cancer management; ear, nose and throat services; cardiology services; and paediatric care.	Various LHDs	Implemented in multiple LHDs.
Co-located services				
19	Aboriginal-specific health clinics	Several LHDs have co-located services to provide seamless care for Aboriginal people. For example, the Gadhu Family Health Centre in Southern NSW LHD provides Aboriginal-specific antenatal, postnatal and early childhood healthcare in one location. The Bungee Bidgel Aboriginal Health Clinic in Northern Sydney LHD provides screening and ongoing care for a raft of health problems like ear, eye and dental disease and other chronic diseases. The Nunyara Aboriginal Health Clinic in Central Coast LHD provides chronic care, hospital liaison and maternity and child health services in a one-stop-shop in Gosford Hospital. Another example is the Bugalwena Aboriginal Health Service in Northern NSW LHD.	Various LHDs	Implemented in multiple LHDs.
Inter-sectoral collaborations				
20	Connected Communities Strategy	Aims to improve the educational and social outcomes of Aboriginal children in 15 schools located in complex and vulnerable communities in NSW. Positions schools as community hubs that deliver services to students that support their educational, health and wellbeing needs. Schools facilitate local agreements and partnerships with a range of agencies including health, police, and family and community services. NSW Health organisations are engaged in coordinating and delivering health services in participating schools.	MoH/LHDs/ NSW Department of Education	Implemented in 11 communities in NSW. Partnerships have been established with local health services to ensure every student has a health and dental check. A key program is the wound clinic at Bourke Public School.
21	Building Community Resilience in Bowraville (Solution Brokerage)	Aims to provide targeted, integrated approaches to improving economic and social outcomes in Aboriginal communities. Brings together relevant Government agencies and non-Government providers and community leaders to address issues adversely impacting the resilience, cohesion, healing, social harmony and quality of life in residents of Bowraville. Mid North Coast LHD and the NSW Ministry of Health have led service mapping, improved communication with the community, and supported co-ordination of services and programs.	Mid North Coast LHD/MoH	Implemented in Bowraville, Mid North Coast LHD. Has increased mental health, drug and alcohol, and child and family services and ensured existing buildings are fit for purpose and new premises are available for health service delivery.

22	Local Decision Making	NSW Health is supporting Local Decision Making in NSW, which puts Aboriginal people at the centre of service design, planning and delivery, enabling the devolution of decision making and accountability to the local level.	Aboriginal Affairs/ NSW Health	NSW Health is partaking in negotiations of Accords between regional alliances and the NSW Government.
23	Aboriginal Housing and Accommodation Support Initiative	Provides stable housing and support services (e.g. clinical care and rehabilitation) for Aboriginal people with a mental illness living in the community. Delivered collaboratively by NSW Health, Housing NSW and non-government agencies. Sites establish Aboriginal cultural reference groups to guide implementation.	NSW Health/ Housing NSW/ NGOs	Implemented across multiple LHDs.
24	Housing for Health Program	Maintains homes, including essential health hardware, in Aboriginal communities. Repairs and modifications involve fixing leaking toilets, electrical repairs, ensuring sufficient hot water, and establishing child bathing areas. This can lead to improved tenant health and reduce the risk of disease and injury. Health Protection NSW and LHDs partner with local Aboriginal Land Councils and Aboriginal Housing Corporations to deliver the program.	Health Protection NSW/ LHDs/Aboriginal Lands Councils	State-wide implementation. In 1997–2017, the program maintained 3,980 houses. People living in houses that received the program were 40% less likely to be admitted to hospital for an infectious disease(s).
25	Nambucca Area Aboriginal Integrated Care Committee	Forum for health and social care providers that aims to provide integrated care for Aboriginal clients with complex health and social problems. Meetings occur once a month, where the group discusses vulnerable Aboriginal clients, identifies duplication and gaps in care provision, and develops strategies to address clients' needs. There is a plan to roll the program out to other Mid North Coast LHD locations over the next year.	Mid North Coast LHD	Implemented in Nambucca, Mid North Coast LHD. Developed a client-held record that lists the services involved in the client's care, which supports seamless and timely care.
26	Isolated Patients Travel and Accommodation Assistance Scheme	Provides money for travel and accommodation costs to eligible patients who need to travel long distances for specialist treatment that is not available locally. Recognises that some Aboriginal patients find it difficult to use the program and allows an Aboriginal health organisation to receive program payments for providing patient transport to eligible patients. Local administrators must ensure that Aboriginal people have the same level of access to the program as the general population. Aboriginal patients can have a support person with them during travel.	MoH/LHDs	State-wide implementation. Improved access to specialist services for Aboriginal patients in rural and remote areas of NSW, where Aboriginal people make up a higher proportion of the population compared to metropolitan areas.
27	Joint Investigation Response Team Program	Coordinates interagency responses to serious child abuse reports which may involve criminality. Agencies work collaboratively to enable timely exchange of information and planned and coordinated responses. Addressing the unique barriers to identifying and responding to abuse in Aboriginal children is embedded in implementation.	NSW Health/ FACS/NSW Police Force	State-wide implementation.

