Standardised Processes

WA Integrated Team Care Program



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An Australian Government Initiative



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Standardised Processes
WA Integrated Team Care

This document provides an overview of the model of care and associated standardised process for the Integrated Team Care (ITC) Program, which is contracted by WA Primary Health Alliance. These processes were developed in accordance with the ITC Guidelines and are required to be complied with by all contracted ITC Service Providers.

ITC Program Model of Care

The ITC Program is a short-term care coordination program designed to support an Aboriginal person to manage their chronic health needs.

The key aims of the ITC Program are to:

- Contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through access to care coordination, multidisciplinary care, and support for self-management; and
- Improve access to culturally appropriate mainstream primary care services (including but not limited to general practice, allied health and specialists) for Aboriginal and Torres Strait Islander people.

The below diagram provides an overview of the eight stages of the ITC Program "Model of Care", in which the ITC client forms the central pillar.



Standardised Processes

WA Integrated Team Care

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STAGE 1: GP REFERRAL

Eligibility Criteria - GP to check

1. Patient identifies as Aboriginal and/or Torres Strait Islander.
2. Patient is enrolled for Chronic Disease Management (CDM) in general practice or Aboriginal health service.
3. Has a GP Management Plan (GPMP). See interim referral options where a GPMP is unavailable.

Note: Not all clients with a chronic condition need ITC assistance. ITC prioritises support of complex chronic needs, multidisciplinary care needs, and/or clients at risk of potentially preventable hospitalisations.

Referral into ITC Program – GP to check then forward to ITC Provider

1. Check that recommended ITC support is included in GP care plan. See Integrated Team Care Pathway for further information (https://wa.healthpathways.org.au).
2. Complete WA ITC GP Referral Form and forward to ITC Provider, along with a copy of a GP care plan (mandatory) and attachments supporting recommendations where applicable.
   a. Preferred/best practice GP care plan: GPMP MBS 721
   b. Interim Referral Options:
      - Team Care Arrangement MBS 723
      - MBS 715/228 and registered for PIP Indigenous Health Incentive (IHI) for CDM (not PBS Co-payment alone).
      - Remote Area Nurse (RAN) referral with interim plan is accepted in remote areas of intermittent GP access, allowing ITC to provide limited care coordination and access to urgent transport.
      - For patient out of their home region a non-usual GP may submit an interim care plan (e.g. using MBS 44). The plan must be comprehensive, relevant to the client's CDM and include recommended ITC Support.

NOTE: Where ITC registration has been accepted initially without a GPMP, a current **GPMP must be provided within 3 months** for review of client needs and continued registration.

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STAGE 2: REFERRAL SCREENING

- Receive referral from GP and/or RAN
- Register referral in MMEx or Communicare.
- Check that all required referral documents have been received.
- Ensure all relevant sections for the referral are completed e.g. clients personal and contact details.
- Ensure client fulfils eligibility criteria
  - People residing in a Residential Aged Care Facility (RACF) are **not eligible** for ITC.
  - ITC **must not duplicate** services for people eligible for a Government funded care package, including an Aged Care and/or NDIS package.
- Send receipt of referral to GP within 24-48 hours.
- Schedule an appointment with client to complete:
  - Registration;
  - Client Consent Form; and
  - Triage assessment.
- Inform client of appointment date and time. If required, arrange transport for the client to and from the appointment.

GP Referral Form

WAPHA Aboriginal Health

WA Integrated Team Care Program

This program supports Aboriginal and Torres Strait Islander people with complex chronic care needs to improve self-management of their condition in partnership with their GP.

Referring GP Details: (stamp accepted)	
Name:	
Practice:	
Practice Address:	
Phone: Fax:	

Patient Details:	
First Name:	Date of Birth:
Surname:	Phone:
Residential Address:	Postcode:
Next of Kin/Alternate Contact:	Alternate Contact Phone:

My patient meets ALL the criteria below (tick applicable):

- ☐ Is Aboriginal and/or Torres Strait Islander
- ☐ Has chronic health needs requiring complex and/or multidisciplinary care
- ☐ Has a chronic condition management plan

Type of Chronic Disease Management Plan (attached)

☐ Current GP **Management Plan MBS721**

Interim referral options are accepted but a GPMP must be provided *within three months*

- ☐ Referral by non-usual GP or Remote Area Nurse (RAN) with an interim CDM care plan[i], or
- ☐ Team Care Arrangements MBS723; or
- ☐ Current Aboriginal Health Check MBS715 and is registered for PIP IHI for CDM with referring practice[ii]

Chronic Condition Details *(tick applicable)*

☐ Diabetes	☐ Chronic renal disease	☐ Co-occurring mental health condition
☐ Cardiovascular disease	☐ Chronic respiratory disease	☐ Cancer

☐ Other[iii]

Is another organisation already currently providing Care Coordination? If yes, specify:

.....

Eg. Aboriginal Community Controlled Health Service; ICDC Program; Aged Care Provider. Provide Client ID Number if available

NDIS and Aged Care:

Is the client registered for NDIS: ☐ Yes ☐ No ☐ In progress

Is the client registered for Aged Care support: ☐ Yes, Level (circle): 1 2 3 4 ☐ No ☐ In progress

The ITC Program must not duplicate services for people eligible for a funded package.

Reason/s for ITC Referral:[iv]

☐ Requires Supplementary Services support ☐ Requires Care Coordination support

THE ITC PROGRAM IS ONLY ABLE TO PROVIDE SUPPORT RECOMMENDED IN THE GP CARE PLAN AND NOT AVAILABLE THROUGH OTHER MEANS.

Comments:

.....

.....

Patient Information and Consent

My GP has explained the purpose of this referral for the ITC Program; I give permission for my care plan to be shared with the ITC Provider; and for the ITC Provider to contact me to discuss how the ITC Program can support me in my care plan needs.

Patient signature: GP signature:

Verbal consent (where signature not practicable[v]) ☐ Date:

WA ITC Providers

PERTH NORTH PHN (see Health Pathways for suburb list)				
Subregion	**Service Provider**	**Contact**	**Fax**	**Secure messaging**
North West	Arche Health	P: 08 9458 0505 Free call: 1300 182 820 E: aht@archehealth.com.au	08 9458 8733	MMEx
North East	Moorditj Koort	P: 08 6174 7000 E: info@moorditjkoort.com.au	08 6174 7098	MMEx

PERTH SOUTH PHN (see Health Pathways for suburb list)				
Subregion	**Service Provider**	**Contact**	**Fax**	**Secure messaging**
South West (Mandurah, Waroona, Murray (6213))	Nidjalla Waangan Mia (NWM) Operated by GP Down South	P: 08 9586 4580	08 6117 0489	HealthLink
South West	Moorditj Koort	P: 08 6174 7000 E: info@moorditjkoort.com.au	08 6174 7099 (Medina) 08 6174 7097 (Cockburn)	MMEx
South East	Arche Health	P: 08 9458 0505 Free call: 1300 182 820 E: aht@archehealth.com.au	08 9458 8733	MMEx

COUNTRY WA PHN				
Subregion	**Service Provider**	**Contact**	**Fax**	**Secure messaging**
Kimberley	Boab Health Services	P: 08 9192 7888 (Broome) P: 08 9168 2560 (Kununurra)	08 9192 7999 08 9168 2560	MMEx
Midwest (South)	Geraldton Regional Aboriginal Medical Service (GRAMS)	P: 08 9956 6555	08 9964 3225	Communicare
Midwest (North)	GRAMS Gascoyne Outreach Service	P: 08 9947 2200	08 9941 2024	Communicare
Pilbara	Mawarnkarra Health Service Aboriginal Corporation	P: 08 9182 0851 E: mhsitc@mhs.org.au	08 9182 1055	Communicare
South West	South West Aboriginal Medical Service (SWAMS)	P: 08 9726 6000 Free call: 1800 779 000	08 9791 7655	Communicare
Wheatbelt (Central & Western)	Wheatbelt Health Network	P: 08 9621 4444 E: northam@wheatbelt.com.au	08 9621 2119	HealthLink
Wheatbelt (Southern, Coastal & Eastern)	Amity Health	P: 08 9842 2797 E: query@amityhealth.com.au	08 9842 2798	MMEx
Goldfields	Hope Community Services	P: 08 9021 3069 (Kalgoorlie & Northern) P: 08 9071 5169 (South East Coastal) E: ITCAllStaff@hopecs.org.au	08 9021 8920 08 9071 5209	MMEx
Great Southern	Amity Health	P: 08 9842 2797 E: query@amityhealth.com.au	08 9842 2798	MMEx

Forward completed ITC Referral Form, patient care plan and other relevant documents to ITC Provider preferably via secure messaging.

