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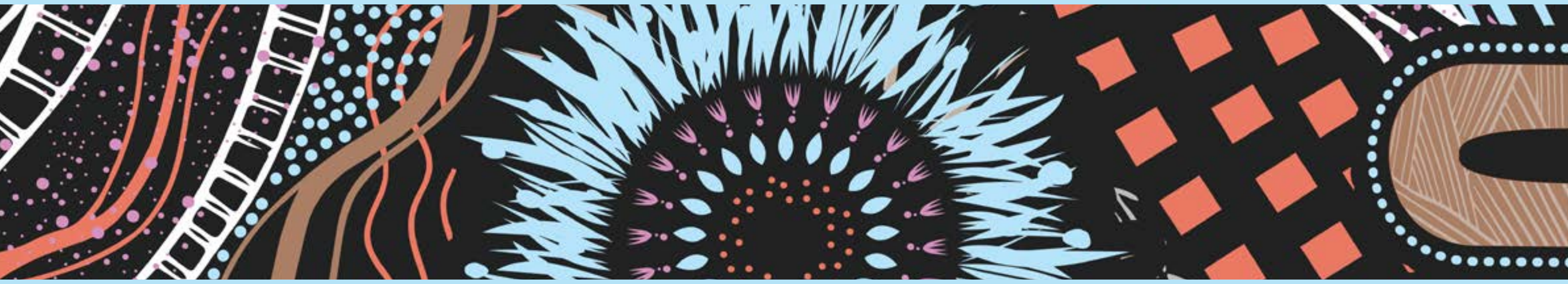

Patient experiences of integrated services for chronic disease and social and emotional wellbeing: a case study of the Integrated Team Care Program

Toni Manton, Cate Dingelstad, Holly Kovac, Merrick Powell, Kieran Sobels and Simon Jordan

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Caution: Some people may find the content in this report confronting or distressing.

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13YARN (13 92 76), Lifeline (13 11 14) or Beyond Blue (1300 22 4636).

The AIHW acknowledges the Aboriginal and Torres Strait Islander individuals, families and communities that are affected by suicide each year. If you or your community has been affected by suicide and need support, please contact **Thirrili's Postvention Suicide Support Service on 1800 805 801.**

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Summary

What we know

Chronic disease is the leading cause of premature death among First Nations communities. In these communities, there can be:

- inherent cultural safety considerations that are not addressed adequately in mainstream health-care services; and
- limited access to affordable and accessible ongoing chronic disease medical treatment.

Best practice chronic disease management requires a multidisciplinary approach – but building trust is imperative and takes a significant investment of time (Reynolds et al. 2018).

There are very few examples of evaluations of integrated programs that take a multidisciplinary approach to managing chronic health issues. This approach must be prioritised as First Nations communities carry multigenerational trauma that cannot be dismissed, and communities are still heavily impacted by the consequences of colonisation (Curtis et al. 2019).

What works

Evidence shows that management of chronic disease among First Nations people works best when First Nations people themselves are involved in designing and implementing models of care, and when both First Nations and non-Indigenous people work together. This paper describes an evaluation of the Integrated Team Care (ITC) Program that incorporates these principles into the development and delivery of chronic disease management, to enable improved outcomes for First Nations people participating in the program.

Evaluation of the Integrated Team Care (ITC) Program

The ITC Program, commissioned by the Hunter, New England and Central Coast (HNECC) Primary Health Network (PHN), has been providing services to First Nations communities in the Hunter, New England and Central Coast regions in New South Wales since 2015. This program works to contribute to improving health outcomes for First Nations people with chronic health conditions in two ways:

- Providing access to care coordination, multidisciplinary care, and support for self-management.
- Improving access to culturally appropriate mainstream primary care providers (including but not limited to general practice, allied health and specialists) for First Nations people.

The evaluation of the ITC Program details the benefits of First Nations-led design and delivery that promotes culturally safe and responsive approaches and practice. First Nations health programs are most sustainable and effective when they incorporate culturally strong components; include a range of healthy lifestyle activities within a holistic understanding of wellbeing; and emphasise cultural safety (AIHW 2023).

Several key factors are required for First Nations people to achieve positive and optimal health outcomes, including shared decision making and trauma-informed care.

Shared decision making

Shared decision making is a collaborative approach between clinician and patient that includes the patient in all treatment decisions that affect their health. This concept is particularly important to First Nations people, as cultural considerations include and involve community, family and kinship; culture; physical and spiritual connections; and lived experience. These considerations must be met to build rapport and trust so that the agreed treatment can be effective (ACI n.d.).

Trauma-informed health services

Trauma-informed health services play a crucial role in supporting the wellbeing of First Nations people in Australia. Trauma-informed care is the foundation that supports First Nations people in achieving positive health outcomes because understanding the person's story and being sensitive to their needs is vital when providing health-care services to First Nations people. Optimal health requires a whole-of-health service and system approach; trauma-informed care requires all staff to be trauma-informed, not just individual clinicians (Milroy et al. 2023).

What does not work

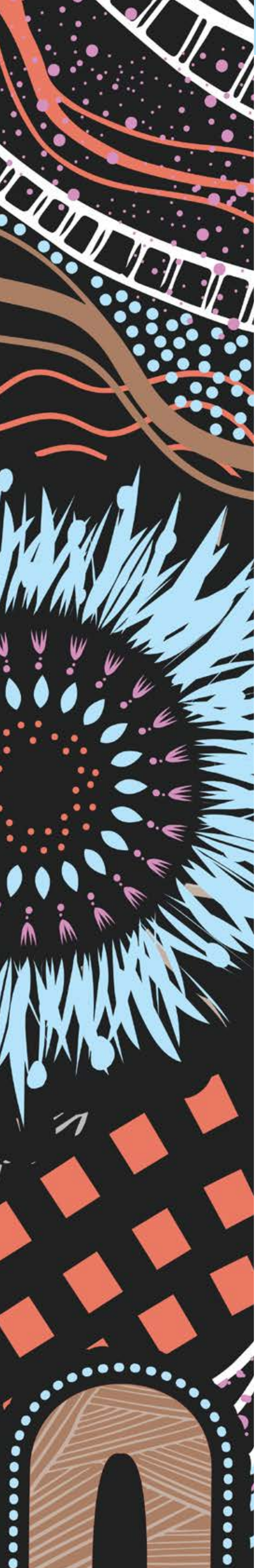
Australia faces a marked cultural divide when managing chronic disease effectively. Systems and models of care that do not include First Nations voices in their development and implementation – and systems that do not consider First Nations social and cultural wellbeing – are far less likely to succeed within a First Nations context.

What we don't know

There are two important gaps in what we know:

- There is a gap in research evidence that links social and emotional wellbeing and the impact of chronic disease.
- There is limited evidence around implementation of holistic models of care, and better data collection is required to capture quality-of-life measures that are important to First Nations people and communities.

The ITC Program described in this paper presents one way to navigate these challenges, to provide a successful collaborative outcome supporting the treatment of chronic disease among First Nations people, and to provide an environment for social and emotional wellbeing benefits.



1

Introduction

1 Introduction

Chronic illnesses and co-morbidities

Chronic illnesses are persistent health conditions that can lead to premature death. Individuals diagnosed with multiple chronic conditions (co-morbidities) often face increased complexities and a lower quality of life.

First Nations people encounter chronic diseases at a greater frequency, and exhibit higher prevalence of certain risk factors, compared with non-Indigenous people in New South Wales (ABS 2019). According to the 2018–19 National Aboriginal and Torres Strait Islander Health Survey, 46% of respondents reported experiencing one or more chronic conditions that significantly impacted their health (ABS 2019). In 2018, 4 of the 5 disease groups causing the most disease burden among First Nations people were largely made up of chronic conditions. These 4 disease groups alone accounted for 51% of the overall disease burden among First Nations people (AIHW 2022a).

The complex nature of these conditions is further compounded by a failure to adequately address the social determinants of health. Implementing culturally relevant models of care helps mitigate the risk factors associated with chronic disease. But often, conventional Western health-care models fail to address these factors, resulting in poor health outcomes for First Nations people.

Implementing the ITC Program in the HNECC PNC

Since 2015, the Hunter, New England and Central Coast (HNECC) Primary Health Network (PHN) has commissioned the Integrated Team Care (ITC) Program to provide culturally appropriate, coordinated and multidisciplinary care services to First Nations people with complex chronic health conditions. The ITC Program is an Australian Government initiative, directed by the Department of Health and Aged Care and commissioned by Primary Health Networks (PHNs). The HNECC PHN commissions the program across its communities and regions. It seeks to address the gap between social and emotional wellbeing and health-care delivery as experienced by First Nations communities, as well as fulfilling the Program's other aims.