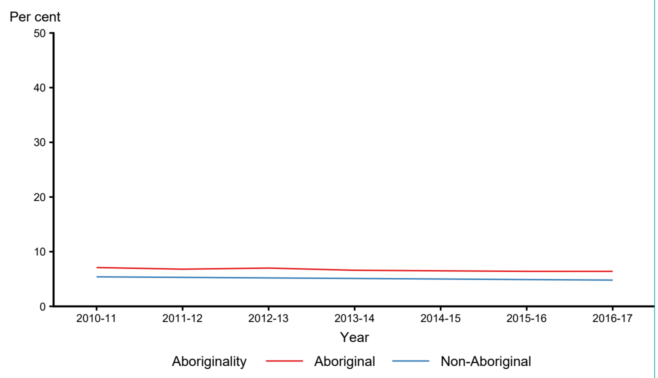
3.3.2 PROGRESS INDICATORS

Unplanned emergency department re-presentations

An unplanned emergency department (ED) re-presentation is when a patient returns to the same ED within 48 hours, and the second presentation is unplanned. It provides an indication of the effectiveness of ED care and the adequacy of primary healthcare follow-up of patients after attending an ED.

In NSW between 2010–11 and 2016–17, the rate of unplanned ED re-presentations in Aboriginal people was stable at 6–7%. During the same period, the rate of unplanned ED re-presentations in non-Aboriginal people was also stable (~5%). The gap in rates of unplanned ED re-presentations between Aboriginal and non-Aboriginal people has not changed since 2010–11 (Figure 8).

FIGURE 8. Unplanned emergency department re-presentations by Aboriginal status of the patient, NSW 2010–11 to 2016–17



Source: NSW Emergency Department Data Collection (EDDC). System Information and Analytics, NSW Ministry of Health.
Notes: An unplanned emergency department re-presentation is when a patient returns to the same emergency department within 48 hours, and the second presentation is unplanned. The number of hospitals reporting to the EDDC varies over time and is more complete for recent years.

CASE STUDY

HEALTHY HOMES AND NEIGHBOURHOODS

Healthy Homes and Neighbourhoods (HHAN) is a cross agency initiative for families where the parents/carers have complex health and social care needs. Many of these families experience barriers to accessing health and social care, and their complex health and social needs influence their capacity to parent effectively or participate fully in their community. HHAN aims to break intergenerational cycles of disadvantage and psychological trauma through an integrated, whole-of-family, holistic, and place-based approach to service delivery.

Commencing in 2015, HHAN is led by the Sydney LHD, and is governed by a multi-agency steering committee with representation from both government and non-government health and social care services. A spatial epidemiology approach is used to identify the areas with the most heightened levels of social disadvantage; HHAN co-locates in some of these areas, such as the RedLink Integrated services hub located in Redfern's McKell Building. The majority of the families that HHAN work with from this hub are Aboriginal.