[i] *GP or RAN may submit an interim care plan (eg. carried out during a long consult) for patients without access to their usual GP. The plan must be comprehensive, relevant to client's CDM, and include recommended ITC support.*

[ii] *Must be registered for the component of PIP IHI for patients with a chronic condition – not for PBS CoPayment alone.*

[iii] *As per the MBS, an eligible condition is one that has been, or is likely to be, present for at least six months*

[iv] *See ITC HealthPathways for further information: https://wa.communityhealthpathways.org/65938.htm*

[v] *Verbal consent is a legal minimum requirement.*

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STAGE 3: INTAKE ASSESSMENT

Registration and Consent Form

Refer to WAPHA ITC Intake Assessment Process, and Client Registration and Consent Form.

The purpose of the registration form is to ensure the client understands:

- what they can expect from the ITC Program, and
- what their rights and obligations are as a client.

Triage Assessment

Refer to WAPHA ITC Intake Assessment Process, and WAPHA ITC Triage Assessment Form and Scale.

The purpose of triage is to determine the priority level of the client based on:

- the complexity of their condition management needs,
- likelihood of recovery with or without treatment, and
- level of urgency.

Client's are triaged based on the following three levels of client need and urgency:

Low

Client is self-managing and requires almost no care coordination support, but still requires access to supplementary service support.

Medium

Client can self-manage aspects of their own care but require a moderate level of care coordination and access to supplementary services support.

High

Client is unable to self-manage and requires a high level of care coordination, and access to supplementary services support.

Allow clients time to yarn and tell their story, as there may be issues not directly related to their health needs that are impacting the management of their condition.

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STAGE 4: CARE COORDINATION PLANNING

[Step by step plan with client, complete, agreed and sign by Care Coordinator and client]

- Develop ITC Care Plan with client according to GP Care Plan and Triage Assessment.
- Plan out each item on the GP Care Plan and discuss priority item.
  - Inform client of the waitlist to receive first service.
- Complete Flinders 'My Health Story' with clients as per Flinders 'My Health My View' score and GP Care Plan.
- Each section of the clients care plan MUST have an end date to be achieved by.
- For ongoing services such as Webster Packs enter review date as end date.
- Both client & Care Coordinator to agree on each action, then date and sign.
- Provide copy of either the ITC or My Health Story Care Plan to GP via My Health Record Event Summary or Secure Messaging.
- Aged Care Package
  - Care Coordination planning should include supporting ITC clients who are eligible to apply for and transition to an Aged Care Package.
- Plan multidisciplinary case conferencing for people who are triaged as high needs.
  - Request inclusion of ITC in Team Care Arrangements.

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STAGE 5: CARE MANAGEMENT

- Progress through ITC Care Plan and Flinders 'My Health Story' Care Plan for clients with high needs.
- Establish and maintain partnerships with key stakeholders to ensure clients are linked to appropriate services and programs.
- Keep GP and client informed.
- Include planned actions for Social and Emotional Wellbeing (home/ relationships/community) issues that may be impacting on client's health outcomes.



Client Registration and Consent Form

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The Integrated Team Care (ITC) Program supports Aboriginal and Torres Strait Islander people with complex chronic care needs to improve self-management of their condition in partnership with their GP. It is the responsibility of the ITC Provider to support clients to understand and complete the form to ensure informed consent.

Patient Details:			
First Name:			Date of Birth:
Surname:			Phone:
Residential Address:			Postcode:
Medicare Number:	Ref No:		Expiry:
Health Care / DVA Card Number:			Expiry:
Primary Language Spoken:			Interpreter Required: ☐ Yes ☐ No
Gender: ☐ Male	☐ Female	☐ Indeterminate / Intersex / Unspecified	
Ethnicity: ☐ Aboriginal	☐ Torres Strait Islander	☐ Aboriginal & Torres Strait Islander	

Next of Kin Details:	
First Name:	Relationship:
Surname:	Phone:
Residential Address:	Postcode:

Emergency Contact Details:	
First Name:	Relationship:
Surname:	Phone:
Residential Address:	Postcode:

Additional Details:			
Do you have dependent children living at home:	☐ Yes	☐ No	If yes, number of children:
Are you the primary carer for another person:	☐ Yes	☐ No	
Do you have mobility issues:	☐ Yes	☐ No	
Do you have access to transport:	☐ Yes	☐ No	

Client Consent

To register for the ITC Program please read the information below and tick to confirm that each point has been explained by an ITC staff member, and that you understand/consent as applicable. Text in **blue** indicates where you may select either Yes or No and still be registered for the ITC Program.

Protecting Your Privacy	The ITC Program is committed to providing you with the highest level of service and confidentiality. The ITC Program is bound by the Commonwealth Privacy Act 1988 and the Privacy Amendment (Private Sector) Act 2000.	☐ Yes
Information Management	All information collected about you is confidential and will be stored securely. You may request to see information held about you, or withdraw from the ITC Program, at any time. The documents released to the ITC Provider from your GP (or hospital, or other relevant health provider) may contain information including, but not limited to, history, diagnoses, and/or treatment of mental illness or communicable disease. The provided information is stored securely, and will remain confidential between you, your GP (or other relevant health provider) and the ITC Provider. Information retained by the ITC Provider cannot be disclosed to a third party without your written authorisation, except where otherwise permitted by law.	☐ Yes



Collection, Exchange and Disclosure of Information	Communication between your GP and ITC Provider: The ITC Provider will support your GP to help you to manage your chronic condition. Your GP must provide a copy of your GP Care Plan to the ITC Provider including recommendations for ITC support. Depending on the recommendations the ITC Provider may require additional information/documents (such as copies of: GP Management Plan; Team Care Arrangements; or allied health and specialist referral forms). The ITC Provider will provide your GP with updates on your progress toward completion of the GP Care Plan, and recommendations for ongoing management of your health condition. Your ITC Provider will require copies of 3-6 monthly reviews of your GP Management Plan.	☐ Yes
	Communication with Allied Health and Specialist Services: Information needed to coordinate appointments with referred Allied Health and Specialists will only be disclosed with verbal consent from yourself. Sharing of clinical information will require your written consent.	☐ Yes
	Communication with Hospitals: If you are admitted to hospital while registered for the ITC Program your ITC Provider and hospital staff involved in your care may liaise to confirm that you are registered for the ITC Program and to discuss your health needs once you are discharged. The hospital may provide your ITC Provider with a copy of your discharge summary.	☐ **Yes** ☐ **No**
	Communication with other ITC Providers: if you are outside your current ITC region, but still within WA, another ITC Provider may be able to assist you. To do this your current ITC Provider will need to share information about your care needs to the other ITC Provider. An ITC Provider will discuss this with you and request additional consent for the inter-region support/transfer process as needed.	☐ Yes
Cancellations	You must provide the ITC Provider and health services 24 hours' notice to cancel an appointment. Failure to do so may result in the appointment being considered a 'Did Not Attend' (DNA) by the health service. A DNA may result in you being re-assigned to the waitlist. Continuous DNA may result in review of your registration with the ITC Program.	☐ Yes
Transport Support	The ITC Program supports clients without access to transport to attend essential health care appointments. This may include coordination with other services who provide transport; assistance to access public transport; or provision of transport by an ITC staff member when available. Where no other transport option is available, a voucher may be provided. Vouchers must only be used for direct travel to and from appointments; and the receipt must be returned to the ITC Provider. You are financially responsible for any misuse of the voucher. Any misuse may result in suspension from future transport support.	☐ Yes
Case Conferencing	You, or one of the health professionals involved in your care, may ask your ITC Provider or GP to arrange a case conference. Case conferences provide an opportunity for you and the people who provide medical and other services to meet and plan your future care.	☐ Yes
My Health Record	Clinical ITC staff directly involved in your care may request to view and upload health information into your My Health Record. Your verbal consent will need to be provided each time this needs to occur. It is possible to set up privacy settings within My Health Record to receive a text whenever your record is accessed; or to limit access to only those whom you have provided a passcode.	☐ Yes
Home Medication Review	A Home Medication Review (HMR) may be recommended to assist in the management of your ongoing medication needs. This will require release of your medical and medication history, as well as Medicare Number to the pharmacist. The pharmacist will communicate the findings of the HMR to you and your ITC Provider.	☐ **Yes** ☐ **No**
Review of ITC Registration	Your ITC needs and ability to self-manage will be reviewed regularly. You may be discharged from the program as you become better able to self-manage. Should your needs change in the future your GP can submit a new ITC referral.	☐ Yes
Discrimination	The ITC Program prohibits discrimination based on age, race, gender identity, sexuality, religious or political beliefs or activity or other characteristics possessed or assumed as protected under Federal and State anti-discrimination law.	☐ Yes
Program Reporting and Evaluation	I understand that the ITC Program is funded by the Australian Government, and that de-identified statistical information will be collected and used to assist in ITC Program reporting and evaluation. This will help ensure continuous ITC Program improvement.	☐ Yes

Client Name:	Signature:	Date:
.....	.....	.....
Parent/Guardian/Carer Name:	Signature:	Date:
.....	.....	.....
ITC Staff Member Name:	Signature:	Date:
.....	.....	.....

