Please find below and attached responses to the two questions on notice posed by the Committee at its recent hearing as part of its inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW.

The questions on notice and RDN's responses are below:

- Information on the model being trialled at each of the five Collaborative Care sites
    - Please find attached summary of each of the five original Collaborative Care trial sites.
- Additional information on when the story of the Waminda South Cast Women's Health and Wellbeing Aboriginal Corporation will be documented and/or published
    - It would be most appropriate for the Committee to contact Waminda directly for this information.
    - RDN has contacted Waminda to inform them that the Committee is interested in their story.
    - RDN would recommend reaching out to Waminda's Chief Executive Officer, Faye Worner, via administration@waminda.org.au, or using the contact details on their website - https://waminda.org.au/contact/.

Please let me know if the Committee would like further clarification.

RURAL DOCTORS NETWORK

COLLABORATIVE CARE

The Collaborative Care Program has been developed by RDN as a community-centred approach to addressing the primary health care challenges in remote and rural communities. These challenges include community access to appropriate care, the recruitment and retention of health practitioners, and the financial sustainability of health services.

The Program works with local health professionals and communities to create a primary healthcare model that fits their needs. It does this by bringing local stakeholders together using a proven methodology to develop shared priorities and solutions to trial. The Collaborative Care Program is an extension of RDN's town-based health planning approach which has proven successful for more than 30 years.

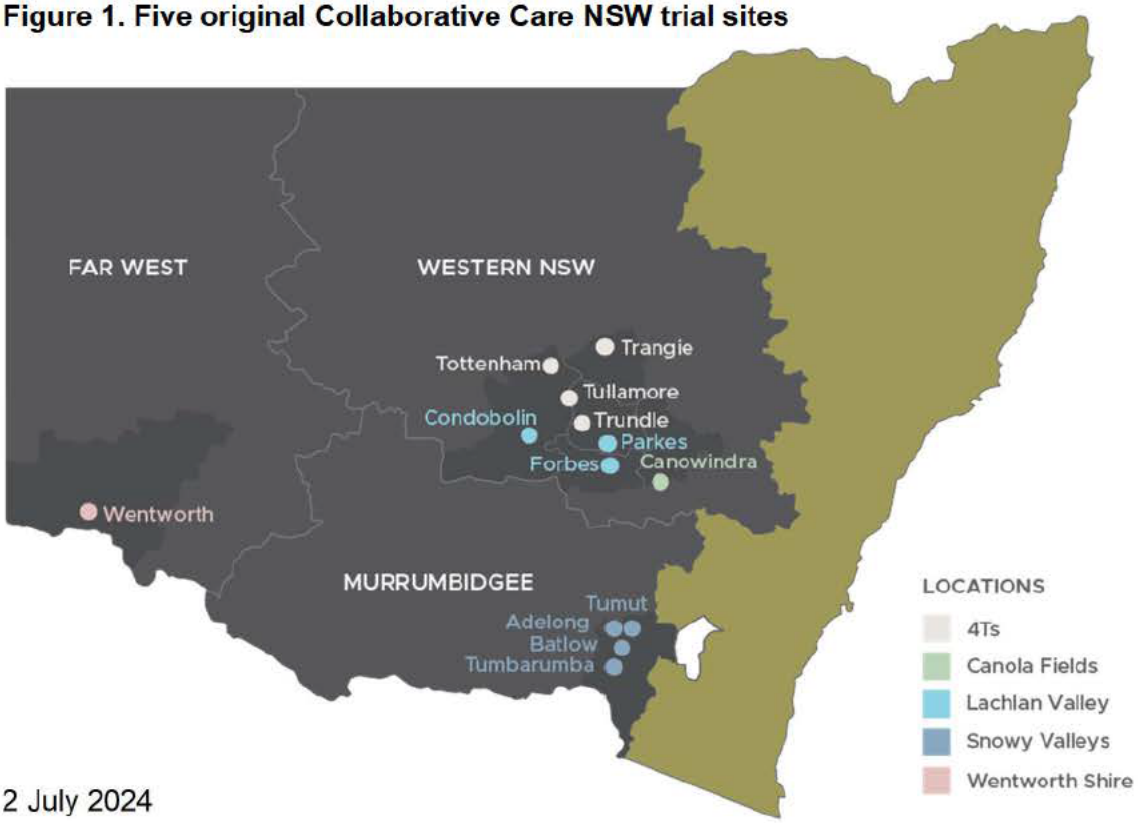
The original program was applied to five trial sites in rural NSW, with funding support from the Australian Government Department of Health and Aged Care (DoHAC). This funding ran until June 2024, with most of the trials now completed and evaluated. The models created and implemented under the Program in these five sites have transitioned their activities to business as usual.