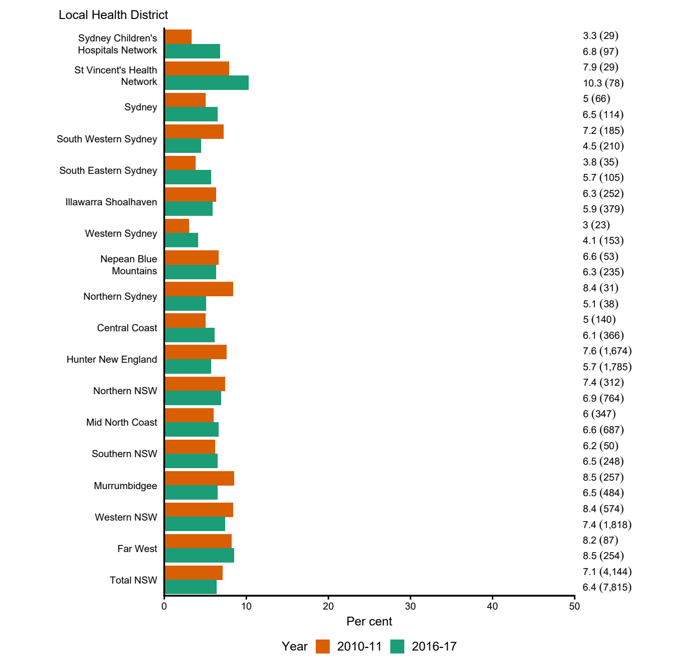
Families come into contact with the HHAN initiative through a collaborative referral approach between local health and community services, partner agencies, and schools. Upon referral, families are connected to multiple core and non-core agencies and relevant health professionals, such as Aboriginal Medical Services, SDN Children's Services, local general practitioners, and Child and Family Health Services. Using a family-centred and wrap-around care approach, the multi-agency team works in partnership together and with families over a sustained period of time to meet the family's health and social needs, and increase the family's capacity to independently manage their health and social care needs.

HHAN is leading the development of child-at-risk and adult-at-risk-pathways on the Sydney HealthPathways platform and leading multi-agency capacity building activities focusing on collaboration, trauma informed care and strengths-based assessments which will ensure the needs of Aboriginal families are appropriately addressed.

Over 400 individuals have received HHAN care coordination, and about 31% of these individuals are Aboriginal.

Between 2010–11 and 2016–17, the change in the rate of unplanned ED re-presentations in Aboriginal people varied between LHDs/SHNs (Figure 9). Since 2010–11, such incidents in Aboriginal people decreased by 3.3 percentage points in Northern Sydney LHD, while they increased by 3.5 percentage points in Sydney Children's Hospitals Network. However, these changes should be interpreted with care, as they are based on small counts.

FIGURE 9. Unplanned emergency department re-presentations in Aboriginal patients by local health district/specialty health network, NSW 2010–11 and 2016–17



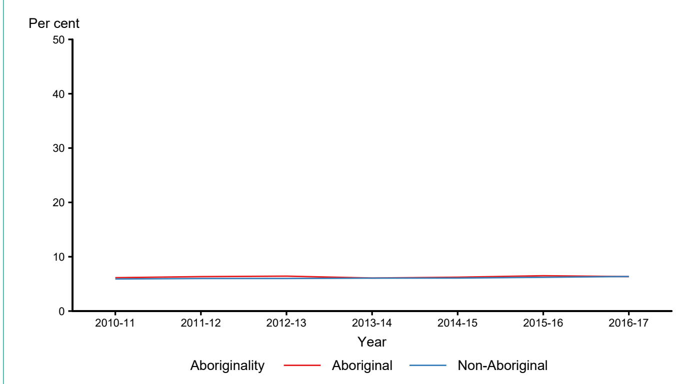
Source: NSW Emergency Department Data Collection (EDDC). System Information and Analytics, NSW Ministry of Health.
Notes: An unplanned emergency department re-presentation is when a patient returns to the same emergency department within 48 hours, and the second presentation is unplanned. The number in brackets ( ) is the numerator. The number of hospitals reporting to the EDDC varies over time and is more complete for recent years.