The ITC Program consists of two core components:

- Culturally competent mainstream services, which are delivered by the HNECC PHN through a dedicated internal team (Component 1).
- Care coordination and supplementary services, provided through ITC service providers commissioned by the PHN (Component 2).

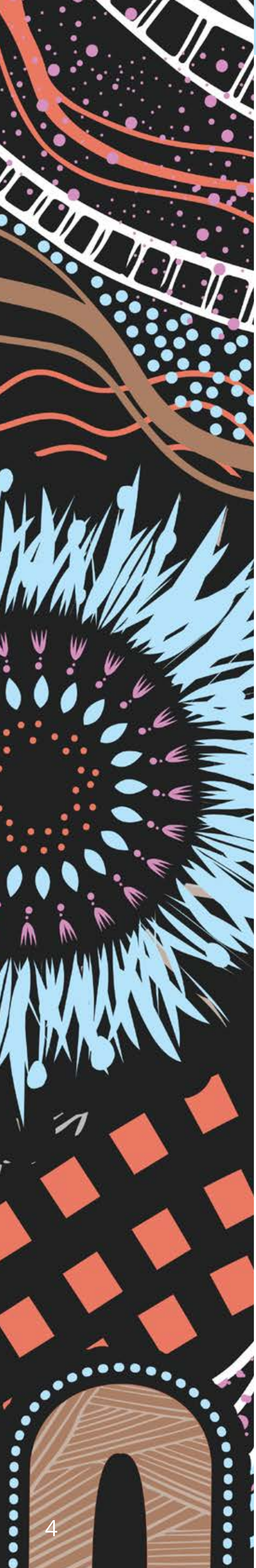
Evaluation of ITC Program delivery in the HNECC PNC

This paper will discuss the process and findings of an evaluation of the ITC Program delivery in the Hunter, New England and Central Coast area recently conducted by Nama Jalu Consulting for the HNECC PCN. This evaluation, completed in September 2023, focused on both implementation processes and outcomes to:

- determine whether the program had been implemented and delivered as intended
- understand participant outcomes and identify opportunities to improve program delivery.

This evaluation used qualitative methods, focusing on participant voice to understand the experiences and needs of people in the program.

This paper will use this evaluation as a case study, because it is the most recent publicly available evaluation of the program that directly consulted users of the ITC Program's services. This case study can provide key insights on the broader implications for integrated services for First Nations people. It also assesses how an integrated, multidisciplinary approach to health can support the social and emotional wellbeing of people with chronic health conditions.



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Background

2 Background

Chronic disease in First Nations communities

Chronic disease among First Nations communities has become a significant public health issue that not only impacts physical health but also social and emotional wellbeing. Chronic diseases are long-lasting conditions that gradually develop and worsen over time leading to limitations in daily activities, reduced quality of life and increased health-care costs. Chronic diseases are long-term conditions and not only pose significant health risks but can also lead to premature death; they are the main contributor to 'fatal burden' for First Nations people over 45 years of age (AIHW 2022a).

Burden of disease measures the impact of disease and injury in a population by estimating the years of life lost (fatal burden) and years lived with disability (non-fatal burden).

First Nations people face disproportionately high rates of chronic disease compared with the non-Indigenous population (AIHW 2022b). These disparities are deeply rooted in historical factors, including the lasting impact of colonisation which has continued to marginalise First Nations communities for hundreds of years.

The deep roots of intergenerational trauma

A key factor in the prevalence of chronic disease in First Nations communities is 'intergenerational trauma' – a lasting trauma can be attributed to the impacts of colonisation and to subsequent harmful government policies (including assimilation and forced removals). The experience of First Nations communities since colonisation has been characterised by loss of culture and language; disconnection from community and Country; and ongoing systemic racism. This history has produced a marked gap in outcomes for First Nations people in comparison with the rest of the Australian population, but particularly in health outcomes and chronic disease.

The need for trust

Furthermore, chronic disease often presents with co-morbidities and is complex – but when trust in mainstream health-care provision is absent, this creates additional challenges for First Nations communities in seeking and receiving the care they need (Yadav et al. 2024).

Several key factors need to be addressed for First Nations people to achieve positive and optimal health outcomes including:

- self-determination: the fundamental right of individuals and communities to govern themselves, make choices and take control in their lives; autonomy, sovereignty and the ability to determine one's own path
- shaping a future aligned with collective aspirations (AHRC n.d.).

Preserving and revitalising cultural identities

The other key factor is how the social determinants of health are addressed to reduce health inequity for First Nations communities (Pinero da Plaza et al. 2023). In recent years, First Nations communities have sought to revitalise cultural practices and traditions, including holistic health that encompasses social, emotional and spiritual wellbeing through connection to Country and family. These are protective factors that support First Nations people to become well.

The Integrated Team Care (ITC) Program

To best support First Nations communities, the ITC Program delivers a range of activities and works directly with:

- First Nations people to improve access to appropriate health care
- mainstream primary care providers to develop and deliver culturally appropriate services.

These activities of care, coordination and support include, but are not limited to:

- ensuring care coordination
- developing stakeholders' self-management skills for chronic conditions
- connecting stakeholders with appropriate community-based services (such as those that provide support for daily living)
- providing access to a supplementary services funding pool to support client access to urgent and essential allied health, specialist services and specified medical aids
- encouraging the uptake of Medicare Benefits Schedule items targeted to First Nations people (such as 715 Health Checks) and ensuring follow-up services are utilised
- developing and implementing strategies to improve the capacity of mainstream primary care providers to deliver culturally appropriate services to First Nations people.

The chronic health conditions that are focus areas within the ITC Program include, but are not limited to, respiratory diseases, cardiovascular diseases, renal disease, mental health, diabetes and cancer. The ITC Program provides a pathway for First Nations people to address some of these health challenges.

2018 review of the ITC program

In 2018, the Department of Health undertook a review of the ITC Program (Department of Health 2018). This review focused on the impact that care coordination has had as part of the ITC Program and, in turn, its impact on the first of its principle aims; to contribute to improving health outcomes for First Nations people with chronic health conditions through better access to coordinated and multidisciplinary care.

However, there was no quantitative data available on patient outcomes resulting from the ITC Program, and it was not possible to collect data directly from ITC clients in this review. 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 with 15 PHNs, including 34 commissioned ITC service providers and 77 members of the ITC workforce. Findings indicated that providers and staff highly valued the program, as well as detailing high program access: the ITC Program had enabled over 75,000 allied health and specialist services and 38,000 patient transport services across Australia in the first six months of 2016–17 (Department of Health 2018).

2023 review of the ITC program

In 2023, the Department of Health and Aged Care initiated a national evaluation to provide key recommendations for future state funding arrangements and for a transition pathway from the current arrangements (Department of Health and Aged Care 2024). These recommendations prepare the way for a future state funding model that prioritises First Nations leadership and self-determination. (Notably, the scope of this evaluation did not encompass the patient journey of ITC clients.)

Population, remoteness and wait times

The insights and recommendations derived from the HNECC PHN's regional ITC evaluation in 2023 can be valuable at the national level. The HNECC PHN's region spans a geography roughly the same size as the UK, with a population of over one million residents spread across urban, regional and rural areas. There are approximately 87,887 First Nations people in the PHN region (6.8% of the population of that region), compared with 3.5% in New South Wales and 3.4% in Australia as a whole. Most of the region is classified as MM5 on the 7-stage Modified Monash Model of remoteness (Department of Health and Aged Care 2023). However the region, as a whole, ranges from MM1 through to MM6. Since 2018, the ITC Program in the HNECC PHN region has provided support and services to over 6,000 First Nations people. However, as the program has grown, so has the demand for the program. The waitlist for the program has continued to be large, with a total of 622 people waiting to access the program.

Staff of the ITC program

The ITC Program is staffed by qualified and skilled First Nations and non-Indigenous workers. The staff are experienced and form passionate teams critical to ensuring that clients feel supported throughout their time in the program. Care coordinators, outreach workers and other team members all go above and beyond the program requirements to ensure that clients have their needs and worries addressed. Staff work well together, support each other with their caseloads, communicate effectively, provide wrap-around support to clients and ensure that referrals, data collection and reporting are managed efficiently.