The Program tested unique models of primary healthcare service delivery in five locations across rural NSW (see Figure 1):

1. The 4Ts (Tottenham, Tullamore, Trangie, and Trundle)
2. Canola Fields (Canowindra and surrounding towns)
3. Lachlan Health Region (Condobolin, Forbes, and Parkes)
4. Snowy Valleys (towns of the Snowy Valleys LGA)
5. Wentworth Shire.

As of June 2024, RDN has come to an agreement with the NSW Ministry of Health to implement the Collaborative Care Program in five additional NSW sites.

Figure 1. Five original Collaborative Care NSW trial sites



How does it work?

The Collaborative Care Program uses a staged approach to place-based primary healthcare planning. The coordinating organisations form a project team that guides their communities through the following five steps (and in Figure 2):

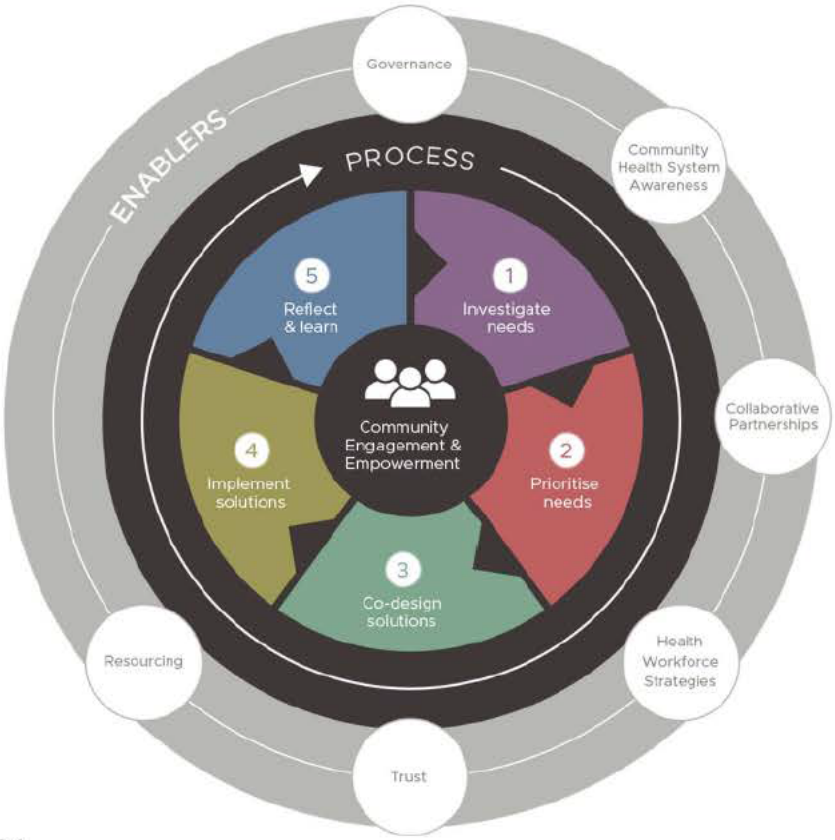
1. Investigate needs: what are the primary health care needs in the community?
2. Prioritise needs: which of these needs should we tackle first?
3. Co-design solutions: decide together how we could improve access to these important services for the community.
4. Implement solutions: put the plan into practice and make sure communities know what to expect.
5. Reflect & learn: look at what is working well and where improvements can still be made.

In practice, it is an iterative process rather than five linear steps as depicted in Figure 2. As the stakeholders continue to collaborate, they uncover more opportunities to improve access to primary healthcare in their communities. The learnings from previous activities lead to new investigations, new opportunities, and new solutions to be trialled.

