HEALTHY NORTH COAST

Aged Care

Activity Work Plan 2022 — 2026

phn NORTH COAST
An Australian Government Initiative

Healthy North Coast is an independent, not-for-profit organisation proudly delivering the PHN Program in North Coast NSW. We are committed to improving the health of our communities through quality primary health care. The PHN program is an Australian Government initiative.

www.hnc.org.au

Contents

AC-CF - 5 - Care Finder ACH Contract Providers

Program Key Priority Area

Aged Care

Aim of Activity

To transition the ACH providers into the Care Finder program for the region.

Description of Activity

Key milestones will be achieved inclusive of a needs assessment, procurement process and ACH transition into the Care Finder program.

Needs assessment

The program will complete a comprehensive needs assessment now available on the organisations website. The needs assessment analysed key vulnerability areas with LGAs. The areas with the highest number of vulnerabilities were the LGAs of Clarence Valley, Kempsey and Richmond Valley. The findings were supported by key stakeholder engagement outlined below.

To accommodate the spread of vulnerabilities and manage the risks and sensitivities of delivering services particularly in rural areas, HNC has developed a zoned approach to the location of care finders. With up to five LGAs grouped together in each with a spread of vulnerabilities and population needs across the zones. A workforce model, of a team of care finders for each of the zones was proposed in the tender process.

The needs assessment identified the need for care finders to be active in the disaster space and provision for this has been included in the provider contracts.

The needs assessment aligns with the consultations undertaken with health, aged care and other agencies, in particular the workforce model demonstrates concerns raised in the consultations. Ongoing integration with the key stake holders is planned through the care finder community of practice.

Commissioning process

The organisation now has two successful care finder providers, EACH and Footprints. EACH provides the cover for 2 of the 3 zones with Footprints covering one.

These services will be fully operational on July 1 2023. The commissioning cycle was held up through internal HNC workforce changes and one of the initial successful providers not accepting the terms and conditions of HNCs contract.

Transition of ACH provide

Two of the three ACH providers have transitioned across to care finders – both services are now active in the provision of Homeless care finders services. The third provider did not transition across

due to conflicts with contractual arrangements. This providers area has been picked up by Footprints. Key stakeholders have been informed of the care finder services for homeless

Community of Practice for care finders

The group has been meeting with the ACH providers since October of 2022, the new providers will be joining into the next meeting. A start up pack has been built for use by the providers and a disaster triage tool for care finders is under development with the group

Needs Assessment Priorities

NCPHN Needs Assessment 2021/22-2023/24

Needs Assessment Priority
Improve access to aged care services, care packages and RACFs in a region with a large proportion of older people
Enhancing care navigation to improve delivery of health and social care services

Target Population Cohort

People who are eligible for aged care services and have one or more reasons for requiring intensive support to:

• interact with My Aged Care and access aged care services

and/or

• access other relevant supports in the community.

Indigenous Specific	No

Coverage

Kempsey – Nambucca

Richmond Valley – Hinterland

Clarence Valley

Consultation

Meetings and stakeholder engagement have been held with Assisted with Care and Housing organisations servicing the North Coast region. Data collected and added to the broader key stake holder engagement included an understanding of their client base, client outputs and the challenges and barriers the clients and care finders face. The average client base for an ACH worker was approximately 100 clients and barriers commonly faced included secure housing for those with mental health issues such as hoarding or drug and alcohol complexities. Supporting Aboriginal

clients with secure housing is particularly challenging with younger generations often causing the older family members issues with their lease security.

The lack of housing stock is causing significant issues in the region pre floods. The floods have now resulted in many people having to move right out of area or are living in unsafe situations. Many Aboriginal people are struggling being off country or are choosing to live in very unsafe situations.

Three focus groups were held in with a mix of local health district staff, community service providers (a mix of aged care and general community programs), other agencies; ambulance, police, Advocacy groups, local government and Aboriginal workers. Specific settlement services and members from the LGTBQI+ community were also included. Consumers were living in a range of accommodation such as caravan parks, retirement villages and in temporary housing. Vulnerable groups were identified and synthesised into the following groups: those with complex mental health conditions; people that are isolate; older carers (i.e. are one or have one); and living in volatile and unsafe situations.