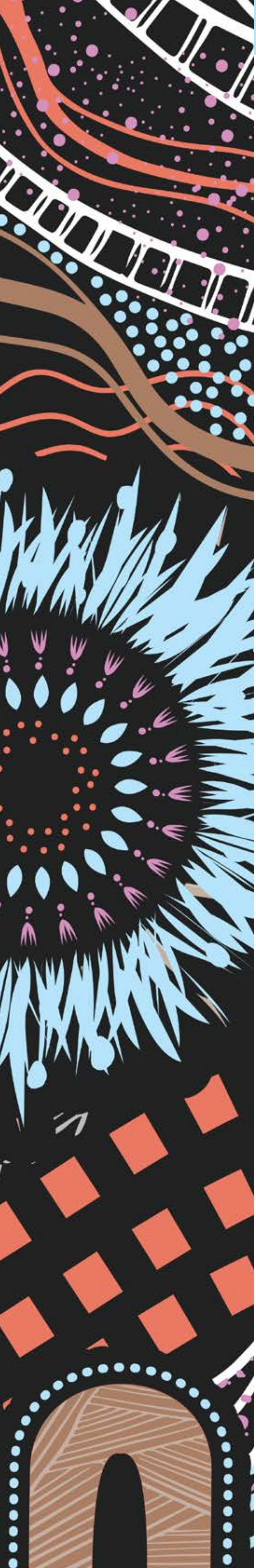
Building capability

The First Nations health access team at HNECC PHN has also implemented several initiatives to enhance the cultural capability of general practices across the region. These efforts include a Practice Quality Improvement (QI) cycle, which focuses on improving First Nations ethnicity recording; increasing the uptake of MBS 715 Health Assessments; and strengthening chronic disease prevention, intervention and management.

Additionally, the team promotes cultural knowledge and safety within general practice settings throughout the region. In 2023, the HNECC PHN conducted several cultural competency webinars, providing education to 125 attendees, including GPs, allied health professionals, nurses and practice managers. Respondents expressed overwhelming satisfaction with the content of the webinars and with their learning experiences, suggesting its positive impact on helping mainstream providers improve the cultural safety of care.

Achieving First Nations-centric health outcomes

It is well known that supporting a First Nations-centric view of health supports better health outcomes (Dudgeon et al. 2020). This can be achieved through cultural activities and lifestyle support for First Nations people including group yarning, healing sessions, holding activities outdoors and on Country, bush tucker education and client gatherings to share arts, craft and music. To achieve better health outcomes for First Nations people, best practice for services is to implement a holistic approach to First Nations health and to address health equity, wellbeing and person-centric care (AIHW 2023).



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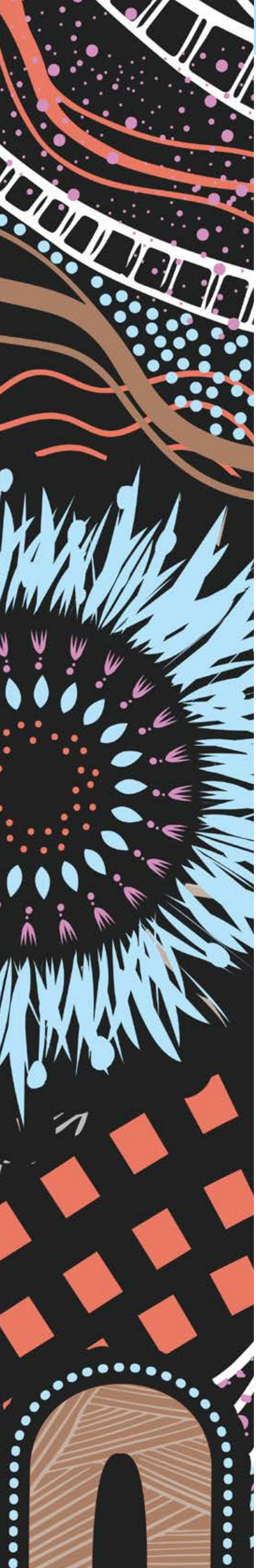
Methods

3 Methods

Preliminary literature review

The 2023 evaluation conducted a brief literature scan of existing integrated initiatives that support the social and emotional wellbeing of First Nations people. The purpose was to identify what primary and integrated care programs were available for First Nations people with chronic health conditions, as well as to highlight the gaps in existing initiatives for culturally safe service delivery for First Nations people.

While the focus for the literature review was First Nations social and emotional wellbeing in chronic care, all domains of health were reviewed based on a holistic view of wellbeing and on the impact on social and emotional outcomes. The specific search terms used for the literature scan included Aboriginal OR Indigenous OR First Nations OR Aboriginal and Torres Strait Islander, WITH 'Chronic care model', 'Chronic care program', 'Chronic disease', 'Integrated Chronic care', 'Chronic disease patient journey'. The literature review focused on both academic and 'grey' literature and the data-bases searched included Google, Google Scholar and Medline. The inclusion criteria included current or past programs or initiatives that involved service integration elements. These did not have to be specifically labelled as 'integrated services', but they did have to be initiatives for First Nations people. There were no other specific inclusion or exclusion criteria.



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Key issues

4 Key issues

Barriers to accessing health care for First Nations people experiencing chronic health conditions

There are many determinants of First Nations health, including historical factors, education, employment, housing, environmental factors, social and cultural capital, and racism. Inequitable access to health care continues to contribute to poorer health outcomes and is a major driver for the life expectancy gap between First Nations people and non-Indigenous Australians (AIHW 2020). This section gives an overview of the key barriers to health-care access for First Nations people.

Systemic racism

Racism underpins many of the health-care challenges that First Nations people face and is strongly related to adverse effects on many aspects of health, including physical, social, emotional and spiritual wellbeing (Kairuz et al. 2021). Systemic and institutional racism continue to impact all aspects of First Nations people's lives, including their experiences accessing health care. A survey of 8,108 First Nations people found that 59% had experienced some form of everyday racism which had negatively impacted their general mental health and was associated with psychological distress and unhealthy behaviours (Thurber et al. 2021). In 2022, 20% of First Nations people surveyed by Reconciliation Australia reported experiencing racial discrimination in interactions with doctors, nurses and/or medical staff (Reconciliation Australia 2022). Racism is also commonly experienced by First Nations health-care professionals (ANTAR 2021). A paper by the Australians for Native Title and Reconciliation (ANTAR 2021) detailed that:

- First Nations doctors are 10 times more likely to experience racism and 5.5 times more likely to experience major stress from bullying than non-Indigenous doctors
- 27% of First Nations health students reported being very stressed by racism.

Cultural safety and cultural safety awareness training

Cultural safety is critical in delivering all types of services to First Nations people. It relates primarily to how health care should be provided, rather than the specific types of care that are provided (Department of Health and Aged Care 2022). Culturally safe approaches to care need to:

- respect and understand culture and people through behaviours, attitude and the culture created by health-care providers
- embed First Nations governance, policies and practices
- recognise, address and prevent individualised and systemic racism in their services (AIHW 2023).

Understanding and providing cultural safety awareness training is one key strategy to combat systemic racism in the health system.

From the experience of First Nations people, cultural safety involves feeling safe, connected and having cultural identity respected (AIHW 2023). Attending a service that is culturally unsafe for First Nations people can have negative effects on their social and emotional wellbeing, such as feeling diminished, demeaned and disempowered (Milroy et al. 2023). Even though the First Nations health-care workforce is increasing and is a key component of developing culturally safe services, the mainstream health system and non-Indigenous workforce also need to continue to develop cultural competence through cultural safety, competency and capability training (AIHW 2024b). Cultural safety training is becoming more prevalent in health care. A national survey of health-care professionals showed that 96% of respondents reported they had access to some form of cultural safety training in their health service. However, the survey also found that very few of the respondents indicated receiving high quality training. These findings also highlighted that half of the respondents had received training in partnership with or by a First Nations trainer or organisation (Hunter et al. 2021).

There appear to be disparities between the quality of cultural safety training being delivered and the implementation of knowledge that translates into service delivery. It follows that a lack of cultural safety in health-care services is a barrier for First Nations people accessing health-care services.

Choice and access

Aboriginal Medical Services (AMS), controlled by First Nations communities are increasingly being empowered to deliver health care through the Australian Government’s First Nations Health Funding Transition Program (FNHFTP) (Department of Health and Aged Care 2023). However, it is important that First Nations communities have access both to AMS and to culturally safe mainstream services, ensuring that communities have a right to choose what service they attend.

As in any community, it is important for people to have a range of options in services in case they face personal issues or have historical context with a particular provider. This highlights the need for choice and control to support self-determination for these individuals. Despite the combination of the FNHFTP program and policies such as the National Agreement on Closing the Gap and The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023, systemic racism issues still prevail and continue to contribute to poor health outcomes in many communities.