ITC Program Verbal Consent:

Verbal consent should only be used where it is not practicable to obtain written consent

I have discussed the above information with the client and/or the parent/guardian and am satisfied that they understand the proposed collection, use and disclosure of personal health information and have provided informed consent to participate in the ITC Program.

ITC Staff Member's Name:	Signature:	Date:
.....	.....	.....

WAPHA ITC Intake Assessment Process

Step 1
Client Registration and Consent

- Review the ITC Client Registration and Consent Form with the client using plain language. Reassure client of privacy and confidentiality.
- Explain to the client the program is short-term to achieve self-management of their chronic condition.
- Obtain written or verbal consent from the client.
- Provide a copy of the completed form to the client and upload a copy to the client's file.
- Review the GP Care Plan with the client and ensure all their needs have been included.

Step 2
My Health My View Assessment

Complete the Flinders 'My Health, My View' assessment to determine client's self-management score.

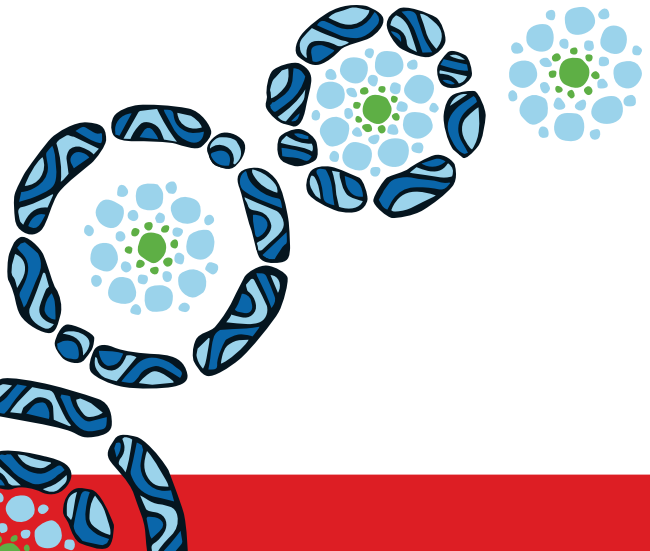
- Any rating of 5 or more – strong points which the client should keep doing.
- Some rating of 4 or less – discuss with the client's GP or health professional and consider completing My Health Story.
- Lots of ratings 4 or less (3 or more questions) – discuss with the client's GP and follow-up with a Chronic Conditions Advisor. Complete My Health Story with the client.

Step 3
Triage Assessment Form

Care Coordinator to complete the WAPHA ITC Triage Assessment Form with the client to assist in determining if the client's level of need is low, moderate or high.

Use the WAPHA ITC Triage Assessment Scale to determine the level of need for each influencing factor within the Assessment section of the Form and the client's overall rating.

Start Care Coordination Planning



WAPHA ITC Triage Assessment Scale

Level of Care Influencing Factors	Low	Medium	High
Flinders My Health My View	Any ratings of 5 or more	Some ratings of 4 or less	Lots of ratings 4 or less (three or more questions)
Transport support need (incl. mobility)	<1 per week	1 per week	> 1 per week
No. of Medications	1 – 2	3 – 4	5 >
Medications support needed (Dose Administration Aids changes)	No DAA required or ongoing with no changes in last 6 months	1 – 2 Occasional changes in last 6 months	1 – 2 changes in last 3 months
Recent Hospitalisations	0 in the last 6 months	Once in the last 6 months	> Once in the last 6 months
No. Specialist and allied health services recommended	1 – 2	3 – 4	5 >
No of Medical Aids and Equipment recommended	1 – 2	3 – 4	5 >
No. of Chronic Conditions	1	2	3+
Estimate of client hours per week	0 – 1	1 – 2	3 >
Mental health needs - level of self-management	Self-Managing	Partly managing own mental health care but requires some support	Acute - requires support for all mental health care needs
Level of Urgency	Within 8 or more days of referral	Within three to seven days of referral	Within two days of referral
Falls Risk	Not a falls risk	Has some falls risk factors	Has been identified as a falls risk
Overall Rating	**Self-managing, requiring almost no care coordination support, but still requires access to supplementary services support.**	**Able to self-manage aspects of their own care but requires moderate level of care coordination and access to supplementary services support.**	**Unable to self-manage own care, and requires high level of care coordination, and access to supplementary services support.**

Triage Assessment Form

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Organisation:	
Assessment Completed By:	Date:

Client Details:	
First Name:	Surname:
DOB:*	Phone:
Address:	Alternate Address:

Emergency Contact Details:				
First Name:			Relationship:	
Surname:			Phone:	
Residential Address:			Postcode:	
ITC Client ID#:			Medicare Care #:	IRN:
Interpreter Required:*	☐ Yes	☐ No	Primary Language Spoken:	
Family Member Required:	☐ Yes	☐ No	Family Member Name:	
Family Member Phone:			Relationship to Client:	

Assessment

	Low	Medium	High
Flinders My Health My View Score	☐	☐	☐
Transport Support	☐	☐	☐
No. of Medications	☐	☐	☐
Recent Hospitalisations	☐	☐	☐
No. of Specialist & Allied Health services recommended	☐	☐	☐
No. of Medical Aids & Equipment recommended	☐	☐	☐
No. of Chronic Conditions	☐	☐	☐
Estimate of client hours per week	☐	☐	☐
Mental Health needs	☐	☐	☐
Level of urgency	☐	☐	☐
Falls Risk	☐	☐	☐
Overall Client is:	☐	☐	☐

Reason for Overall Client Rating

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STAGE 6: MONITORING AND REVIEW

At the three (3) month follow up with the client:

- Complete My Health My View Self-assessment.
- For clients with a My Health Story, review and update.

Discuss with client:

- What is working, what is not working;
- What changes can be made;
- Complete and incomplete actions;
- Record what has been agreed to by the client and Care Coordinator; and
- Update plan with new details and end dates.

Support client to attend three to six monthly GPMP reviews.

- Low triage assessment risk: six monthly.
- Medium to high triage assessment risk: three monthly.
- Discuss with GP any identified issues or concerns.

If no issues or concerns, then;

- Client and Care Coordinator sign off when all actions in the Care Plan are achieved.
- Commence discharge planning (see Stage 7).

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STAGE 7: DISCHARGE PLANNING

The purpose of discharge planning is to work with the ITC client and their GP and family/carer to make sure the necessary arrangements are put in place to enable the smooth transition of the ITC Client out of the Program and to ensure their health needs will continue to be managed and supported by their usual GP and/or an alternate Service Provider.

There are several reasons an ITC client is discharged from the Program including client has completed the items within their GP Care Plan; client is self-managing, transferring to a new service or region, deceased or identified as being non-compliant.

Refer to WAPHA ITC Discharge Guide and Process.

DISCHARGE PRINCIPLES

Discharge planning is underpinned by a core set of principles, these include:

Communication and Collaboration

1. Clients are involved as partners in their own care.
2. Work in partnership with GPs to share the care of clients with complex and chronic conditions.
3. The client's GP is informed of the client's care needs and progress.
4. There are effective processes to support the transition of care between specialists and community-based care.

Care pathways and processes

1. Policies, protocols and practices are sensitive to the needs of Aboriginal people.
2. Discharge planning commences as part of the client's initial assessment.
3. Implementation of standardised discharge protocols and criteria to promote consistency of practice.
4. Referral pathways are clearly defined for clients to access external service providers to ensure continuity of care.
5. Streamlined mechanisms for re-referral to the ITC Program if the client's condition changes.

Staff roles and responsibilities

ITC clinical staff are supported to ensure appropriate discharge of clients.

Service monitoring

Information on discharge rates and related aspects of service demand and capacity are collected and monitored.

DISCHARGE NOTIFICATION LETTER CRITERIA

The discharge letter to the client should include:

- The intention of the letter;
- Reason for discharge;
- Clear date for transfer to a new provider, if required (e.g. Aged Care or NDIS Provider);
- Clear discharge date from the Program;
- Continuation of care until date of discharge; and
- Explanation of re-referral into the ITC program and to discuss with GP.
  - If the clients condition changes, the GP can re-refer the client back into the ITC Program.