Collaboration

The care finder organisations have been provided with listings of key stakeholders in the region to collaborate with as they promote the new services and provide inreach

Activity Milestone Details/Duration

Activity Start Date	30/06/2022
Activity End Date	30/06/2025
Service Delivery Start Date	1/01/2023
Service Delivery End Date	30/06/2025

Procurement approach

Not yet known.

Is this activity being co-designed?	Yes
Is this activity the result of a previous co-design process?	No
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No
Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No

AC-EI - 3 - Early Intervention

Program Key Priority Area

Aged Care

Aim of Activity

To support senior Australians to maintain their functionality and live at home for as long as possible by commissioning early intervention initiatives.

Description of Activity

- Analyse HNC's Healthy Ageing systems dynamic model developed in 2021-2022 by the SAX Institute to model and test the impact of a range of different healthy ageing initiatives. Shortlisted interventions include: healthy housing options for Aboriginal and older people; chronic disease wrap around models, healthy ageing health promotion campaign; rural telehealth hubs; healthy communities inclusive of healthy lifestyles, social prescribing and rural living.
- Analyse HNC's Health Ageing Social Research developed in 2021-2022 by ARTD to better understand how older people want to age and what services they need to age well.
- Design early intervention options that utilise population health approaches to reach the greatest number of people. Support the options with primary care early intervention screening resources through face to face in house training pilot.
- Commission early intervention initiatives in communities in high need.
- Monitor and evaluate the impact of commissioned services.

The interventions will include a mix of all the determinants of health ensuring diversity in approaches influencing better health outcomes. Awareness campaigns and education programs will be used to promote the program of commissioned activities

Needs Assessment Priorities

NCPHN Needs Assessment 2021/22-2023/24

Needs Assessment Priorities
Promote prevention and management of chronic disease to reduce hospitalisations and death
Reduce the rate of falls-related hospitalisations in older people
Support the use of digital health technologies for improved chronic disease prevention and management and to improve access to services, information, resources and address workforce maldistribution
Co-design solutions to Improve health literacy - development of higher levels of health literacy and competence in patients for managing their own health.

Target Population Cohort

People aged 65 years and over.

Indigenous Specific	No

Coverage

Whole Region

Consultation

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health), HNC's Healthy Living and Ageing Strategy Reference Group and academics.

Collaboration

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health), HNC's Healthy Living and Ageing Strategy Reference Group and academics.

Activity Milestone Details/Duration

Activity Start Date	01/06/2022
Activity End Date	30/06/2024
Service Delivery Start Date	1/04/2023
Service Delivery End Date	30/06/2024

Procurement approach

Expression of Interest

Is this activity being co-designed?	Yes
Is this activity the result of a previous co-design process?	Yes
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No
Has this activity previously been co-commissioned or joint-commissioned?	No

Decommissioning	No

AC-VARACF - 1 – Virtual Access in RACFs

Program Key Priority Area

Aged Care

Aim of Activity

Increase RACFs residents' access to clinically appropriate virtual care health services

Description of Activity

- Undertake an environmental scan of RACFs' digital health and virtual care service capacity.
- Analyse data for gaps, common trends and current solutions that are working well.
- Coordinate consultations between RACFs, GPs and LHD services to co-design solutions to create enhanced virtual care services for RACF residents.
- Assist RACFs to have appropriate telehealth facilities and equipment to enable their residents to virtually consult with their primary health care professionals. These facilities will compatible with the existing virtual consult technology used by providers across the North Coast and will be guided by recognised eHealth standards (e.g. the Australian College of Rural and Remote Medicine telehealth framework).
- Provide training to RACF staff to support them to have the capabilities to assist their residents in accessing virtual consultation services.
- Promote the use of enablers of digital health (such as My Health Record);
- Consult with LHDs to ensure the initiative complements, but does not duplicate, efforts underway by state and territory governments to improve technological interoperability between the aged care and health systems

Needs Assessment Priority

NCPHN Needs Assessment 2021 - 2024

Needs Assessment Priority
Reduce the rate of falls-related hospitalisations in older people
Support the use of digital health technologies for improved chronic disease prevention and management and to improve access to services, information, resources and address workforce maldistribution
Reduce the rate of potentially preventable hospitalisations

Improve access to end-of-life services and prevention of avoidable ED attendances

Target Population Cohort

Residents in residential aged care facilities

Indigenous Specific	No

Coverage

Whole Region

Consultation

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health), HNC's Healthy Living and Ageing Strategy Reference Group and academics.