Unemployment rates and lack of bulk-billing services

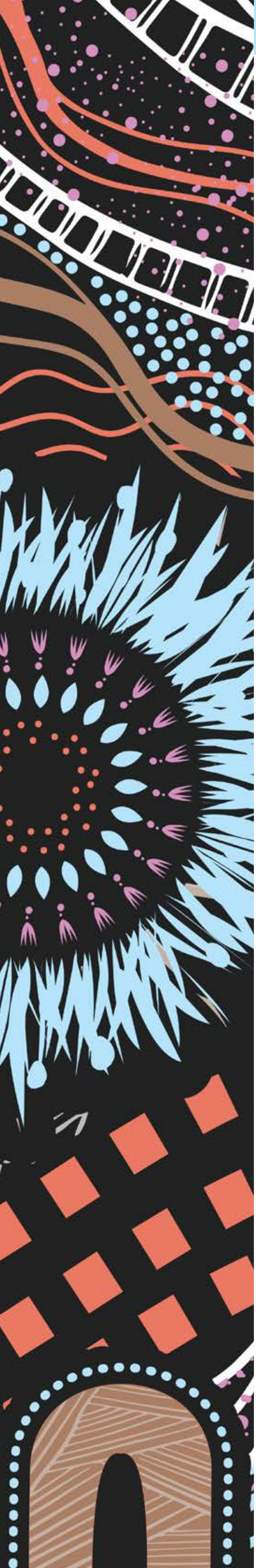
The affordability of health care is a major access barrier for First Nations people living with chronic conditions, particularly in rural and remote communities. Obtaining and maintaining employment is either difficult or not possible for people living with complex chronic health issues. In 2021, First Nations people (aged 25–64) with one or more long-term health condition had lower employment rates (as low as 17% with some conditions), compared with those with no chronic conditions (65%) (AIHW 2024b). This means that these individuals do not have an income and rely on government or other financial assistance. This further decreases their likelihood of being able to access the health-care services they need to address their chronic health issues.

The number of general practitioners (GPs) that bulk bill has decreased to only 35.1% nationally and this rate varies widely from community to community (Gillespie 2023). Specialist appointments are also often not covered by Medicare, or at least are not sufficiently covered, meaning that out-of-pocket expenses are very high. In 2018–19, around one in 5 (21%) of First Nations people aged 15 and over in non-remote areas had private health insurance (AIHW 2024c). Increasing costs of health care are a significant barrier to accessing the services that this cohort needs.

Access in rural and remote communities

People who live in regional and remote communities experience many barriers to accessing health care. Medicare data from 2017–18 showed that access to most types of health services reduced as remoteness increased (AIHW 2024c). The proportion of the First Nations population in Australia who live in regional, remote and isolated areas is much higher than the proportion of the non-Indigenous population that lives in those areas (ABS 2023). Compared with the non-Indigenous population, First Nations people are more likely to have reduced access to important and safe services. The shortage of doctors in rural and regional areas has been well documented, with several government initiatives implemented to try and increase service access. In 2018–19, one-third (33%) of First Nations people who did not seek health care when needed reported that this was due to access, including wait times that were too long or services not available when required (21%), transport/ distance (13%) and services not available in the area (7%) (AIHW 2024c).

Challenges with cultural safety can be exacerbated in rural and remote communities. Often doctors and specialists must be brought into regional and remote areas, and many services are seen as lacking sufficient cultural competency to provide safe care for First Nations people, even in areas of New South Wales with high First Nations populations (Simpson 2009). In order to overcome these barriers and to support people in accessing necessary care, funded transport services are essential – but so is cultural safety training for providers who are working or providing outreach in these communities.



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Policy context

5 Policy context

Across Australia, the ITC Program is used by Primary Health Networks (PHNs) to address the health and support needs of First Nations people who live with complex chronic conditions. It is one activity funded under the Indigenous Australians' Health Program (IAHP), which commenced on 1 July 2014. Under the National Agreement on Closing the Gap, funding for the ITC Program is managed by the Australian Government Department of Health and Aged Care, while PHNs are charged with commissioning organisations to provide ITC Program services. PHNs manage the funds for the program, working with the First Nations health sector to ensure that mainstream and First Nations health services can deliver care coordination and supplementary services to eligible clients.

The ITC Program combines the former Care Coordination and Supplementary Services (CCSS) Program with the Improving Indigenous Access to Mainstream Primary Care (IAMPC) Program. As a part of a PHN's contractual obligations to the Department of Health and Aged Care, PHNs are required to publish a range of plans and reports which demonstrate how the implementation of the government's primary health-care reform activities are being supported and how the associated funding is being managed.

The following section describes the broader national plans that are dedicated to First Nations people, and that are relevant to chronic disease and to the ITC Program.

These key frameworks support working with the strength and diversity of First Nations people; consider the social determinants of health in achieving health outcomes for First Nations communities; and include the important aspects of self-determination and connection to Country and culture.

National frameworks

When working with First Nations people and communities it is imperative to acknowledge their strength, resilience and diversity. Four key national documents that support this way of working are:

- National Aboriginal and Torres Strait Islander Health Plan 2021–2031
- National Agreement on Closing the Gap
- National Strategic Framework for Chronic Conditions
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023.

National Aboriginal and Torres Strait Islander Health Plan 2021–2031

The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 is a national policy aimed at improving health and wellbeing outcomes for First Nations people over the next 10 years. Developed in genuine partnership with First Nations communities, this plan takes a holistic and strengths-based approach, emphasising cultural and social factors throughout individuals' lives. This plan acknowledges the diversity, knowledge and innovative voice of First Nations people who have lived experience. The plan recognises that First Nations health outcomes are a whole-of-system responsibility and raises the importance of creating culturally safe and responsive health care (Department of Health and Aged Care 2022).

Key aspects of the plan include:

The Community-Controlled Health Sector

The plan identifies opportunities to strengthen and prioritise the community-controlled health sector.

Culturally Safe Care

The plan outlines the necessary mechanisms for mainstream health services to provide culturally safe and responsive care.

The National Agreement on Closing the Gap

The National Agreement on Closing the Gap is the national policy for governments across Australia to work in collaboration with First Nations people to improve their life outcomes. It includes four priority reforms that support the transformation of the health sector to achieve this and 19 national socio-economic targets.

Targets 1 and 17 and their outcomes are relevant to this paper:

Target 1: Close the Gap in life expectancy within a generation, by 2031.

Outcome 1: Aboriginal and Torres Strait Islander people enjoy long and healthy lives.

Target 17: People have access to information and services enabling participation in informed decision-making regarding their own lives and by 2026, Aboriginal and Torres Strait Islander people have equal levels of digital inclusion.

Outcome 17: First Nations people have access to information and services enabling participation in informed decision-making regarding their own lives.

National Strategic Framework for Chronic Conditions

The National Strategic Framework for Chronic Conditions has been developed to guide the implementation of policies, strategies, actions and services to improve health outcomes for people with a chronic disease. The framework includes a targeted objective for priority populations including First Nations people, which sets out strategies to work with First Nations communities (AHMAC 2017).

These strategies include:

- culturally safe services that are provided by a culturally competent workforce
- services that are flexible and can meet the local needs of the community to minimise First Nations people having to travel long distances away from community to access services
- increasing the First Nations health workforce.

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023

The domains of social and emotional wellbeing from a First Nations perspective are outlined in this framework. One of the domains notes the importance of 'connection to body' which encompasses feeling strong and healthy and able to physically participate as fully as possible in life. This concept has been strongly supported in the outcomes for stakeholders participating in the ITC Program (Australian Government 2017).

Action area 1 within the framework is called ‘Strengthening the foundations’. In Outcome 1.3, effective integration and partnerships between Primary Health Networks and Aboriginal Community Controlled Health Services and other health service centres are recommended.

Some of the key strategies noted in this framework that are highly relevant to this paper include:

- Improving service equity for rural and remote communities and for under-serviced populations, including through place-based models of care.
- Preferencing funding for Aboriginal Community Controlled Health Services to deliver mental health, suicide prevention and other primary health programs and services where feasible.
- Ensuring planning strategies incorporate the joint planning processes of the state.
- Facilitating continuity of care and information sharing between services through the use of the My Health Record.

Other relevant national frameworks, plans and supports

Other relevant plans and agreements include the:

- Australian Health Performance Framework (to inform policy, planning and programs)
- Aboriginal and Torres Strait Islander Health Performance Framework
- AIHW National Strategic Framework for Chronic Conditions
- Australia’s Primary Health Care 10 Year Plan 2022–2032 (Department of Health and Aged Care 2022b)
- National Preventive Health Strategy 2021–2030
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031
- Fifth National Mental Health and Suicide Prevention Plan
- Australian National Diabetes Strategy 2021–2030.

In addition to the four key national documents discussed, the states and territories also have frameworks, strategies and approaches that support chronic disease prevention and management for First Nations people. Two of these are described below.

The South Australian Aboriginal Chronic Disease Consortium

The South Australian Aboriginal Chronic Disease Consortium is a collaborative alliance involving both government and non-government organisations. Its primary objective is to shape First Nations health policy and service systems in South Australia with a focus on chronic disease prevention, care and management. The consortium brings together a diverse group of stakeholders across the health system, including lead clinical experts, First Nations peak body representatives and leaders, First Nations community experts, policy makers, university partners and private enterprise (SAHMRI 2017). The consortium is tasked with the implementation of three chronic disease health plans:

- The SA Aboriginal Heart and Stroke Plan
- The SA Aboriginal Diabetes Strategy
- The SA Aboriginal Cancer Control Plan.