WAPHA ITC DISCHARGE GUIDE

The below table provides a guide on the reasons an ITC client is discharged from the program and when caution should be used, or additional support measures should be put in place before the client is discharged.

ACCEPTABLE DISCHARGE	USE CAUTION	HIGH RISK

• Is deceased
• Requests to be discharged
• Is 100% self-managing their health needs
• Client is non-compliant (**refer to non-compliance criteria**)
• Moving out of the ITC Providers service catchment area
• Requires support from another ITC Provider
• Going to be out of region for more than 3 months
• A regional client being supported by a metro ITC Provider
• Competent and dependable support/carers
• Stable chronic condition
• Mentally and Cognitively alert
• Compliant with following GPMP or Care Plan
• Completed recommendations on GPMP or Care Plan.
	• Has moderate psychological or mental health issues
	• 5 + medications
	• Social determinant risk factors
	  • Carers
	  • Environment
	  • Limited appropriate support/ carers
	  • Client safety
	  • Financial concerns
	• Low literacy or language barrier
	• Live alone (50+)
	• In process of applying for NDIS or Aged Care Package
	• CPAP machine
		• Not eligible for Aged Care or NDIS support
		• Recent hospitalisation (related to Chronic Condition/s)
		• Falls risk
		• Help with managing medications
		• Receiving treatment for cancer
		• Receiving dialysis treatment
		• Diabetic complications
		• Chronic heart failure
		• Chronic obstructive pulmonary disorder
		• Has acute psychological or mental health issues

NON-COMPLIANCE CRITERIA:

The following criteria is to be used when determining if a client is non-compliant:

1. Attempted to phone client three times
2. Attempted to visit client at home once
3. Contact one next of kin and/or emergency contact
4. Sent client a letter requesting contact
5. Client has missed three consecutive appointments (Did Not Attend)

For high needs and unknown transient clients repeat 1 to 3 within a one-month time frame.

WAPHA ITC DISCHARGE PROCESS

Step 1
Discharge Planning

For all clients:

- Care Coordinator to contact the client's GP to discuss the client's discharge and set an agreed discharge (exit) date.

Client is identified as self-managing or having completed the items in their GP Care Plan:

- Develop a discharge plan with the client and relevant family and/or carers.
- Complete the Discharge Assessment Form (**Refer to Discharge Assessment Form and Scale**)
- Complete the Flinders My Health My View with the client to create an ongoing self-management plan.

For clients requiring support from another ITC Provider **refer to the Inter-Region Support and Transfer Process**.

Step 2
Discharge Notifications

- Send client a Discharge Notification Letter and medical release form (**refer to Discharge Notification Letter Criteria**).
- Provide their GP with a discharge summary and copy of the client's Discharge Notification Letter.

Client is identified as self-managing or having completed the items in their GP Care Plan:

- Notification of discharge and handover provided to other relevant services, if required.
- Client given contact details for relevant ongoing service providers, if required.

If client is deceased:

- Notify GP and other relevant service providers of client's passing.

Step 3
Discharging Client

For all clients:

- Make required changes in clinical software to discharge client.
- Upload discharge summary into My Health Record.

Client is identified as self-managing or having completed the items in their GP Care Plan:

- Provide client with all required information.
- Follow up client within three months from discharge date.

Client is Discharged



WAPHA ITC Discharge Assessment Scale

Level of Care Influencing Factors	Low	Medium	High
Flinders My Health My View	Any ratings of 5 or more	Some ratings 4 or less	Lots of ratings 4 or less
Transport support need (incl. mobility)	<1 per week	1 per week	> 1 per week
No. of Medications	1 – 2	3 – 4	5 >
Medications support needed (Dose Administration Aids changes)	No DAA required or ongoing with no changes in last 6 months	1 – 2 Occasional changes in last 6 months	1 – 2 changes in last 3 months
Recent Hospitalisations (related to their chronic condition/s)	0 in the last 6 months	Once in the last 6 months	> Once in the last 6 months
No. Specialist and allied health services required	1 – 2	3 – 4	5 >
No. of Medical Aids and Equipment required	1 – 2	3 – 4	5 >
No. of Chronic Conditions	1	2	3+
Estimate of client hours per week	0 – 1	1 – 2	3 >
Mental health needs - level of self-management	Self-Managing	Moderate - Partly managing own mental health care but requires some support	Acute - requires support for all mental health care needs
Falls Risk	Not a falls risk	Has some falls risk factors	Has been identified as a falls risk
Aged Care Package	Aged Care package is approved – priority for discharge	Eligible – application in process	Not Eligible for Package
NDIS Package	NDIS package is approved – and supports chronic condition/s care needs	Eligible – application in process OR NDIS package is approved but does not support chronic condition/s care needs	Not Eligible for Package

Discharge Assessment Form

WA Integrated Team Care Program

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Organisation:				
Assessment Completed By:			Date:	
Client Details:				
First Name*:			Surname*:	
DOB:*			Phone*:	
Address*:			Alternate Address:	
ITC Client ID#:			Medicare Care #:	IRN:
Interpreter Required:*	☐ Yes	☐ No	Primary Language Spoken:	
Family Member Required:	☐ Yes	☐ No	Family Member Name:	
Family Member Phone:			Relationship to Client:	

Assessment

	Low	Medium	High
Flinders Score	☐	☐	☐
Transport Support	☐	☐	☐
No. of Medications	☐	☐	☐
Recent Hospitalisations	☐	☐	☐
No. of Specialist & Allied Health services recommended	☐	☐	☐
No. of Medical Aids & Equipment recommended	☐	☐	☐
No. of Chronic Conditions	☐	☐	☐
Estimate of client hours per week	☐	☐	☐
Mental Health needs	☐	☐	☐
Falls Risk	☐	☐	☐
Aged Care Package	☐	☐	☐
NDIS Package	☐	☐	☐
Overall Client is:	☐	☐	☐

Outcome

Non-Compliance Criteria: ☐ Met ☐ Partially Met ☐ Not Assessed

Client requires: ☐ Transfer out of Region ☐ Discharging ☐ Care Coordination

Inter-Region Support and Transfer Process

INTER-REGION SUPPORT PROCESS

- Client is out of region and requires support from another ITC Provider (for up to 3 months).
- Complete Inter-Region Support/Transfer (IRST) form and send a copy to the other ITC Provider involved/to be involved in the client's care.
- ITC Provider receiving IRST form completes relevant fields and responds within 24/48 hours.
- Supporting ITC Provider provides care coordination and access to clinically urgent medical aids or services.
  - Non-urgent CPAP machines, spectacles and medical footwear is to be provided by the usual ITC Provider unless the supporting ITC Provider agrees otherwise (capacity dependant).

Refer to ITC Handover Policy and Guide to Inter-Region Support/Transfer Form.

TRANSFER PROCESS

- Client is expected to be out of region for an extended period of time (i.e. more than 3 months) and requires transfer to a new ITC Provider.
- Complete Inter-Region Support/Transfer (IRST) Form and send a copy to the other ITC Provider involved/to be involved in the client's care.
- ITC Provider receiving IRST form completed relevant fields and responds within 24/48 hours.
- Usual ITC Provider informs GP of discharge and of new ITC Providers details.
- The new ITC Provider initiates Referral Screening and Intake Assessment Processes.

Refer to ITC Handover Policy and Inter-Region Support/Transfer Form

ITC COUNTRY TO CITY PROGRAM

The ITC Country to City Program supports ITC clients from Country regions to access essential health care to ensure continuity of care for their chronic condition/s while in the Perth metro area.

The Program can help with:

- Care Coordination;
- Support and advocacy for the client with doctors, hospitals, Government agencies and other service providers;
- Transport to and from essential medical appointments, with priority given to primary health care appointments;
- Keeping the client connected with family;
- Access to clinically urgent medical aids and services; and
- Access to medication.

Eligibility:

- Be a registered ITC Client or eligible to be registered.
- In Perth from Country and requiring support to access health care.
- Preferred/best practice - client is referred by a Country ITC Provider using the **Inter-Region Support and Transfer Form** accompanied with a GPMP or Care Plan.
- Non-ITC clients referred by another Service Provider (e.g. hospital) will require an Interim referral into the ITC Program (**refer to Stage 1: GP Referrals**). The ITC Provider from the client's home region will also be notified of their referral into the ITC Program, to ensure continuity of care upon returning home.

For further information about the service please contact: Moorditj Koort Aboriginal Corporation on (08) 6174 7000 or Free call 1800 318 212

Handover Policy and Guide to Inter-Region Support/Transfer Form

WA Integrated Team Care Program



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Background:

The WA Primary Health Alliance Integrated Team Care (ITC) Inter-Region Support and Transfer Policy (the policy) and Guide to Inter-Region Support/Transfer Form details core principles and a prescribed structure that should be followed for support of ITC Clients where there is movement across multiple ITC Provider regions.