Collaboration

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health), HNC's Healthy Living and Ageing Strategy Reference Group and academics.

Existing collaborative meetings and relationships will be utilised in scanning the environment and determining solutions. RACH, GPs and the LHD will participate in all aspects.

Activity Milestone Details/Duration

Activity Start Date	18/04/2022
Activity End Date	30/06/2024
Service Delivery Start Date	1/07/2022
Service Delivery End Date	30/06/2024

Procurement approach

Not yet known.

Is this activity being co-designed?	Yes
Is this activity the result of a previous co-design process?	No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No
Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No

AC-AHARACF - 2 - After Hours Access in RACFs

Program Key Priority Area

Aged Care

Aim of Activity

Help reduce unnecessary hospital presentations among RACF residents by addressing awareness or utilisation issues of available local out of hours services among RACFs located on the North Coast.

Description of Activity

- Undertake an assessment of current after-hours strategies available to, and used by, RACFs. Analyse data for gaps, common trends and current solutions that are working well.
- Coordinate consultations between RACFs, GPs and LHD services to codesign solutions to create enhanced after hours care for RACF residents.
- Provide guidance to RACFs to develop and implement after-hours action plans which will support their residents to access the most appropriate medical services out-of-hours.
- Educate RACF staff on out-of-hours health care options and processes for residents inclusive of digital and telehealth options, older persons HealthPathways and clinical communication tools.
- Encourage RACFs to implement procedures for keeping residents' digital medical records up to date, particularly following an episode where after-hours care was required
- Support engagement between RACFs and their residents' GPs (and other relevant health professionals), as part of after-hours action plan development.

Needs Assessment Priority

NCPHN Needs Assessment 2021/22-2023/24

Needs Assessment Priority
Promote prevention and management of chronic disease to reduce hospitalisations and death
Support the use of digital health technologies for improved chronic disease prevention and management and to improve access to services, information, resources and address workforce maldistribution

Reduce the rate of potentially preventable hospitalisations
Improve access to primary care services (GPs)

Target Population Cohort

Older people.

Indigenous Specific	No

Coverage

Whole Region

Consultation

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health), HNC's Healthy Living and Ageing Strategy Reference Group and academics.

Collaboration

Existing collaborative meetings and relationships will be utilised in scanning the environment and determining solutions. RACH, GPs and the LHD will participate in all aspects. Resulting from the relationships will be a place based integrated model of wrap around support for RACHs will be one outcome from this project

Activity Milestone Details/Duration

Activity Start Date	18/04/2022
Activity End Date	30/06/2024
Service Delivery Start Date	1/07/2022
Service Delivery End Date	30/06/2024

Procurement approach

Is this activity being co-designed?	Yes
Is this activity the result of a previous co-design process?	No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No
Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No

AC-CF - 4 - Virtual Care Finders

Program Key Priority Area

Aged Care

Aim of Activity

The Care Finder program is to establish and maintain a network of care finders that will provide specialist and intensive assistance to help people within the target population to understand and access aged care services and connect with other relevant supports in the community.

The program targets vulnerable groups that would be unlikely to receive assistance without this intensive program to navigate and access services.

Vulnerable groups may include those who are socially isolated, have minimal English language skills and/or literacy, have difficulty processing information, have resistance to engage with government agencies in any capacity, and/or those who are in insecure housing or sleeping rough.

The program will result in a network of care finders across the regional foot print, who will provide intensive support to the vulnerable population identified. Care finders within the HNC footprint will have local knowledge of aged care supports, other agencies required to support set up the older person to receive services and an understanding of the local needs of clients on the NSW North Coast.

Care finder services will be delivered by organisations that have experience in supporting vulnerable older people's needs i.e. mental health, capacity, distrust in the system etc and have local knowledge of services and the relevant agencies available.

Care finders will actively engage with vulnerable communities through an outreach model. Clients will be supported to access My Aged Care and other related services. Care finders will stay involved with the client until the client does not require or want any further support from the care finder.