Unplanned hospital readmissions

An unplanned hospital readmission is when a patient is readmitted to the same facility within 28 days of discharge from the first admission, and the second admission is unplanned. It is an indicator of the quality and continuity of healthcare provided to patients while in hospital and in the weeks following discharge.

In NSW between 2010–11 and 2016–17, the rate of unplanned hospital readmissions was stable in both Aboriginal people and non-Aboriginal people (6%), with no gap in rates observed (Figure 10).

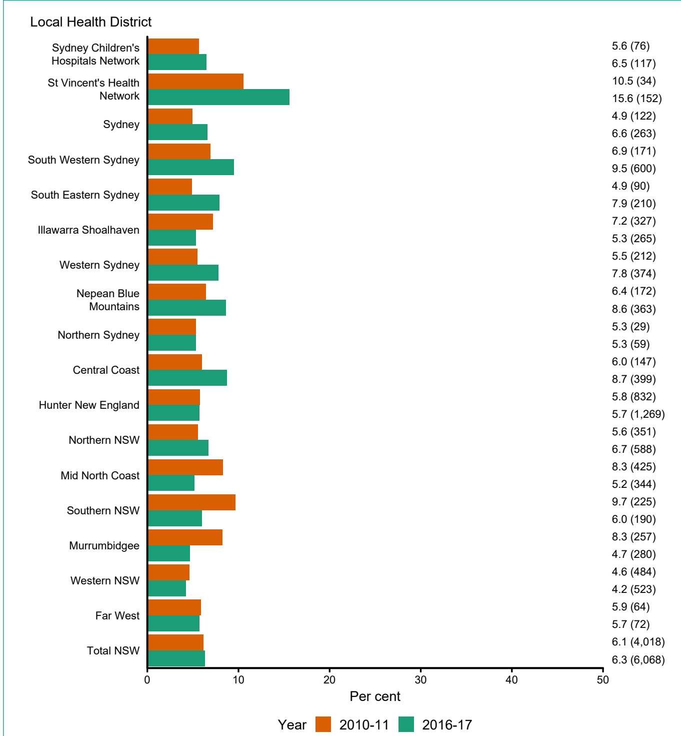
FIGURE 10. Unplanned hospital readmissions by Aboriginal status of the patient, NSW 2010–11 to 2016–17



Source: NSW Admitted Patient Data Collection (HIE). System Information and Analytics, NSW Ministry of Health.
Notes: An unplanned hospital readmission is when a patient is readmitted to the same facility within 28 days of discharge from the first admission, and the second admission is unplanned.

Between 2010–11 and 2016–17, the change in the rate of unplanned hospital readmissions in Aboriginal people varied between LHDs/SHNs (Figure 11). Such incidents in Aboriginal people decreased by three percentage points or more in Southern NSW LHD, Murrumbidgee LHD and Mid North Coast LHD, while they increased by three percentage points or more in St Vincent's Health Network and South Eastern Sydney LHD. However, the increase in St Vincent's Health Network should be interpreted with care, as the baseline rate is based on small counts.

FIGURE 11. Unplanned hospital readmissions in Aboriginal patients by local health district/specialty health network, NSW 2010–11 and 2016–17



Source: NSW Admitted Patient Data Collection (HIE). System Information and Analytics, NSW Ministry of Health.
Notes: An unplanned hospital readmission is when a patient is readmitted to the same facility within 28 days of discharge from the first admission, and the second admission is unplanned. The number in brackets ( ) is the numerator.