The South Australian Aboriginal Chronic Disease Consortium provides a strategic platform for collaboration, holistic coordination, pooling of resources, cultural competence, advocacy and shared learning. A roadmap has been developed by the consortium which ensures the implementation of the three plans.

NSW Aboriginal Health Plan 2013–2023

The NSW Aboriginal Health Plan represents the NSW Government's commitment to addressing the health disparities experienced by First Nations people. This plan gave NSW Health the opportunity to reassess collaborative approaches to transform health services in order to achieve health equity.

The plan outlines a roadmap that guides the planning, execution and monitoring of health systems that relate to First Nations health. All staff members of Local Health Districts (LHDs), Specialist Health Networks, Pillars and other New South Wales health-related statutory authorities are required to comply with this plan (NSW Health 2015). It identifies six strategic directions to lead and transform the health system to improve First Nations health. These include:

- fostering trust via local partnerships
- gathering evidence and implementing proven strategies
- guaranteeing integrated planning and service delivery
- amplifying the Aboriginal workforce
- ensuring culturally safe work environments and health services
- reinforcing performance monitoring, management and accountability

The plan emphasises the implementation of specific strategic actions that align with each goal to transform health services impacting positively on health equity.

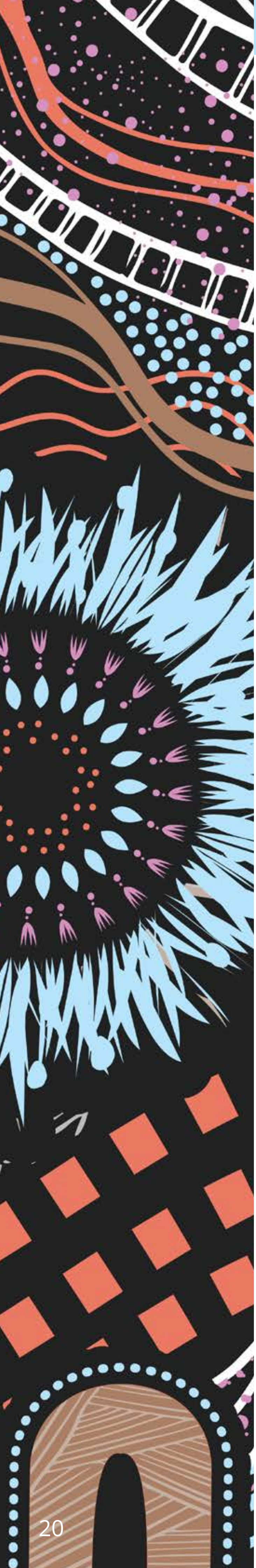
The Indigenous Mental Health Program

The Indigenous Mental Health (IMH) Program is also funded through the Primary Health Networks, under the suite of programs funded by the IAHP. The IMH Program works to engage culturally appropriate, evidence based mental health services for First Nations people. Stakeholders are often referred from the IMH Program to the ITC Program and back again, demonstrating the value added by each program and the need for collaboration.

Other relevant NSW-based frameworks, plans and supports

- Respecting the difference Aboriginal Cultural Training (NSW Health)
- Aboriginal Chronic Conditions Network (Agency for Clinical Innovation, NSW Health).

These different strategies and initiatives support the ongoing improvement of health-care delivery and disease management for First Nations people in New South Wales, seeking to promote models of care that strive to improve access, quality and cultural safety of health care.



6

Programs and initiatives

6 Programs and initiatives

Integrated services, by nature, are diverse and take on different forms and delivery models depending on the local environments and community needs they are seeking to support (SNAICC 2012). There are examples of integrated services that are having a positive impact on the social and emotional wellbeing of First Nations people across Australia, including in health, family services, child protection and many other domains. One of these is the ITC Program, delivered across Australia. Below, we will detail a specific case study of the ITC Program, commissioned by the HNECC PHN.

Case study: HNECC PHN's delivery of the ITC Program

The ITC Program in the HNECC PHN

The Australian Department of Health's Program Implementation Guidelines for the ITC Program provide a framework for service delivery for PHNs funded to deliver the ITC Program. However, they also support individual PHNs to flexibly commission services based on the needs of local First Nations communities (Department of Health 2019). The HNECC PHN's ITC Program incorporates a team of internal staff including ITC Service Coordinators and a First Nations Health Access Team, and engages six ITC providers in their district: four Aboriginal Medical Services (AMS) and two mainstream service providers:

- Biripi AMS (Taree)
- HealthWISE (Mehi, Tablelands and Peel Clusters)
- Hunter Primary Care (Newcastle, Lake Macquarie, Lower Hunter and Port Stephens)
- Tobwabba AMS (Foster, Tuncurry and Gloucester)
- Ungooroo AMS (Singleton, Muswellbrook and Upper Hunter).
- Yerin AMS (Central Coast).

These organisations were chosen to be service providers of the ITC Program based on their commitment to holistic care and service integration. Each of these providers offer a range of services that support the physical, social, emotional and cultural needs of their client base, and seek to ensure that their programs provide ongoing support and engagement with all members of their local communities.

The HNECC PHN is committed to ensuring that the ITC Program meets its objectives and the needs of First Nations communities. Equally importantly, the PHN team is embedded in local community and regularly seeks to ensure that the program is responsive to the specific needs of local clients, families, service providers and the communities in which they work.

Evaluation of the HNECC PHN ITC Program

As part of this commitment to meeting the needs of local First Nations communities, the HNECC PHN recently commissioned an evaluation of their ITC Program (HNECC PHN 2023). The purpose of this project was to conduct a process and summative evaluation of the ITC Program.

The evaluation sought to:

- assess how well the program has been implemented
- assess the overall performance of the program against its objectives
- identify how program delivery could be improved.

The evaluation prioritised qualitative methods of interviewing and yarning with different program stakeholders, with the main focus being the voice and stories of clients. This was the preference of the ITC providers and community representatives who formed the First Nations Reference Group. These evaluation stakeholders felt that a qualitative approach was more culturally appropriate and fit for purpose for the program.

In total, 69 stakeholders were interviewed across 28 individual and 11 group interviews. The response rate among all stakeholders contacted to participate in the evaluation was 84%, and 25 of the 26 ITC clients contacted were interviewed. The total breakdown of the interview cohort and type is presented in Table 1 below.

Table 1. Interview sample size and stakeholder type

Stakeholder cohort	n	Individual interviews	Group interviews
Program clients	25	7	4
HNECC PHN internal staff	13	13	0
ITC providers	25	4	6
Other stakeholders (GPs, specialists, allied health)	6	4	1
Total	**69**	**28**	**11**

The specific questions for the evaluation were developed through a collaborative approach between the HNECC PHN, the ITC providers, a First Nations Reference Group convened for the evaluation, and the consultants undertaking the evaluation (Nama Jalu Consulting).

One key evaluation question which this case study will focus on was understanding how the program and its support for clients' management of their chronic conditions supported their social and emotional wellbeing and quality of life. The next section will describe the findings in relation to this question, focusing on clients' experience of the program and how it supported their wellbeing.

Key findings from the evaluation

The first key finding from the evaluation was that all clients were 'Happy' or 'Very happy' with the overall service and support received from the ITC Program. Clients overwhelmingly felt that the program met the majority of their medical, physical, personal, social and emotional needs.

Almost all clients interviewed reported that their capacity to engage with the health-care system had greatly improved. Clients reported feeling more educated about their health and chronic conditions and having greater trust in the health-care system. This often appeared to improve attendance at appointments and appropriate use of medication and other necessities, and has reduced appointment 'no shows'. These positive client outcomes were consistent across different provider regions.

Importantly, clients also reported that the ITC Program improved their social and emotional wellbeing. The extent of wellbeing and quality-of-life improvements was highlighted by many of the clients interviewed, several making mention that they 'may not be here today' if not for the program:

> *They [care coordinators] are all great, I couldn't do it without them.* (Client)
>
> *I don't know where I would be today if it wasn't for this service.* (Client)

Other stakeholders interviewed, including service provider staff, also had a strong conviction that the program was contributing to achieving broader health and wellbeing outcomes beyond clients' chronic physical conditions:

> *They're happier, general wellbeing and mental health. They are grateful to have someone to lean on for support and encouragement.* (ITC Provider)

A thematic analysis of participant responses found that clients had highlighted two interlinking factors that contributed to social and emotional wellbeing outcomes. These were the social supports that the program provided for them and their families, and the culturally safe approach taken to care coordination.

Social supports facilitated through care provision

When asked about the factors that contributed to the success of the program, clients most frequently mentioned the skilled and passionate care shown by coordinators in the program, who made them feel supported in all aspects of their health and wellbeing. The social and emotional supports coordinators provided were often not structured or built into specific aspects of program design, but rather came from the coordinator's warm, empathetic and responsive approach to client needs throughout their daily care provision.