Description of Activity

- Undertake a comprehensive needs assessment which complements HNC's regional Health Needs Assessment. The needs assessment summarises local needs through an analysis of data and literature and consultation with local stakeholders.
- Undertake a procurement process to contract Care Finder providers.
- Transition the existing Assistance with Care and Housing program over to the Care Finder program (excluding hoarding and squalor services).
- Care finder model of care:
  - Assertive outreach: Tailored to regional and rural environments, connections with health practitioners, agencies, and rural community groups. Flexibility as to how and where they meet with community members promoting awareness. Building new networks and sources of trusted third parties to be referred to/connected with most vulnerable.
  - Integration between aged care, LHDs, primary care and other agencies such as police, ambulance, housing etc has begun in other activities in the region and the care finders assertive outreach program will continue to imbed these relationships.
  - Registration, screening, and assessment: the organisation will have an efficient person-centred informed intake process, preferably using local people that know regional living and the community. Intake will ensuring the person being referred is within the care finder target population and where it is not a warm referral process will be in place to other agencies. The assessment phase with the care finder will begin with contact with the referring agency, in a meeting with the consumer in a place that is safe for them. The assessment process will be undertaken over a period of contacts using the most suitable approach for the consumer e.g., storytelling focused on what is most important to the person, first balanced with introducing supports that will ensure security, e.g., housing, finance, nutrition.
  - Support post assessment: support to access services, any further or changed needs are addressed and the person is empowered to manage life. Warm referrals are made with the consumer to differing agencies and eventually the aged care provider.
  - High level check-ins: will be conducted by the care finder until the consumer has settled into a trusted relationship with the new provider and their current needs are being supported.
  - Follow up support: is made available to the consumer as needs change or if initial services are short term.
  - Each care finder will continue to build networks of local agencies that have been established through HNC's own networks and key stakeholder engagements.

HNC will review and monitor the outcomes of the Care Finder Program locally using the combined NSW PHN performance measures currently under development which aligns with the Australian Govt., Evaluation of the care finder program, Summary evaluation plan (2022). HNC will also review the performance of each provider, via HNC's commissioning processes, to ensure consumers are receiving a high quality service and the providers are meeting all key deliverables under their contracts.

Needs Assessment Priority

NCPHN Needs Assessment 2021-2024

Needs Assessment Priority
Improve access to aged care services, care packages and RACFs in a region with a large proportion of older people
Enhancing care navigation to improve delivery of health and social care services

Target Population Cohort

People who are eligible for aged care services and have one or more reasons for requiring intensive support to:

- interact with My Aged Care and access aged care services

and/or

- access other relevant supports in the community.

Indigenous Specific	No

Coverage

Whole Region

Consultation

Meetings and stakeholder engagement will be held with Assisted with Care and Housing organisations servicing the North Coast region. Data collected and added to the broader key stake holder engagement included an understanding of their client base, client outputs and the challenges and barriers the clients and care finders face. The average client base for an ACH worker was approximately 100 clients and barriers commonly faced included secure housing for those with mental health issues such as hoarding or drug and alcohol complexities.

Supporting Aboriginal clients with secure housing is particularly challenging with younger generations often causing the older family members issues with their lease security. The lack of housing stock is causing significant issues in the region pre floods. The floods have now resulted in many people having to move right out of area or are living in unsafe situations. Many Aboriginal people are struggling being off country or are choosing to live in very unsafe situations.

Three focus groups were held with a mix of local health district staff, community service providers (a mix of aged care and general community programs), other agencies; ambulance, police, Advocacy groups, local government and Aboriginal workers. Specific settlement services and members from the LGTBQI+ community were also included. Consumers were living in a range of accommodation such as caravan parks, retirement villages and in temporary housing.

Vulnerable groups were identified and synthesised into the following groups: those with complex mental health conditions; people that are isolate;, older carers (i.e. are one or have one); and living in volatile and unsafe situations

Collaboration

Key members from the stakeholder engagement will be included in the design and implementation of the program. In particular, the local ACH providers. LHD staff that will interface with the program include Emergency Department, social workers and discharge planners. Councils providing access to remote community halls, Aboriginal workers ensuring those Aboriginal people not wishing to use the Trusted Indigenous Facilitators are provided for, National seniors providing a consumer's voice, migrant groups representatives and LGTBQI+ organisations will all be collaborated with on an ongoing basis.

Activity Milestones Details/Duration

Activity Start Date	01/07/2022
Activity End Date	30/06/2025
Service Delivery Start Date	1/01/2023
Service Delivery End Date	30/06/2025

Procurement approach

Not yet known

Is this activity being co-designed?	Yes
Is this activity the result of a previous co-design process?	No
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No
Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No