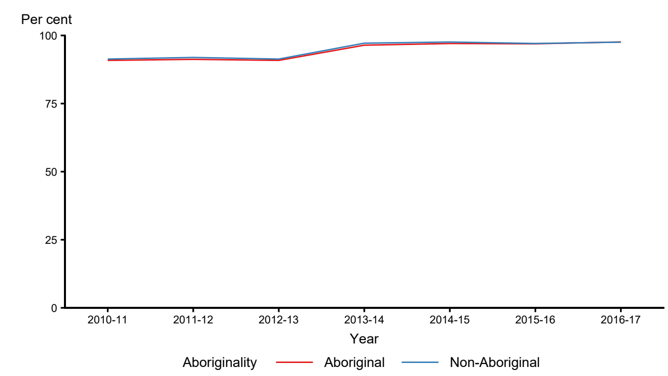
Elective surgery patients treated on time

Elective surgery is an inpatient procedure that, in the opinion of the treating clinician, is necessary but can be delayed for at least 24 hours. NSW Health patients are placed on a waiting list and given a clinical priority depending on the seriousness of their condition. Clinical priority categories are: category 1 (admission within 30 days desirable); category 2 (admission within 90 days desirable); category 3 (admission within 365 days acceptable); and category 4 (either not ready for care for clinical reasons (staged) or not ready for care for personal reasons (deferred)).

The proportion of elective surgery patients who were treated on time (based on the clinical priority category assigned) is an indicator of the effectiveness of waiting list management and coordination of care within and across primary, secondary and tertiary care providers.

In NSW between 2010–11 and 2016–17, the proportion of elective surgery patients who were treated on time increased from ~91% to ~98% in both Aboriginal and non-Aboriginal patients (Figure 12).

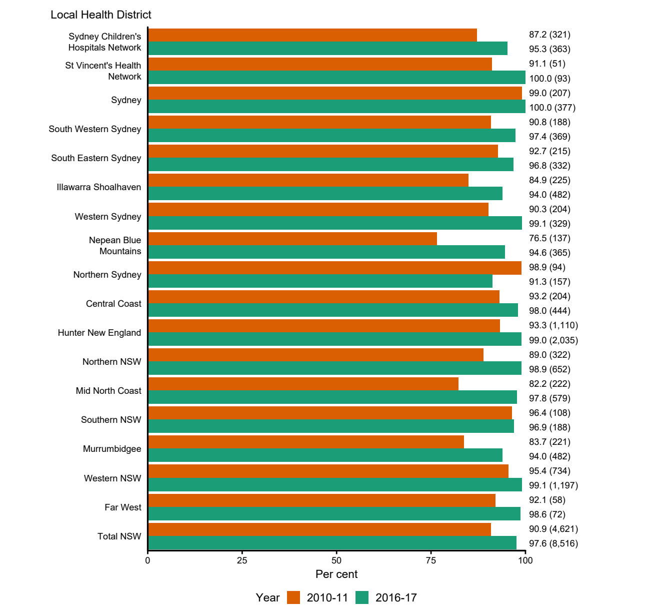
FIGURE 12. Elective surgery patients treated on time by Aboriginal status of the patient, NSW 2010–11 to 2016–17



Source: NSW Waiting List Collection On-Line System (via EDWARD). System Information and Analytics, NSW Ministry of Health.
Notes: Elective surgery is an inpatient procedure that, in the opinion of the treating clinician, is necessary but can be delayed for at least 24 hours. Clinical priority categories 1, 2, and 3 have been combined.

Between 2010–11 and 2016–17, the proportion of Aboriginal elective surgery patients who were treated on time increased in 16 of 17 LHDs/SHNs, although the size of the change varied between LHDs/SHNs (Figure 13).