One factor that came up in many interviews was that care coordinators went 'above and beyond' for their clients in providing social supports. Coordinators often called clients and visited them to check in, contact which (many clients reported) evolved into genuine friendships. Both clients and providers reported that they valued these times together. Clients also appreciated the time spent with care coordinators who joined them at appointments and travelled with them. This time spent together helped to build trusting relationships, which meant that clients felt open to sharing health information with their care coordinator.

> *It doesn't feel like someone just taking me somewhere, it feels like family.* (Client)

Not only did this kind of contact help clients understand more about their health conditions and have advocacy in the health system, but it also allowed them time to yarn in a safe space and feel supported in a more holistic way. With their clients' permission, care coordinators could then share information about the health needs of the client to specialists and supplementary service providers – information that they otherwise may not have shared. This also created a comfortable means of feeding back information from health-care services to their clients in a safe and accessible way.

Several clients mentioned that their coordinator supported family members to attend important appointments with clients. In one instance, a care coordinator was able to arrange for a client's spouse to visit a client when they were in hospital, which otherwise would not have been possible:

> *In 2020 I had to go down to Sydney … and I spent 20 days in hospital down there … some days they brought [client's partner] down and I spent a couple of hours down there with them. It was a very very big help … took a lot of pressure off.* (Client)

Some ITC providers also had specific social activities and programs built into their ITC service provision. One provider had adapted an optional Shared Health Appointment model, in addition to their regular care provision. This model involved having people with similar health issues attend medical appointments and educational sessions together in groups. While individual health needs were attended to, these were done in a supportive group environment which facilitated peer support and social connection, as well as education sessions about how to manage different conditions and to promote self-management. In a group interview, one of these groups shared how beneficial the social aspects of the group sessions had been for their wellbeing:

> *Finding out that you are not in this alone and the support that you get with the rest of the team and from the nurses and dietitians makes it a wonderful program.* (Client)

In many instances, clients suggested that service providers need more coordinators, as they are often stretched in doing their jobs. The PHN has recognised these challenges and has removed certain KPIs that were causing stress for the service providers – but a restructuring of the program at a national level could enhance the amount of invaluable support that clients could receive.

A culturally safe approach to care coordination

The evaluation showed how attuned all providers were to the broad range of client needs, including cultural needs, and how important it was to address these holistically in order to see client progress. Both the Aboriginal Medical Services (AMS) and mainstream providers clearly understood the cultural needs of their clients, with the two mainstream providers having First Nations care coordinators who were active members in their communities. Almost all of the service provider staff were local community members, along with some Elders, which was important in making clients feel safe and which further facilitated cultural connection.

ITC service providers delivered culturally safe services by providing a holistic focus on wellbeing for their clients and a wrap-around 'circle of care' for them and their families. Clients reported that they appreciated not having to tell their story over and over again and trusted their providers to link them with other culturally safe services. This was particularly important as many clients in the program have had previous negative experiences with health-care services.

Providers also understood the cultural and community factors that may lead to people missing appointments, such as sorry business or family matters, which can often have difficult implications for clients when accessing services that are not culturally aware. Building in flexibility and understanding the local community was integral to delivering successful services:

> *She's from my culture, I get the feeling she understands what I am going through.* (Client)

> *I just feel comfortable talking to another Aboriginal person who knows what you are going through, and I have never been one to ask for help.* (Client)

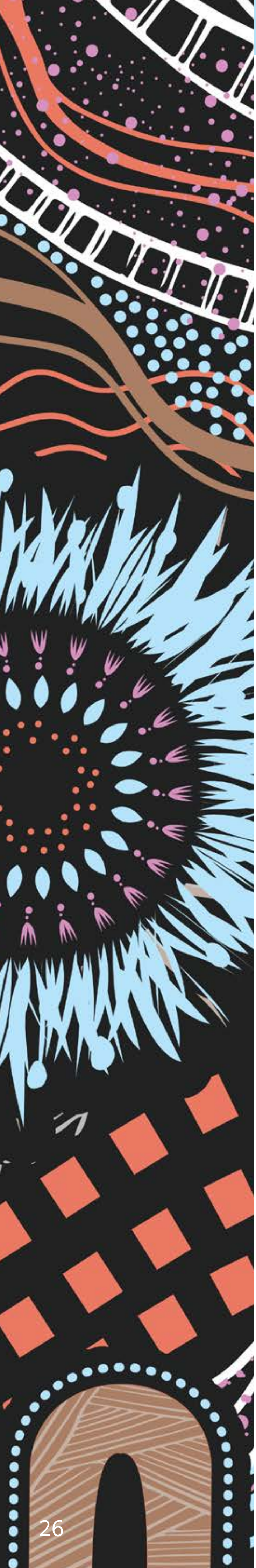
The PHN's activities support mainstream primary care providers (for example GPs, specialists and allied health) to deliver culturally safe care through running cultural awareness programs, which has also helped to highlight the current and historical challenges that First Nations people face in accessing health care. Some PHN staff reported feeling that these activities have been successful, and some ITC providers noted that they felt the PHN staff were helping in addressing these cultural issues.

> *That mentality is being broken down slowly.* (ITC Provider)

However, many ITC service providers reported that there is still a lack of cultural understanding by mainstream primary care providers, and that some care coordinators felt upset if taking clients to providers who were not as culturally safe as expected. (In one case, an ITC provider mentioned that a GP in their area referred to administering 715 health checks for First Nations people as 'charity cases'.) This shows the need for these PHN cultural awareness sessions to continue, and to increase in regularity.

Stakeholders also suggested that more cultural activities and experiences could be embedded in the program, such as group yarning sessions, gatherings on Country and the sharing of skills in arts, craft and music. There was also mention from PHN staff that the data collection tools could be more culturally safe, using yarning methods alongside the strictly quantitative measures used currently.

While there is still room for services to facilitate better links and to incorporate new elements to support the needs of First Nations people, the evaluation's findings show that the design of this integrated care program is creating many positive outcomes for the health, social and emotional wellbeing of First Nations people.



7

Overarching strategies, approaches and best practice

7 Overarching strategies, approaches and best practice

From the literature on integrated services and the experience and evidence collected from the evaluation of HNECC PHN's ITC Program, several learnings have been developed to inform future strategies, approaches and best practice in providing integrated health services to First Nations people. There were three clear enablers to success for program delivery and the uptake of these programs by First Nations people. Further, there were some clear gaps and limitations of services and broader system-level structures that need to be addressed to build a best practice approach to integrated care for First Nations people.

Key enablers to success

Several key enablers to success in delivering integrated approaches to health care for First Nations people emerged from the case study of the ITC Program. It is clear that integrated care works best in supporting First Nations people when:

- they are supported to access and navigate the health-care system
- service providers are considered culturally safe
- providers and commissioners work in collaboration.

Support to access and navigate the health-care system

A proven success factor from the ITC Program case study was the program's ability to re-engage First Nations clients with the health-care system.

- By supporting clients to navigate the health-care system (for example, by organising appointments, providing financial aid, and offering education on their conditions and how to manage them), client engagement with health care was increased as well as clients' capacity to interact with the system.
- Financial aid was also a key factor for improving a client's capacity to engage with the health-care system. As mentioned above, the affordability of health care is becoming more and more challenging, especially for First Nations people who live with chronic conditions and are unable to work.

Empowering clients through support and education is critical in encouraging service engagement. This can serve to help them manage their chronic physical conditions, as well as alleviate their stress and anxiety about accessing health care. By addressing these challenges and creating a supportive environment, clients reported that they felt like they had more trust in the health-care system, including mainstream primary care services. Hence, it is critical that programs for First Nations people are designed with services that work together to facilitate educational, financial and social supports for clients. Such design should be prioritised in the field of health care and beyond, such as in the housing sector.

Holistic approaches to care coordination

In the ITC Program, service providers are committed to a holistic approach to service delivery, which considers the whole person, not just the client's chronic health condition. Holistic care considers the cultural needs of clients, which was embedded in the program by having a prominent First Nations workforce. The majority of service providers hired care coordinators who identified as First Nations, which was proven to be effective in understanding and meeting clients' cultural needs. Providing a culturally safe service further reduces the barriers to accessing health care and provides a wrap-around circle of care for clients and their families.

One integral component of holistic care is understanding how to provide referrals and linkages to other appropriate initiatives such as NDIS and My Aged Care. Facilitating these referrals can enhance sustainable support for clients, complementing the services received through the ITC Program. While it was acknowledged that this was often outside of the remit of the role of care coordination in the ITC Program, the fact that the providers, especially AMS, offered a range of health services made these connections to different programs achievable.