The aim of having a standardised and structured handover policy is to achieve a minimum practice level for handovers to ensure:

- continuous support of ITC clients across their patient journey,
- effective, high quality communication of relevant information,
- clear lines of responsibility for a client's care needs, and
- appropriate resources are allocated for handover.

In and of itself, effective handover does not guarantee quality care – the responsibility and information handed over still need to be acted upon.[1]

Definitions:

Handover is the transfer of professional responsibility and accountability for all or some aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.[2]

Inter-Region Support refers to the partial handover of an ITC Registered client where the client requires ITC support while temporarily outside their usual ITC Providers' region. For example, where a client registered in the Pilbara is required to visit Perth to access necessary health care, but will be returning to the Pilbara within three months.

Transfer refers to the complete handover of an ITC Client's care when a registered client is expected to be out of their usual ITC region for an extended period of time (ie. more than 3 months) and will continue to require ITC support. For example, where a client registered in the Pilbara intends to move to Perth.

Usual ITC Provider refers to the ITC Provider where the client is currently registered.

Supporting/New ITC Provider refers to the ITC Provider that will be responsible for carrying out ITC support for the client in a region which is not their usual region. This may be on a temporary or permanent basis.

Scope and WAPHA expectation of ITC Providers

1. All WA ITC staff members employed or subcontracted by a WAPHA-contracted ITC Provider must comply with the handover policy.
2. In accordance with this policy, all ITC clients who need a handover must receive it.
3. Regardless of the type of handover, client information conveyed must be documented in the Inter-Region Support/Transfer Form (IRST form) to support client safety and continuity of care.
4. Handover must be understood as an explicit transfer of clinical accountability and responsibility, not just information.

1 WA Health Clinical Handover Policy, November 2013, Perth: Department of Health, WA
2 Australian Medical Association, Safe Handover: Safe Patients. Guidance on Clinical Handover for Clinicians and Managers. Canberra: Australian Medical Association; 2006

Responsibilities

All ITC staff:

- Acknowledge that handover is part of the duty of care for all health services
- Ensure their complete participation in the handover process contributes to a culture that values handover
- Ensure that all handovers follow the criteria outlined within the IRST form

Principles of handover

5. **Client/carer involvement** – The IRST form should be completed in the presence of the ITC client/carer. Verbal discussion of the IRST form, including Agreed Plan and consent, may be acceptable where the client has completed a *WA ITC Registration and Consent form*, and were the signed registration form can be forwarded with the IRST form.
6. **Consistent structure and content** – Handover content should:
    - be clear, concise, and use easily understood words with minimal, accepted, abbreviations;
    - include all information which is necessary for the ITC team to provide safe care to the client;
    - provide all relevant contact details to facilitate any required discussion of handover information; and
    - ensure acknowledgement of receipt of IRST form occurs.
7. **Leadership and complete team involvement** – all ITC staff members involved in the client's care should support the handover process and be available to facilitate handover where possible.
8. **Agreement on responsibilities and accountability** – Handover must be understood by ITC staff as an explicit transfer, not just of information, but of accountability and responsibility. Roles, responsibilities and accountabilities must be clearly described, and agreed by all. Factors to be considered include availability of resources (eg. care coordinator time, supplementary services funding), and inclusion in GP care plan.
9. **Prioritisation of Inter-Region Support/Transfer Clients** – Clients requiring inter-region support or transfer to a new region must be triaged within the existing client group in the supporting/new region, and not waitlisted for the registration process.
10. **Supporting client documents** – all handovers must be supported by current, appropriate documentation as per IRST form.
11. **Education – All staff must receive education on the site/service handover protocol and this policy**. It is recommended that this be included in staff induction and repeated following revision of this policy; and that this should include education to ensure capture for relevant reporting purposes.



WA Inter-Region Support/Transfer (IRST) Form

See Appendix A

The standardised WA Inter-Region Support/Transfer (IRS) form aims to support the concise capture of pertinent and relevant handover information. It is expected that comprehensive or specific assessments will be attached to provide further detail as necessary.

Ideally the IRST form should be completed by the client's usual ITC Provider before the client has left the region, and then forwarded to the supporting/new ITC Provider for acknowledgement and clarification of agreed plan details. However, where the client is out of their usual ITC region and an IRST form has not been initiated prior to travel the supporting/new ITC Provider should initiate by completing basic known criteria and then forwarding to the usual ITC Provider. The usual ITC Provider is responsible for the completion of additional mandatory information and provision of the completed form, including required attachments, in order for ITC support to commence in the new ITC region.

Where sections of the IRST form do not apply/are irrelevant to the client, these should be clearly marked as 'not applicable' or 'not relevant' or, may refer to a specific attachment.

Mandatory fields are denoted with an * are required for both types of handover, or where applicable to client need.

Non-Mandatory fields should all be completed for clients requiring Transfer to a new ITC Provider.

Completing the IRST Form

Each of the following sections provides instruction on completion of the corresponding section within the IRST form.

IDENTIFY

- **Usual ITC Provider** – Enter name of Organisation (ITC Provider) that the client usually receives ITC support from.
- **Supporting/New ITC Provider** – Enter name of Organisation (ITC Provider) that the client will be receiving ITC support from while out of their usual ITC region.
- **Client Details** - Ensure adequate contact details for the client including carer/guardian/next of kin and their awareness of the transfer. The unique client ID# refers to the unique number allocated by the ITC Providers clinical software.

SITUATION

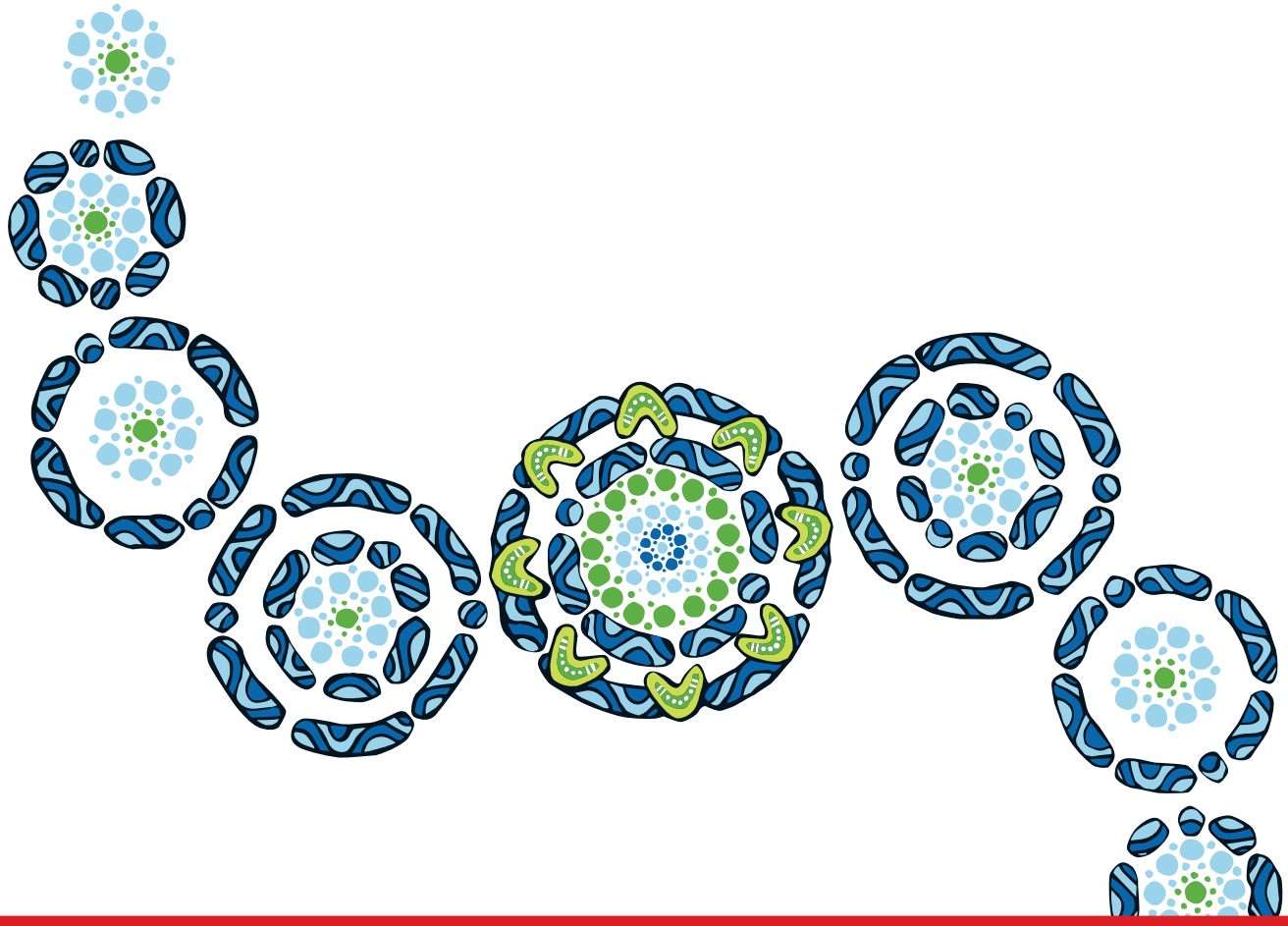
- **State the primary reason for requiring inter-region support/transfer** – Include all information most relevant to the supporting/new ITC Provider.
- **Date of arrival** – note expected (or actual) date of arrival within supporting/new ITC region.
- **Planned transfer date** – Specify the date at which the responsibility for the client will be completely transferred to the new ITC Provider.
- **Relevant appointment dates** – For example: hospital admission, specialist, or outpatient appointment dates.