FIGURE 13. Aboriginal elective surgery patients treated on time by local health district/specialty health network, NSW 2010–11 and 2016–17

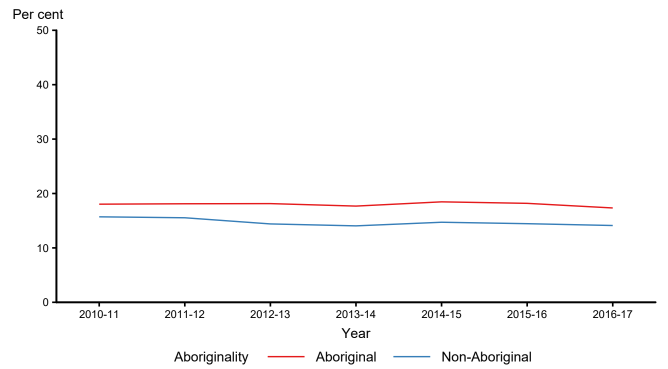


Source: NSW Waiting List Collection On-Line System (via EDWARD). System Information and Analytics, NSW Ministry of Health.
Notes: Elective surgery is an inpatient procedure that, in the opinion of the treating clinician, is necessary but can be delayed for at least 24 hours. Clinical priority categories 1, 2, and 3 have been combined. The number in brackets ( ) is the numerator.

Unplanned mental health readmissions

An unplanned mental health readmission is when a patient is readmitted to the same or another public acute mental health unit within 28 days of discharge from the first admission, and the second admission is unplanned. It provides information on the effectiveness of inpatient care and the adequacy of primary healthcare follow-up post hospital discharge.

FIGURE 14. Unplanned mental health readmissions by Aboriginal status of the patient, NSW 2010–11 to 2016–17



Source: NSW Admitted Patient Data Collection. System Information and Analytics, NSW Ministry of Health.
Notes: An unplanned mental health readmission is when a patient is readmitted to the same or another public acute mental health unit within 28 days of discharge from the first admission, and the second admission is unplanned.

In NSW between 2010–11 and 2016–17, the rate of unplanned mental health readmissions in Aboriginal people was stable at 17–18%. During the same period, the rate of unplanned mental health readmissions in non-Aboriginal people decreased slightly, from 15.7% to 14.1%. Since 2011, the gap in rates of unplanned mental health readmissions between Aboriginal and non-Aboriginal people increased slightly (Figure 14).

3.3.3 STAKEHOLDER FEEDBACK

Views of NSW Health staff

NSW Health staff considered effective partnerships between health agencies and healthcare providers fundamental to providing coordinated and integrated care to Aboriginal patients. They also highlighted common barriers to providing continuous care to this patient cohort, including inadequate:

- sharing of information between LHDs and ACCHSs
- engagement of non-NSW Health organisations in coordinating integrated healthcare initiatives
- staff visibility and senior executive prioritisation of clinical redesign
- accountability mechanisms, particularly in ensuring that Aboriginal organisations and communities are engaged in project design and implementation.

Regarding the last point, Directors and Managers of Aboriginal Health in LHDs described several ways in which they engaged ACCHSs when planning and implementing models of care, including through partnership agreements, executive meetings, Local Decision Making groups, consortiums, elders groups and community forums. One interviewee mentioned that, in their LHD, Aboriginal communities provided input into Aboriginal health priorities through a series of community forums:

"Our community partnership agreement stipulates there has to be regular community forums. We've had a couple of these where we had about 35 community members attend. They identify priorities which we take on board. So the top 5 priorities of our plan are those chosen by the community." (LHD 6)

Views of the Aboriginal community-controlled health sector

Section 3.1.2 of this report describes factors that Aboriginal community-controlled health sector staff felt influenced the quality of their partnerships with

CASE STUDY

HOUSING FOR HEALTH

Social factors like income, employment status, educational attainment and housing are associated with inequities in health. Housing for Health (HfH) is an evidence-based program that aims to assess, repair or replace health hardware (e.g. leaking toilets, adequate hot water, and facilities for bathing children) so that houses are safe and occupants have the ability to carry out healthy living practices (such as washing people, clothes and bedding; improving nutrition; reducing overcrowding; and reducing the impact of animals, vermin or dust).