Community engagement and empowerment are central to each step and essential for solutions to be effective. Through the five trials, RDN also identified several key enablers depicted on the outer ring of the diagram. These enablers must be in place for the process to work effectively. If some of the enablers are missing the process will undertake specific activities to address them.

This process was developed and codified by RDN's Collaborative Care team from learned experience in facilitating the five trial sites between 2021-24. A range of tools were also developed to support project teams in navigating each of the steps.

Figure 2. Collaborative Care Process



Trial 1: The 4Ts

Service model	- Introduced by Western NSW Local Health District (WNSWLHD) following ceasing of all private general practice in these towns - Services towns of Trangie, Tottenham, Tullamore, and Trundle in Central Western NSW - Single employer model provides networked primary care clinics across the four communities - Four part-time primary care clinics, co-located with each town's WNSWLHD multipurpose service (MPS), delivered in a networked arrangement - Clinics staffed by Rural Generalist GP, rural generalist primary care nurses, administrative staff, and a medical centre manager employed by WNSWLHD. - Clinics are further supported by the WNSWLHD Virtual Rural Generalist Service (VRGS) telehealth service.
Funding	- COAG 19(2) exemption allows WNSWLHD to bill Medicare for primary care items - Financially underwritten by WNSWLHD
Benefits	<u>Patients</u> - increased access to health services (location, affordability, timeliness, appropriateness) - increased patient satisfaction (compared with WNSWLHD and NSW Health averages) <u>Workforce</u> - Attractive for staff recruitment and retention, due to: ○ Employment stability ○ Professional collegiate support and team environment ○ Professional development ○ Accommodation supports ○ Competitive salary <u>Health system</u> - Reduced ED presentations, non-urgent ED presentations, and hospital readmissions - MPS data indicates a reduction in episodic care and an increase in holistic care.
Challenges	- Model operates on an 'acceptable loss' basis for WNSWLHD. - Options to improve financial sustainability have been identified, however some state-level financial support would likely still be required.

Trial 2: Canola Fields

Service model	- Deliberate Team-Based Care (DTBC) model introduced into a private GP clinic (Nyrang Health Team) in Central Western NSW. - DTBC designed to holistically manage chronic conditions in patients at high-risk of health decline, and enhance the ability of the local workforce to provide coordinated patient care. - Patients are risk stratified on first presentation to the GP clinic - If deemed appropriate for DTBC, and consent is provided, the patient is enrolled in the DTBC model. - The model delivers patient-centred care planning by a multidisciplinary team, including monthly case conferencing. - Both chronic and acute health needs of enrolled patients are managed by the DTBC team.
Funding	- Model is financially sustainable with adequate billing and adequate patient throughput - Patients are bulk-billed whilst enrolled in DTBC - GP – MBS funded, private practice - Pharmacist – not specific funding for participation - Physiotherapist, occupational therapist, social worker, dietician, speech pathologist, registered nurse, enrolled nurse – funded by WNSWLHD (participation is part of their WNSWLHD roles)
Benefits	<u>Patients</u> - Improved patient satisfaction (with both care experience and health outcomes) - Improved relationships with clinical care team - Increased health literacy - Increased access (reduced costs, in-place care delivery, reduced time to clinical care) <u>Workforce</u> - Helps GP with procedural/clinic workload balance - Reduces risk of staff burnout, and increased retention, due to increased autonomy, role satisfaction and enablement of working at top of scope of practice. - Improved team support and collaboration <u>Health system</u> - Estimated savings of $1.08m over five years to the health system from reduced hospitalisations.
Challenges	- Strong workload demand on lead GP - Funding inadequate to cover administrative tasks - No dedicated funding sources for non-GP team members - Lack of dedicated facility