OBSERVATION

- Document the current situation.
- Note relevant observations and pertinent assessment findings. For example:
  - client's ability to self-manage;
  - registered for PBS Co-Payment (CTG Scripts);
  - receiving Patient Assisted Transport Scheme (PATS) support;
  - registered for Aged Care Package;
  - registered with NDIS; and/or
  - sleep study completed (attach associated report/s if client transferring).

BACKGROUND

- **Precautions/Alerts**
  - **Requires care coordination** – indicate if client has complex needs and is unable to coordinate own appointments, or may need other care coordinator support.
  - **Requires supplementary services** –
    - indicate if client will require supplementary services fund support while in the supporting/new ITC Provider region; or
    - client requires minimal support, and is able to coordinate own appointments, but will still need supplementary fund access (for example, Dose Administration Aids (DAA) and transport to GP).
- **Supplementary Services provided within the last 12 – 24 months** – specify if CPAP, spectacles or medical footwear have been provided in the last 12 – 24 months and include date of provision.
  - **For clients requiring Inter-region support** – the supporting ITC Provider provides care coordination and access for clinically urgent medical aids and services where supplementary services criteria have been met, and funding permits.
    - Care coordination for non-urgent CPAP machines, spectacles and medical footwear is to be provided by the usual ITC Provider.
  - **For clients requiring Transfer of support** - if these have been recommended in GP care plan, ensure that any progress towards providing these has been included in Observation.
- **Relevant social/home situation** – Specify any issues that require consideration/awareness by the supporting/new ITC Provider. In particular:
  - communication barriers,
  - family and carer support requirements,
  - accommodation considerations – eg. family/friends vs PATS supported, and/or
  - relevant previous experiences that may impact ability to access health care.



AGREED PLAN

- **Intervention/support required**

  This should be developed with the client (and/or relevant carers) and the supporting/new ITC Provider with consideration of the service capacity of the supporting/new ITC Provider.

  - **Note handover type**
  - **Level of support** – indicate the client's ability to navigate in the new ITC region, especially in relation to accessing required health care.

    When determining the level of support required consider the client's ability to self-manage: ie. make their own health appointments; manage their health condition; know when to seek help if condition changes; navigate new health services; organise their own transport; and understand and comply with medication regimes.

Low	Medium	High
Self-managing, requiring almost no care coordination support, but still requires access to supplementary services support.	Able to self-manage aspects of own care, but requires moderate level of care coordination and access to supplementary services support.	Unable to self-manage own care, and requires high level of care coordination, and access to supplementary services support.

  - **Support required** – Detail specific intervention/s required, the level of urgency and required frequency of the intervention given the care needs of the client. Specify where arrangements will need to be made in the supporting/new ITC region to maintain ongoing access to required supports. Where identified support/s require the use of supplementary services funding supporting documentation, referrals and/or reports are required to be sent to the supporting/new ITC Provider.
  - **Level of urgency** – Note the level of urgency for each intervention/support required.

Low (L)	Medium (M)	High (H)
Will require intervention/ support within eight or more days of receipt of IRST form	Will require intervention/ support within three to seven days of receipt of IRST form	Will require intervention/support within two days of receipt of IRST form
Example	**Example**	**Example**
Coordinate GP Management Plan review.	Coordinate/provide transport to outpatient appointments.	Coordinate access to dose administration aids.

  - **Attachments to be forwarded** – specify attachments to the handover and ensure provision of mandatory documents; as well as any other assessments, investigations and specific treatment programs/protocols relevant to the provision of ITC support in the supporting/new region. Where a client needs access to services and/or medical aids which will require supplementary services funding ensure that supporting documentation, referrals and/or reports have been included with the IRST form.
    - For example: a transferring client requires continued access to Dose Administration Aids in a new ITC Provider region. Include 'DAA' within the IRST form under 'Support required'; plus tick the box 'allied health assessments/reports'; plus attach (in addition to GP care plan) copies of supporting pharmacy assessments/reports confirming details of arrangement for medications to be included in DAA with the IRST form.
  - **MMEx client files** – Where both ITC Providers use MMEx discuss with the client the option to share or transfer their client file.
  - **Notification to usual GP** – The client's usual ITC Provider is responsible for notifying the client's GP where a client is transferring to another ITC Provider. The new ITC Provider is responsible for any subsequent communication with the GP to request documents/medical records, as this will first require renewal of WA ITC Registration and Consent form in the new ITC region.
- **Other significant contributors** – Provide contact details for other contributors for a multidisciplinary handover. This should include GP details; and may also include others such as specialists, allied health, or Aboriginal Hospital Liaison contacts.

READOVER/HANDOVER

This is where both ITC Providers confirm shared understanding of their roles and responsibilities following handover of the client's care.

- **Handover made to ITC Provider via –** select relevant handover option/s
- **IRST form sent by** – to be completed by initiating ITC Provider. Ensure adequate details of the best/preferred staff contact (Name) are included. If possible, include both a landline and mobile number.
  - If initiated by the usual ITC Provider:
    - All mandatory fields are required to be completed.
    - Ideally, the IRST form should be completed by the ITC staff member with the most comprehensive knowledge of the client's care needs.
  - if initiated by the supporting/new ITC Provider:
    - The IRST form should be completed including all known details. It may not be possible to complete all mandatory fields initially.
    - The usual ITC Provider is responsible for completing all other information as relevant to the type of handover.
- **Receipt of IRST form** – The receiving ITC staff member is to send receipt of IRST form within 24-48 hours of IRST form being received. The ITC Provider receiving the IRST form must complete any missing relevant details before sending acknowledgement of IRST form and required attachments back to the initiating ITC Provider. Ensure adequate details of the best/preferred staff contact are included. If possible, include both a landline and mobile number.
- **Release of Information** – The ITC staff member initiating the IRST form ensures the client:
  - understands the handover process,
  - provides informed consent (verbal consent should only be used where it is not possible to obtain written consent), and
  - has been provided with a copy of the IRST form and contact details for the supporting/new ITC Provider.

Reporting:

The following data must be included within the ITC reporting template:

- inter-region client's home suburb;
- number of clients transferred to another ITC Provider; and
- number of referrals from another ITC Provider region, including name of transferring ITC Provider.

Review:

This policy will be reviewed six months from initial release, and annually thereafter.

Acknowledgement: This document has been based on the WA Health Allied Health Clinical Handover Guideline and Form, October 2016, Department of Health WA services.

Inter-Region Support/ Transfer Form

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Complete this Integrated Team Care (ITC) clinical handover form for ITC clients requiring support from, or transfer to, another ITC Provider region.

IDENTIFY

Usual ITC Provider

Organisation:*

Supporting/New ITC Provider

Organisation:*

Client Details

First name:* Surname:*

DOB:* Phone:*

Address:* Alternate Address:

ITC Client ID #: Medicare Card #: IRN:

Interpreter required:* ☐ Yes ☐ No Primary language spoken:

NOK/Alternate Contact:* Alternate Contact Phone:*

Relationship to client: Aware of support/transfer: ☐ Yes ☐ No

SITUATION

Reason for requiring inter-region support/transfer:* *Eg. attending health appointment in metro area*

.....

.....

.....

Date of Arrival* & Expected Duration: ..... **OR: Planned transfer date:** .....

Relevant appointment date/s:* .....

.....

.....

OBSERVATION

Relevant Information: .....

.....

.....

.....