NSW Health partners with Local Aboriginal Land Councils and Aboriginal Housing Corporations to deliver HfH in Aboriginal communities in NSW. Partnerships occur between the: Aboriginal Environmental Health Unit; housing provider(s); local Public Health Unit; and the HfH Project Manager. The HfH process consists of seven stages, of which community consultation, consent and reporting are key components. The housing provider and/or Land Council are generally the first points of contact within the community, however, the project manager relies on the advice and relationships between the local Public Health Unit and the community to identify the appropriate 'community representatives' to speak with. Community or tenant meetings are scheduled and the project teams (which include local community members trained in the survey) visit each eligible house within the community to gain consent for the surveys and planned repair work. Wherever possible, the program uses local companies and tradespeople to carry out the work.

The HfH program provides a platform for Public Health Units to expand their work with Aboriginal communities, providing opportunities to explore and develop environmental health-focused projects in partnership with the communities and, where appropriate, form gateways for other service providers (e.g. local government, RSPCA) to work with communities on health issues.

A HfH review found that those who received HfH had a significantly reduced rate of hospital separations (40% less) for infectious diseases than those who did not. The HfH principles have been adopted by the National Framework for Design, Construction and Maintenance of Indigenous Housing and the National Indigenous Housing Guide.

Between 1997 and 2017, NSW Health delivered 124 HfH projects with communities, surveying 3,980 houses, fixing over 104,000 items related to improving safety and health, and benefiting over 16,600 people.

NSW Health. All of these factors apply in the context of integrating and improving coordination of healthcare for Aboriginal people—for example, ACCHSs interviewees highlighted the importance of both parties being flexible in reaching shared priorities.

Additionally, some interviewees felt that hospital discharge planning for Aboriginal patients was sub-optimal in some areas, which in turn would mean that some patients were not followed up effectively post discharge:

"The LHD does not do discharge planning … the hospital staff have advised us 'we don't do those'. Unless our clients tell us that they have been to hospital, we have no idea." (ACCHS 5)

Interviewees described factors that they perceived impeded effective hospital discharge planning for Aboriginal patients, including that in some hospitals:

- there was no clear system in place for providing discharge summaries to ACCHSs
- staff did not understand the role of ACCHSs in providing comprehensive primary healthcare to Aboriginal people and therefore did not provide a discharge summary
- staff would ask patients to nominate a regular general practitioner, which interviewees felt was problematic because they perceived that many of their clients see multiple general practitioners in their service.

Conversely, interviewees provided examples of discharge planning working well in some areas, which they attributed to regular case conferencing between NSW Health staff and ACCHS staff and effective 'coordination of care' systems; Orion was highlighted as an effective system that allows general practitioners to access their clients discharge summaries, to create an electronic shared care plan, and to share the plan with other relevant providers.

Some interviewees felt there was a need to improve the coordination of care for Aboriginal people more broadly—that is, not just for people who are leaving hospital—especially among those with complex care needs:

"There is room for improvement in the way that complex clients are managed with the LHD. In particular, in getting patients from detox into rehab and managing clients in mental health crisis. It should be all about working together for what is best for the patient. We need all staff to know what is happening." (ACCHS 9)

Contrastingly, a few interviewees reported that LHDs and ACCHSs worked effectively in coordinating the care of Aboriginal people, especially if there was a good relationship with the Aboriginal Hospital Liaison Officer:

"There is a good partnership that supports case conferencing of mental health clients at our service. This includes psychologists, psychiatrists, Mental Health Workers and Social Workers at the local hospital who are involved in discharge planning … The discharge summaries are sent to the Nurse Practitioner at our service … Our service has a great relationship with the Aboriginal Hospital Liaison Officers." (ACCHS 4)

3.3.4 SUMMARY AND IMPLICATIONS

NSW Health is implementing whole-of-system initiatives aiming to improve healthcare integration. These initiatives focus, to varying degrees, on improving the health and healthcare experiences of Aboriginal people, however, this focus could be enhanced.