Trial 3: Lachlan Valley

Service model	This project did not reach the stage of trialling a model of care, however, significant outcomes and learnings were achieved and may pave the way for new models of care in future. - Covered a sub-region in Central Western NSW that included the towns of Condobolin, Forbes and Parkes. - These trials were predicated on communities coming together to identify common needs and identify innovative ways to improve access to health services. - This region was greatly impacted by natural disasters during the funded trial period (drought, COVID-19 pandemic, floods) impacting the ability of these communities to dedicate time to this project. - This site did not reach the stage of trialling a model of care within the funding period of 2021-2023, however learnings did emerge from this project that will inform future health service strategies in this region.
Funding	n/a
Learnings	- Initial agreement on primary care needs is a prerequisite to uniting multiple stakeholders an ensuring shared, clear objectives. - The importance of having mutual agreement and trust between partners cannot be underestimated. - If larger towns, multiple towns and/or LGAs are involved (with potentially differing needs) the project will need more time to build momentum and reach consensus on models to be trialled. - There should be a separate focus for Aboriginal and Torres Strait Islander people and, if preferred, a separate working group to guide activities. - Activities such as health workforce recruitment or community health system education may be necessary and require additional time and budget. - It may take 4 to 5 years to co-design, trial, and evaluate a model of care in a new location that does not have a pre-existing model.

Trial 4: Snowy Valleys

Service model	- Initiated in the Snowy Valleys LGA, it expanded into neighbouring LGAs in the Riverina region during the trial
	- Shared Medical Appointment (SMA) model for chronic disease management
	  ○ Scheduled group appointment for patients with the same chronic condition, e.g. type 2 diabetes, COPD.
	  ○ Appointments often run according to a structured program.
	  ○ Group appointments are delivered by a group facilitator and run for approximately 1.5 hours.
	  ○ The GP will attend part of the appointment to address each patient's needs and concerns within the supportive peer environment.
	  ○ Visiting allied health practitioners are also scheduled to attend to respond to specific concerns or deliver interventions relevant to the patient group.
	  ○ The facilitator summarises the information and encourages sharing among the patients.
	  ○ Following the appointment, the GP prepares any scripts or referrals required.

Funding	- Patients billed as for individual appointments - Financial viability for ongoing operation achieved with groups of 7 or more patients - However, set-up costs are unfunded (e.g. service model planning, recruitment, infrastructure set-up, staff training)
Benefits	<u>Patients</u> - More time with GP and health team (within a group) - Peer-support environment and associated shared discussion <u>Workforce</u> - Efficiency gains as similar information is delivered once to the group, rather than to each member individually - More time for GP to build rapport with patients - More time for clinicians to build health literacy and healthful behaviour change in patient group - Can help manage GP waitlists <u>Health system</u> - Improves multidisciplinary, holistic chronic disease care and coordination - May assist in reducing GP wait times by servicing more patients - May assist in decreasing ED presentations and hospitalisations due to exacerbation of chronic conditions.
Challenges	- Groups of 8-12 patients are necessary for financial sustainability if reliant on bulk billing. Developing patient groups of this size can take time. - The GMA model requires planning and investment in staff training, which is currently unfunded.

Trial 5: Wentworth

Service model	- The cross-border community of Wentworth in Far West NSW experienced market failure when two local private GP clinics closed their doors. - Coomealla Health Aboriginal Corporation (CHAC) partnered with Wentworth Shire Council to open a GP Clinic in Wentworth that would serve the whole community. - CHAC deliver the Wentworth clinic within a networked model of two clinics, in Dareton and Wentworth, with outreach services to remote communities. - This networked model allows sharing of software, management systems, and clinicians across services and locations. - The Wentworth clinic provides GP services and some part-time allied health services. All services are bulk-billed, and the clinic is fully-funded via MBS billings.
Funding	- 100% funded through Medicare billing via Indigenous 19(2) exemption - Salaried model for GPs - Networked model with centralised management reduced management costs per patient service - Financial support (from Wentworth Shire Council) was necessary for establishment of the model in the first two years of operation - Ongoing financial sustainability is possible, but reliant on a stable GP workforce.
Benefits	<u>Patients</u> - Access to primary care services, bulk-billed and long consults as required - Services are described as high quality - Strong referral linkages to allied health practitioners <u>Workforce</u> - Positive working environment for GPs - Salaried model offers GPs ability to focus on patient care <u>Health system</u> - Use of ACCHO additional capacity to deliver care to non-Aboriginal cohort reduced duplication and improves efficiency
Challenges	- Ongoing instability of local GP workforce, with GPs becoming unavailable for a variety of reasons.