BACKGROUND

Precautions/Alerts:*

Mobility issues	☐ Yes	☐ No	☐ Unknown	Comment: .....
Support person required at appts.	☐ Yes	☐ No	☐ Unknown	Comment: .....
Requires care coordination	☐ Yes	☐ No	☐ Unknown	Comment: .....
Requires supplementary services	☐ Yes	☐ No	☐ Unknown	Comment: .....

Supplementary Services provided within the last 12-24 months*

☐ CPAP
Date Provided: .....

☐ Spectacles
Date Provided: .....

☐ Medical Footwear
Date Provided: .....

**denotes mandatory fields.*



BACKGROUND

Relevant social/home situation: .....

.....

.....

.....

AGREED PLAN

Intervention/support required

Handover type:* ☐ Inter-Region Support ☐ Transfer

Level of support:* ☐ Low ☐ Medium ☐ High

Support required:	**Level of urgency:**	**Frequency of support:**
.....	.....	.....
.....	.....	.....
.....	.....	.....

Attachments to be forwarded

☐ GP Care Plan*

☐ WA ITC Registration and Consent form*

MMEx client file is to be:

☐ Shared with supporting ITC Provider

☐ Transferred to new ITC Provider

Additional attachments as applicable:

☐ Copies of relevant medical records and/or results

☐ Self-management plan

☐ Allied health assessments/reports

☐ Allied health referral/s

☐ Copy of approved ITC Exceptional Circumstances Request/s (ECR), including unique client ID#

Notification to usual GP sent: ☐ Yes - Date sent:..... ☐ No

Other significant contributors to this client's CDM:

Name:	Role:	Contact No:
Name:	Role:	Contact No:
Name:	Role:	Contact No:

READOVER

Readover/Handover

Handover made to ITC Provider via* ☐ Phone ☐ Email ☐ Secure Fax ☐ Face to face ☐ Secure Messaging

Inter-Region Support/Transfer form sent by:*

☐ Usual ITC Provider ☐ Supporting/New ITC Provider

Name: ..... Phone: .....

Email:.....

Signature:

.....

Date/Time:.....

Receipt of Inter-Region Support/Transfer form sent by:

☐ Usual ITC Provider ☐ Supporting/New ITC Provider

Name: ..... Phone: .....

Email:.....

Signature:

.....

Date/Time:.....

Release of Information:

I hereby authorise and consent to ..... disclosing, releasing or discussing records containing my personal medical information (as outlined in the agreed plan above) to .... according to my signed WA ITC Registration and Consent form. I understand that the sharing of this information is required for the purposes of determining and managing the services & supports which I currently receive as part of the Integrated Team Care Program.

Client has been provided a copy: ☐ Yes ☐ No

Client/Carer Signature:

.....

Date/Time:.....

Verbal Consent - I have discussed the above information with the client/carer and am satisfied that they understand the proposed collection, use and disclosure of personal health information and has provided informed consent.

ITC staff member name:

.....

Signature:

.....

Date/Time:.....

SUPPLEMENTARY SERVICES

To access the Supplementary Services (SS) Fund a recommended Medical Aid or Service must meet one or more of the following criteria:

- Address risk factors, for example:
  - clinically inappropriate wait period;
  - likely to reduce hospital admission or length of stay;
  - not available through other funding sources;
  - ensure access to a service that would be otherwise inaccessible due to transport cost.
- The Medical Aid or Service must be related to the client's CDM; be included within their GP care plan; and be part of a primary health care service provided by a GP, specialist or allied health provider.
- Pre-approved Medical Aids include:
  - Blood sugar/glucose monitoring equipment (excluding Continuous Glucose Monitors);
  - Dose Administration Aids;
  - mobility aids (excluding electric wheelchairs) and shower chairs;
  - spectacles (up to $250 where specific conditions are met);
  - medical footwear (prescribed and fitted by a podiatrist);
  - Assisted breathing equipment.
- Medicare Sleep Study requirements must be met, and sleep trial completed before a CPAP machine can be purchased/hired. See Obstructive Sleep Apnoea Pathway for further information (https://wa.healthpathways.org.au).
- For all requests review urgency, clinical need, and availability of SS fund. If determined appropriate, the ITC Care Coordinator can approve use of SS fund and advises client and relevant health service/s.
- Client must be educated on use and maintenance of Medical Aid, associated accessories and consumables.
- SS fund may be used to support transport to closest regionally available health care professional where the request meets SS criteria.

Pre-Approved Medical Aids/Services:

- Submit an ITC Frequently Requested Items Exceptional Circumstances Request via the ITC Community of Practice page on Primary Health Exchange. Pre-approved Medical Aids or Services can be provided to the client using the SS Fund immediately upon completion of the form. Pre-Approved Medical Aids must be included as part of ECR reporting.

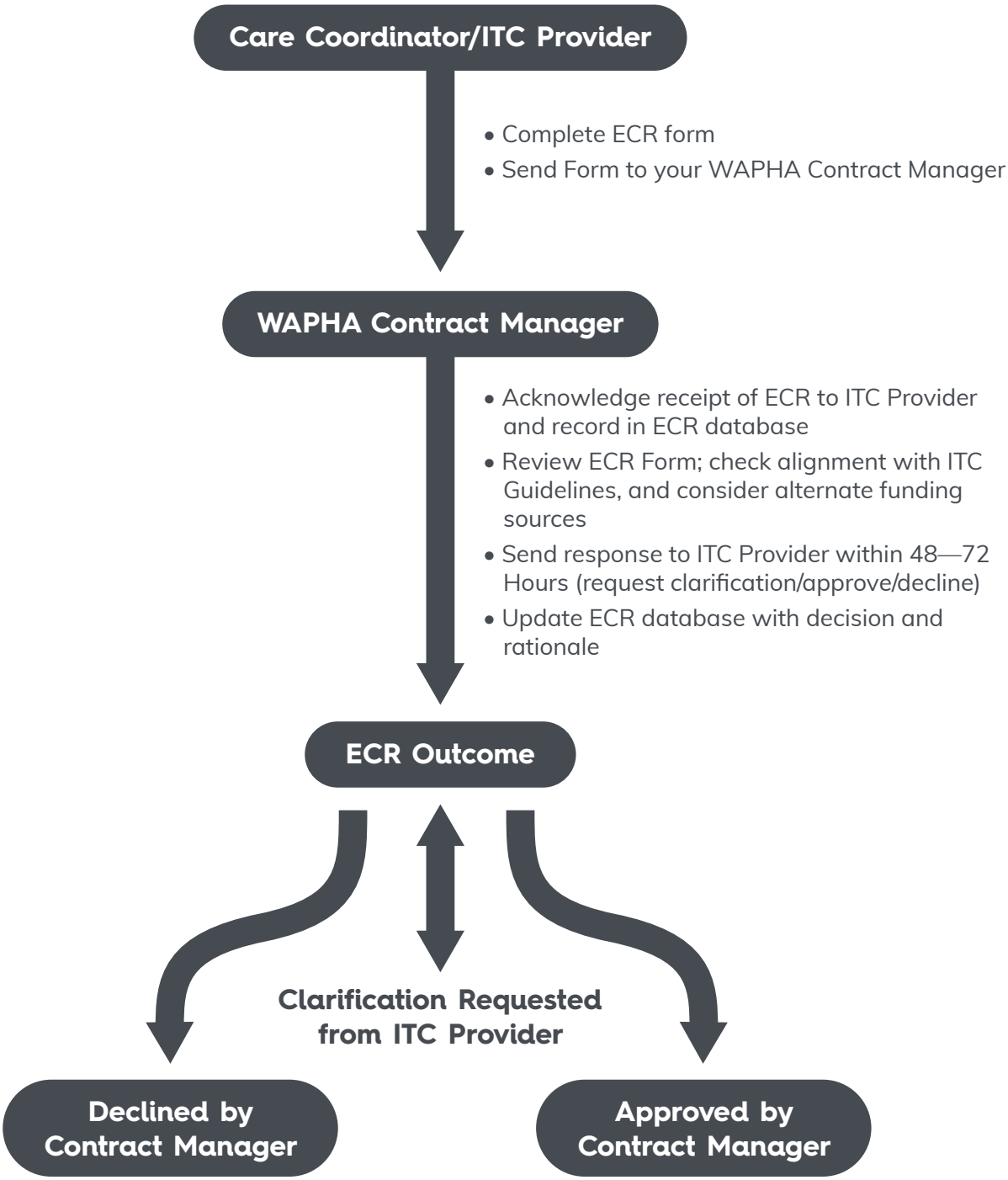
Medical Aids or Services that meet SS criteria but are not a pre-approved medical aid/service:

- Submit an Exceptional Circumstances Request (ECR) form to WAPHA. If approved by WAPHA the Medical Aid or Service can be provided to the client using the SS Fund.