NSW Health is supporting clinical redesign projects and enabling the diffusion of effective innovations in various ways, including by: establishing dedicated integrated care support teams, champions, websites and clearinghouses; providing staff training; and forming clinical and professional networks and interagency partnerships. Some of the clinical networks that are supported by the NSW Agency for Clinical Innovation, such as the Cardiac Network, have established an Aboriginal health program of work. There is scope for more clinical networks to do the same.

Service Agreements between the MoH and LHDs/SHNs include performance indicators that compel and support NSW Health services to improve the coordination and integration of healthcare for Aboriginal people, in collaboration with other organisations and providers. Broadening the range of indicators that include disaggregation by patient Aboriginal status could further elucidate the extent to which healthcare is continuous for Aboriginal patients, and could drive clinical innovation, quality and safety.

NSW Health has established policies and strategic frameworks that support the delivery of coordinated and integrated health services in NSW and that pay particular attention to improving the healthcare experiences and health outcomes of Aboriginal people. Correspondingly, NSW Health organisations are implementing many clinical redesign and integrated care projects targeting Aboriginal people. Some of these projects have been evaluated using robust methods and some are achieving good outcomes, however, others require better monitoring systems and well designed 'deep dive' investigations of outcomes. Patient-reported measures can be a useful data source for program monitoring and evaluation, especially if such measures investigate aspects of the healthcare experience that are disproportionately common among Aboriginal people, such as experiences of racism.

Almost all Aboriginal elective surgery patients are treated on time in NSW; the rate has steadily increased since 2010–11. Additionally, levels of unplanned hospital readmissions, emergency department re-presentations and mental health readmissions among Aboriginal people in NSW have been stable. Encouragingly, there is no gap in rates of unplanned hospital readmissions between Aboriginal and non-Aboriginal people. Overall, these trends suggest modest progress in providing coordinated and integrated care for Aboriginal people in NSW and that further work is required in this area, especially for Aboriginal people living with a mental illness.

ACCHSs reported a need for better collaboration between LHDs and their services in planning and delivering healthcare, especially in the context of supporting Aboriginal people who have complex care needs and/or are leaving hospital. Strengthening collaboration, communication and sharing of information between ACCHSs and LHDs would enable the delivery of timely, culturally safe and continuous healthcare to Aboriginal people.

The continuity of healthcare for Aboriginal people across settings and providers could be strengthened by enhancing collaboration and joint planning between the MoH and the Australian Government Department of Health.

Many of the factors that shape the health of the Aboriginal population—such as employment, education and family income levels—are outside the direct control of the health system. Nevertheless, NSW Health is influencing these social factors through various inter-sectoral and whole-of-government initiatives; there are opportunities to build on this work.

ASSESSMENT OF PROGRESS AGAINST KEY ACTIONS[†]

Based on the data presented in this report, progress against the key actions of Strategic Direction 3 of the *NSW Aboriginal Health Plan 2013–2023* is moderate:

1. *Improving the coordination and integration of programs and services across providers, governments and funding bodies*: Moderate progress.
2. *Ensuring the needs of Aboriginal communities are addressed in the strategic plans of state health organisations*: Moderate progress.
3. *Collaborating with ACCHSs in developing LHD healthcare plans to achieve a shared, coordinated and joined up approach to service delivery:* Moderate progress.
4. *Addressing the needs of Aboriginal communities through specific planning processes for priority health issues, in partnership with the AH&MRC:* Moderate progress.
5. *Ensuring that relevant NSW Health initiatives consider Aboriginal people a priority population and reflect the needs of Aboriginal communities:* Moderate progress.
6. *Strengthening the role of NSW Health in addressing the social determinants of Aboriginal health:* Moderate progress.

[†] Assessments are based on the investigators' appraisal of the evidence presented in this report with respect to the breadth and quality of relevant initiatives.