Collaboration between service providers and PHN commissioners

When working with First Nations communities, relationships are crucial for achieving outcomes (Hunt 2013). A key enabler of the ITC Program identified in the evaluation was the strong relationships between the commissioner, service providers and stakeholders. Service providers appreciated support and advice from the PHN commissioner that then built a pathway for two-way learning streams and developed rapport and trust in the relationship. These relationships were the basis for further collaboration between the PHN commissioner and service providers, which allowed them to tailor certain aspects for local program delivery and to embed these within their funding contracts. By tailoring funding contracts during negotiations, the ITC Program was able to better meet the needs of clients holistically across the HNECC PHN service area.

Service providers were also able to develop relationships with GPs and specialists which provided clear pathways for clients to navigate the system and increased the capacity of GPs to be able to clearly understand the ITC Program's referral requirements for new clients. This also provided a platform for service providers to advocate for bulk-billing opportunities for clients as well. The value of local knowledge and genuine collaboration highlights the value of allowing such decisions to be made at a local level. Designing programs that prioritise local insights can facilitate trusting relationships to be formed across the provision of care and can help ensure that ongoing communication between stakeholder groups is possible and can allow the program to perform effectively.

Ongoing challenges for the ITC Program

While the delivery of the HNECC PHN's ITC program provided some valuable insights into the success factors in program delivery, some issues were identified with the program in the area. While these may not necessarily reflect concerns about all ITC programs across New South Wales or Australia, some broader program structure and health-care system-level challenges were identified as contributing to local delivery concerns:

- The national ITC Program guidelines need to be updated to ensure the program’s sustainability
- Health-care services need to be both more affordable and accessible for First Nations people
- Standards need to be raised in terms of delivering culturally safe support to First Nations people in the health-care system.

Updating the federal ITC Program guidelines for sustainability

The ITC Program was originally developed in 2014, with the guidelines previously updated in 2019 (Department of Health 2019). Since then, both the delivery of the ITC Program and the understanding of First Nations health have been informed by understanding of the importance of holistic health care. For the ITC Program to continue to better meet the needs of its First Nations clients, an update to the program delivery guidelines is needed.

Throughout the evaluation, it became clear that the program seeks to help clients to eventually self-manage their conditions, but the current guidelines and program structure do not support this. While some clients were able to start to learn how to manage their own conditions, clients heavily relied on their care coordinators to achieve health outcomes.

By shifting the guidelines to clearly focus on empowering clients to further prioritise self-management and autonomy, this will improve clients’ capacity to be independent. It is important to note that the ability to self-manage a condition does depend on the nature of the client’s condition, and self-management may not always be appropriate, particularly when diseases are terminal. But in cases where it can be achieved, it is important that clients and care coordinators work towards empowering clients to take on self-management.

The structure of the program could place a greater focus on providers having empowering conversations with clients from the start of their client journey to set self-management goals. Additionally, the PHN could offer sessions to clarify the programs’ purpose and guidelines, along with more specific training and support for frontline workers on how to empower self-management.

The health-care landscape has shifted in recent years and the financing of the program needs to be updated in line with these changes. For example, there is a need for expanding the subsidy ranges within the ITC Program to include:

- GP appointments, given the decline in bulk-billing services, especially in rural and remote communities.
- increasing funding support to facilitate transport to services, including funding local community organisations to be transport providers.
- more group activities to help create a holistic approach and to increase the social and emotional benefits from the ITC Program, which would require expanding subsides to assist clients with accessing cultural activities, groups and other forms of holistic support.

Wider advocacy for affordable health-care services to increase accessibility

As a health-care system, there is a duty of care to provide affordable and accessible health care to all, including priority populations. As mentioned above, affordability is a barrier to accessing health services for First Nations people living with chronic conditions. This is particularly due to the limited employment options for those living with chronic health conditions, but also because there is a decrease in the number of bulk-billed services, along with cuts to public health services and Medicare.

The ITC Program evaluation has demonstrated that service providers have been able to find creative ways to work around this barrier to some degree, at a local level. Some care coordinators were able to advocate for their clients with local GPs and specialists for a form of subsidy or bulk-billing option, or were able to find funds from other sources within their organisation. However, this is an additional responsibility which is out of scope according to the program guidelines and was undertaken due to care coordinators feeling obligated to support their clients with high needs.

While service providers are finding their own ways to deal with affordability, the systemic issue of inaccessible and expensive services remains. To support all First Nations people in accessing affordable health-care services, larger system reform is needed.

Continuing to strengthen and celebrate the cultural aspects of the program

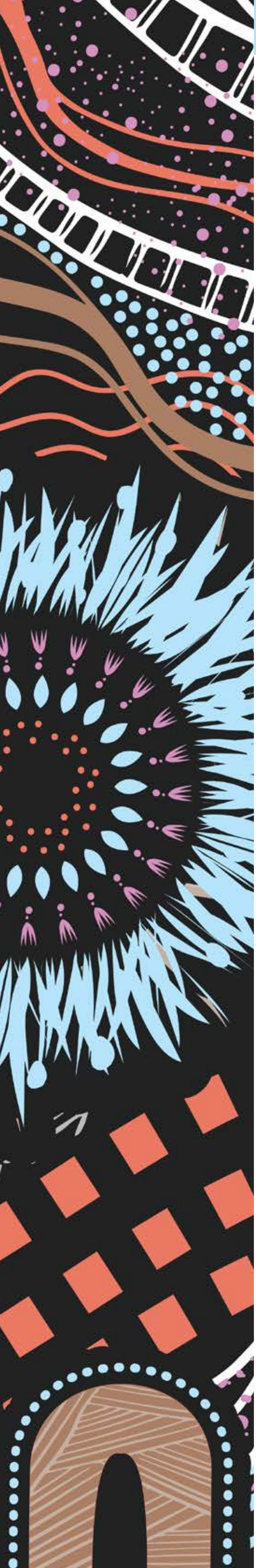
The ITC Program has had great success in providing culturally safe and holistic care to clients, as well as providing cultural safety education to mainstream health-care providers. However, efforts still need to be made towards challenging the larger systemic issues of culturally unsafe practice in the health-care system.

There is room for the standards of cultural safety training and evaluation of training to be increased, which will require sustained effort, attention and resourcing from government in partnership with Aboriginal Community Controlled Organisations (ACCOs). Investment into local ACCOs and First Nations businesses to develop and roll out training packages or existing programs is needed to ensure high quality training is being delivered by First Nations people and reaching the right services. PHNs should continue to play a supporting role in this, through dedicated funding provided by the Australian Government to support cultural capability improvements.

The Royal Australian College of General Practitioners (RACGP) is also making efforts to ensure cultural safety training is implemented under a GP's continuous professional development (CPD) hours. To maintain their accreditation, GPs must complete at least one activity each year relating to culturally safe practice as part of their CPD hours (RACGP 2023). This commitment could be increased, as one activity per year is unlikely to provide sufficient education, engagement and relationship-development between mainstream GPs and local First Nations communities. Further, the RACGP, in partnership with the PHNs, could implement a process for First Nations communities to report culturally unsafe practice.

As well as a continuing commitment to increasing cultural safety, the program should also seek to further celebrate First Nations culture. Cultural activities are a key facilitator of social and emotional wellbeing benefits (Gupta et al. 2020). By conducting activities on Country, having more music, dance and arts built into the program, or whatever other cultural activities program participants want to engage with, the program can continue to expand its focus on leveraging local First Nations culture and history to positively impact on health outcomes.

As mentioned above, the HNECC PHN program does have a prominent component of local adaptability and flexibility which supports many of the positive program outcomes. Hence, some of these issues, especially around integrating more cultural activities, may have been addressed in other ITC Programs, and lessons from other PHNs could help enhance program delivery in the HNECC area.



8

Conclusions

8 Conclusions

While integrated services are beginning to address the complex and challenging needs of people with chronic diseases, little evidence has been gathered to understand the impacts of these programs on the social and emotional wellbeing of First Nations people. The recent evaluation of ITC Program in the HNECC PHN provides initial evidence that overwhelmingly supports its positive impacts on all aspects of the lives of First Nations clients and communities. When integrated care services are delivered by local organisations that understand the needs of their communities – and which employ First Nations staff who attend to clients' cultural needs and wellbeing – clients feel supported, safe and respected and are more likely to achieve positive health and wellbeing outcomes. The relationships formed between passionate and empathetic care coordinators in culturally safe organisations and their clients have led to a range of wellbeing and quality of life improvements.

The ITC Program is designed to be adapted to different local needs, and the HNECC PHN has ensured the program is delivered flexibly. This means giving autonomy to local providers to deliver their own ITC Program that both meets government requirements and also develops local innovations and adaptations. Such adaptations have allowed providers to connect with other services to further address the social and emotional wellbeing needs of clients where they see fit, helping the program to continue to evolve and meet more client needs.