Refer to Exceptional Circumstances Request Process and Form

For further information on Supplementary Services please refer to the ITC Handbook.

Exceptional Circumstances Request (ECR) Form Process



If the Commonwealth Department of Health needs to be consulted please allow an additional 10-15 working days.

Exceptional Circumstances Request Form

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WA Integrated Team Care Program

This Form must be completed and submitted to WA Primary Health Alliance for consideration if an item or service falls outside allowable medical aids and equipment and is not included in the ITC Frequently Requested Items ECR online form.

ITC Client Details:	
ITC Provider:	ITC Region:
Unique Client Identification Number:	Date of Birth:

ECR Criteria:

- ☐ Client has a GP care plan which includes specific reference to the item/service for which ECR is being completed
- ☐ This request falls outside the list of Medical Aids allowable under Supplementary Services Funding
- ☐ The cost can be funded within your available Supplementary Services ECR budget[1]
- ☐ Two quotes have been attached for items costing more than $500
- ☐ Client's personal details have been removed or de-identified on supporting documentation

DO NOT CONTINUE COMPLETING THE FORM IF ANY OF THE ABOVE CRITERIA HAS NOT BEEN MET

Tick ALL applicable to ITC Client

Chronic Disease Details	
☐ Diabetes	☐ Eye health condition associated with diabetes
☐ Cardiovascular disease	☐ Chronic kidney disease
☐ Cancer	☐ Chronic respiratory disease
☐ Other – specify:	

Please provide comprehensive answers/information for each question, as this assists WAPHA in rapid consideration of ECR

Question	Response	
What is the item/service requested?		
Cost of item/service: Attach two quotes if the requested item is more than $500.	Estimate cost to supplementary services: $ Estimate client contribution – if relevant [2]: $	
ECR for ongoing items will only be approved for a period of three months (until next GP Care Plan review).	☐ One-off expense	☐ Ongoing
If hired, what will be the cost to the Supplementary Services fund in the event the item is damaged while in the client's use?	☐ Purchased	☐ Hired Replacement cost: $
Is the client aware maintenance costs for ECR items cannot be funded by the Supplementary Services fund?	☐ Yes	☐ No
Have you explored all other publicly funded/affordable programs relevant to this request (e.g. Aged Care, NDIS, Silverchain)?	☐ No. **If no, do not submit this ECR.** ☐ Yes. **List all, and why they can't be accessed:**	
The following MUST be answered comprehensively: a) List ALL programs/services explored b) Detail why the client is unable to access these		
How/where does the ITC Implementation Guidelines support this request?		

1 ECR must be approved by WAPHA, but the cost deducted from the ITC Provider Supplementary Services ECR budget.
2 E.g. client contribution towards spectacles exceeding allowable cost under ITC Guidelines of $250

Exceptional Circumstances Request Form

WA Integrated Team Care Program

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Question	Response		
How will the management of the client's chronic condition improve and benefit from the service/aid?			
Is the patients access to this item/service necessary from both a clinical and ethical perspective? And why? *For example, it addresses risk factors, such as waiting period for a service that is longer than clinically appropriate.*	☐ Yes	☐ No	
Has the client agreed to participate in medical aid/ equipment training, adhere to treatment and attend service follow-up?	☐ Yes If no, explain:	☐ No	
How will the item/service reduce the client's risk of an unplanned/avoidable hospital admission/presentation?			
How will the item/service contribute to the client's self-management of their chronic condition(s)?			
Is there an immediate clinical risk to the client if the service/aid is not provided? *For example, client is in a high-risk category for infection or spread of disease to the community.*	☐ Yes If yes, explain:	☐ No	
If this request is approved, what is the impact on community expectations?	☐ Low	☐ Medium	☐ High
What is the impact of increased community expectations on the Supplementary Services budget?	☐ Low	☐ Medium	☐ High
Can this request be applied equitably across the community for other clients with a similar case?	☐ Yes If no, explain:	☐ No	
Does your local clinical advisory team support this request?	☐ Yes	☐ No	

Exceptional Circumstances Request Form

WA Integrated Team Care Program

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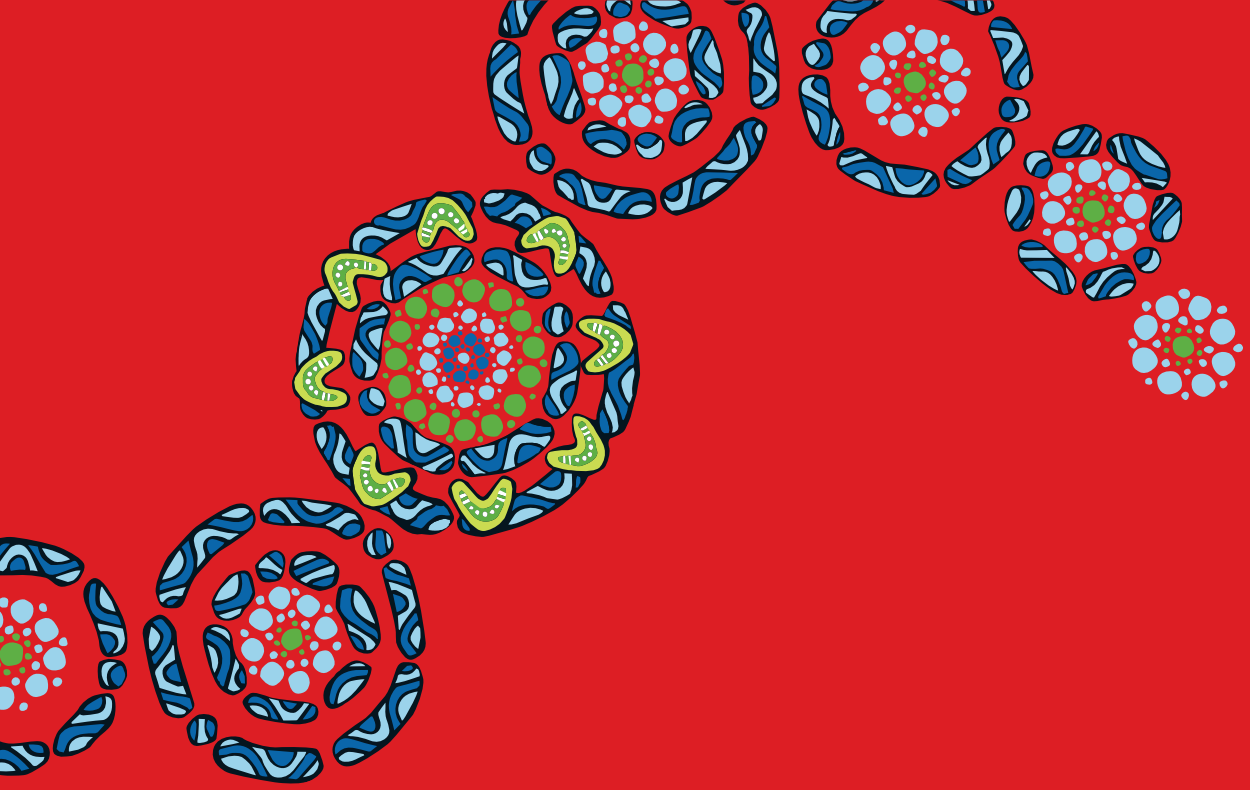
To be completed by ITC provider submitting request to WAPHA for consideration			
PHN Region (select)	☐ Perth Metro	☐ Perth South	☐ Country WA
Care Coordinator completing ECR and approving as per SS criteria:	Name:	Signature:	Date:
	Phone:	Email:	
Reviewing Manager / Team Leader:	Name:	Signature:	Date:
	Position:		
	Phone:	Email:	
Request submitted by:	☐ Care Coordinator	☐ Manager / Team Leader	
Submit to your WAPHA ITC Contract Manager, and copy in: aboriginalhealth@wapha.org.au			

For WAPHA office use only:			
ITC Contract Manager:	Name:	Signature:	Date:
Request reviewed by:	Name:	Signature:	Date:
	Position:		
Requested item/Service	☐ Approved ☐ Declined If declined, reason:		Date:
Response sent to ITC Provider:	Name: Position:		Date:
Details entered in ECR spreadsheet:	☐ Yes		Date:

Notes

Notes

Notes



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Artwork: Koorn Koorl Danjoo (Coming Together) **Artist:** John Walley

WA Primary Health Alliance acknowledges and pays respect to the Traditional Owners and Elders of this country and recognise the significant importance of their cultural heritage, values and beliefs and how these contribute to the positive health and wellbeing of the whole community.

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