Increasing and pooling funding

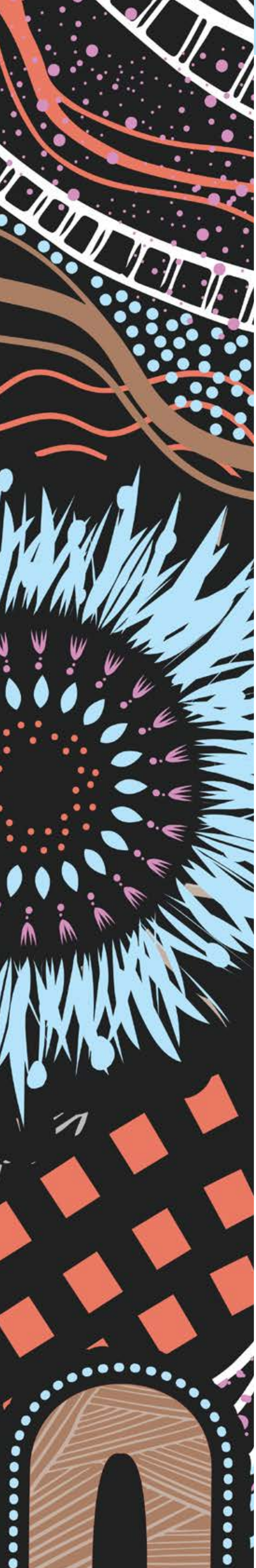
Seeing the overwhelmingly positive client response to the program shows that these innovations and delivery modes are successful and can serve as a strong example for the future of health service delivery for First Nations people. However, there are several aspects of this program, and health programs in general, that require ongoing commitment to ensure their success is sustained.

The funding for the program needs to be updated to reflect the extent of work and diversity of services that clients require in order to truly function as an integrated service.

The HNECC PHN and ITC Program service providers work together to deliver a range of other physical and mental health programs. One potential future direction for health-care delivery is to combine pools of program funding to deliver wrap-around supports that can be further tailored to meet the needs of community members.

Moving away from a single disease model of funding towards a holistic approach, which is place-based and co-designed with local community, is best practice (Verbunt et al. 2021).

With appropriate system-level funding and further refinement of initiatives like the ITC Program, along with insights into the successes and challenges faced by other PHNs, we can better support the holistic health needs of First Nations people. This approach will provide culturally safe care that enhances the social and emotional wellbeing of these communities.



Appendixes

Appendix A: Policies and frameworks

Table A1. Description of policies and frameworks

Name	Details	Key recommendations	Implementation
National Agreement on Closing the Gap	The agreement has been designed to overcome the inequality faced by First Nations people, so they have life outcomes equal to all Australians. The Agreement identifies five priority reforms that support the transformation of the health sector to achieve this and 19 national social and economic targets,	The National agreement contains 5 key priority reforms. 1. Shared decision making 2. Building the community-controlled sector 3. Improving mainstream institutions 4. First Nations led data.	All parties are required to develop their implementation plans to support the agreement. All parties will be accountable through a dashboard and annual data compilation report.
National Aboriginal and Torres Strait Islander Health Plan 2021–2031	The plan encompasses a strength-based approach which includes the diversity of First Nations people. It addresses the knowledge that First Nations people, when included, have the innovative solutions to determine their health outcomes, which includes the voices of people with a lived experience. The plan recognises that First Nations health outcomes is a whole-of-system responsibility and raises the importance of creating culturally safe and responsive health care.	The plan requires a holistic approach when considering priorities. There are 12 priorities: 1. Genuine shared decision making and partnerships. 2. Aboriginal and Torres Strait Islander community controlled comprehensive primary health care 3. Workforce 4. Health promotion 5. Early intervention 6. Social and emotional wellbeing and trauma aware, healing informed approaches. 7. Healthy environments, sustainability and preparedness 8. Identify and eliminate racism 9. Access to person centred and family centred care 10. Mental health and suicide prevention 11. Culturally informed and evidence-based evaluation, research and practice 12. Shared access to data and information at a regional level.	The Australian Government is responsible for implementing the plan at a national level through a leadership approach including First Nations organisations.

Continued

Table A1 (continued): Description of policies and frameworks

Name	Details	Key recommendations	Implementation
The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023	The framework aims to respond to the high incidents of social and emotional well-being issues of First Nations people.	The framework has 5 actions areas: 1. Strengthen the foundations 2. Promote wellness 3. Build capacity and resilience in people and groups at risk 4. Provide care for people who are mildly or moderately ill 5. Care for people living with a severe mental illness	The Australian Government is committed to implementing the framework through existing First Nations partnerships although there is no dedicated implementation plan that supports this.
National Strategic Framework for Chronic Conditions	The Framework is an overarching policy document for chronic conditions that seeks to develop further strategies, actions and specific policies that relate to the prevention and management of chronic diseases.	There are 3 objectives areas: 1. Focus on prevention for a healthier Australia. 2. Provide efficient, effective and appropriate care to support people with chronic conditions to optimise quality of life. 3. Target priority populations. 3.1. Priority populations have reduced risk of developing chronic conditions. 3.2. Priority populations experience fewer complications, multimorbidity's or disabilities associated with chronic conditions. 3.3. Aboriginal and Torres Strait Islander people have reduced risk of developing chronic conditions and those with chronic conditions have an improved life expectancy.	A reporting framework has been developed to monitor the progress of the objectives, 45 indicators that measure key aspects of chronic condition prevention and control.

Continued

Name	Details	Key recommendations	Implementation
The South Australian Aboriginal Chronic Disease Consortium	The South Australian Aboriginal Chronic Disease Consortium is a collaborative alliance involving both government and non-government organisations to ensure the implementation of three chronic disease health plans.	The SA Aboriginal Chronic Disease Consortium provides a strategic platform for: • Collaboration • Holistic coordination • Pooling resources • Cultural competence • Advocacy • Shared learning	A roadmap has been developed which ensures the implementation of the three chronic disease health plans
NSW Aboriginal Health Plan 2013–2023	The NSW Aboriginal Health Plan represents the NSW Government's commitment to addressing the health disparities experienced by First Nations people. This plan gave NSW Health the opportunity to reassess collaborative approaches to transform health services in order to achieve health equity.	It identified 6 strategic directions to drive changes in the health system to improve Aboriginal health: • Fostering trust via local partnerships • Gathering evidence and implementing proven strategies • Guaranteeing integrated planning and service delivery • Increasing the Aboriginal workforce • Ensuring culturally safe work environments and health services • Reinforcing performance monitoring, management and accountability	The NSW Government was responsible for implementing the plan and there was an implementation plan that will guide this.

Appendix B: Programs

Table B.1 Description of programs, the associated evaluations and outcomes

Program	Program details		Evaluation	Evaluation details		Outcomes
The Integrated Team Care Program	Location(s)	Nationally delivered in Australia	Nama Jalu Consulting and HNECC PHN – Process and Summative Evaluation	Location(s)	Hunter, New England and Central Coast, NSW, Australia	• Program delivery largely aligns with program guidelines. • Self-management aspect of program requires greater focus and resourcing. • Clear communication, strong relationships and passionate staff are key enablers for program delivery. • Barriers to delivery include systemic and local-level funding and resourcing issues. • Clients reported increased health outcomes and engagement with the health system. • Mixed success in supporting clients towards self-management of health conditions. • More work needed to improve capacity of mainstream primary care providers to deliver culturally appropriate care. • Program was especially effective for clients with diabetes and multiple chronic conditions.
	Participants	N/A		Participants	69	
	Duration	Ongoing		Duration	June 2022 – July 2023	
	First Nations specific	Yes		First Nations specific	Yes	
	Focus	Chronic conditions		Focus	• To what extent are the activities being delivered as intended? • To what extent is the program meeting the needs of clients and other key stakeholders? • What was the provider's experience of implementing the program? • Can the program be refined to improve efficiency in the delivery of activities?	

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Abbreviations

ACI	Agency for Clinical Innovation
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Services
CCSS	Care Coordination and Supplementary Services
CPD	continuous professional development
FNHFTP	First Nations Health Funding Transition Program
GPs	General practitioners
HNECC	Hunter, New England and Central Coast
IAHP	Indigenous Australians’ Health Program
IAMPC	Indigenous Access to Mainstream Primary Care
IMH	Indigenous Mental Health
ITC	Integrated Team Care
PHN	Primary Health Network
QI	Quality Improvement
RACGP	Royal Australian College of General Practitioners

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This paper outlines an evaluation of the Integrated Team Care program undertaken by the Hunter, New England and Central Coast Primary Health Network. It focuses on the success of the program in supporting the social and emotional wellbeing of First Nations clients, alongside chronic health conditions. It also identifies future opportunities to improve integrated service delivery.

Stronger evidence,
better decisions,
improved health and welfare