Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks:
Integrated Team Care Funding

Activity Work Plan 2016-2017:

- **Annual Plan 2016-2017**
- **Annual Budget 2016-2017**

Country WA PHN

When submitting this Activity Work Plan 2016-2017 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

The Activity Work Plan must be lodged via email to *Qld_PHN@health.gov.au* on or before 15 July 2016.

Introduction

Overview

The aims of Integrated Team Care are to:

- Contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care; and
- Contribute to closing the gap in life expectancy by improved 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 objectives of Integrated Team Care are to:

- Achieve better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people, through better access to the required services and better care coordination and provision of supplementary services;
- Foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors;
- Improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people;
- Increase the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule (MBS) items, including Health Assessments for Aboriginal and Torres Strait Islander people and follow up items;
- Support mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify; and
- Increase awareness and understanding of measures relevant to mainstream primary care.

Each PHN must make informed choices about how best to use its resources to achieve these objectives. PHNs will outline activities to meet the Integrated Team Care objectives in this document, the Activity Work Plan template.

This Activity Work Plan covers the period from 1 July 2016 to 30 June 2017. To assist with PHN planning, each activity nominated in this work plan should be proposed for a period of 12 months. The Department of Health will require the submission of a new or updated Activity Work Plan for 2017-18 at a later date.

The Activity Work Plan template has the following parts:

1. The Integrated Team Care Annual Plan 2016-2017 which will provide:
    a) The strategic vision of your PHN for achieving the ITC objectives.
    b) A description of planned activities funded by Integrated Team Care funding under the Indigenous Australians' Health Programme (IAHP) Schedule.
2. The indicative Budget for Integrated Team Care funding for 2016-2017.

Activity Planning

PHNs need to ensure the activities identified in this Annual Plan correspond with the:

- ITC aims and objectives;
- Item B.3 in the Integrated Team Care Activity in the IAHP Schedule;
- Local priorities identified in the Needs Assessment;
- ITC Implementation Guidelines; and
- Requirement to work with the Indigenous health sector when planning and delivering the ITC Activity.

Annual Plan 2016-2017

Annual plans for 2016-2017 must:

- Base decisions about the ITC service delivery, workforce needs, workforce placement and whether a direct, targeted or open approach to the market is undertaken, upon a framework that includes needs assessment, market analyses, and clinical and consumer input including through Clinical Councils and Community Advisory Committees. Decisions must be transparent, defensible, well documented and made available to the Commonwealth upon request; and
- Articulate a set of activities that each PHN will undertake to achieve the ITC objectives.

Activity Work Plan Reporting Period and Public Accessibility

The Activity Work Plan will cover the period 1 July 2016 to 30 June 2017. A review of the Activity Work Plan will be undertaken in 2017 and resubmitted as required under Item F.7 of the ITC Activity in the IAHP Schedule.

Once approved by the Department, the Annual Plan component must be made available by the PHN on their website as soon as practicable. Sensitive content identified by the PHN will be excluded, subject to the agreement of the Department. Sensitive content includes the budget and any other sections of the Annual Plan which each PHN *must list at Section 1(b)*.

Once the Annual Plan has been approved by the Department, the PHN is required to perform the ITC Activity in accordance with the Annual Plan.

Useful information

The following may assist in the preparation of your Activity Work Plan:

- Item B.3 of Schedule: Primary Health Networks Integrated Team Care Funding;
- PHN Needs Assessment;
- Integrated Team Care Activity Implementation Guidelines; and
- Improving Access to Primary Health Care for Aboriginal and Torres Strait Islander People theme in the IAHP Guidelines.

Please contact your Grants Officer if you are having any difficulties completing this document.

1. (a) Strategic Vision for Integrated Team Care Funding

Please outline, in no more than 500 words, an overview of the PHN's strategic vision for the 12 month period covering this Activity Work Plan that demonstrates how the PHN will achieve the Integrated Team Care objectives.

The Integrated Team Care (ITC) will see the development of innovative and effective primary health care strategies for Aboriginal[1] people with chronic health conditions in rural, regional and remote communities. Promoting and improving access to coordination and appropriate multidisciplinary care in sparsely populated and underserviced areas challenge service delivery design and implementation; workforce attraction, development and retention; and engagement with service provider groups who may not traditionally work together. Our vision is to promote and enhance collaboration to ensure all Aboriginal people requiring ITC have options and choices within their communities.

Facilitating the development of effective, regionally connected networks of providers to support the ITC is central to the commissioning activities undertaken by the PHN. Successful networks will depend on the PHN's ability to identify and cultivate appropriate strategic relationships with organisations with shared values.

Given the intersection of the ITC activity with mainstream primary care, the PHN will encourage and support the provision of culturally appropriate services across all facets of its primary health commissioning activities. In addition, the PHN will duly prioritise supporting collaboration and links with social care agencies in recognition of the impact of the social determinants of health on the ITC activity.

Key to the collaborative commissioning approach for Country WA PHN are the seven (7) Regional Clinical Commissioning Committees (RCCCs) established to provide robust localised input to commissioning approaches and service models in their individual regions. In recognition of the importance of regionally tailored services, the WA PHN is guided by the RCCCs, Regional Aboriginal Health Planning Forums and other regional advisory groups. Through local and regional consultation Country WA PHN can target services more effectively and efficiently.

Through the alignment of program outcomes we will avoid duplication and address gaps in the provision of coordinated care for Aboriginal people, reducing the propensity for Aboriginal people to present to hospital for avoidable admissions. This integrated, collaborative approach also provides further opportunity to work in partnership with the WA Country Health Service.

This collaborative approach seeks to support workforce development and capacity building within service providers, a critical issue in rural and remote areas, ensuring an appropriate response to the identified needs of the target population.

[1] Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community as they are eligible to access any program run under the ITC framework.

Improving the health system literacy is a priority of the PHN across a range of its primary health commissioning activities and is particularly relevant to the ITC activity. The provider networks will be supported by the PHN to improve their own and clients' health literacy and cultural awareness and subsequent ability to be active participants in the management of their own health and wellbeing. The PHN recognises this is integral to the provision of optimal coordinated, person-centred wrap around care.

Monitoring and evaluation are of utmost importance to ensure the ongoing development and sustainability of the ITC activity. The PHN will work with provider networks to identify the challenges, barriers and enablers associated with the ITC activity.

Regular communication with providers and communities will facilitate relationship development and honest respectful two-way engagement, acknowledging the importance of stakeholder engagement in supporting change management and transitioning priorities for the PHN.

1. (b) Planned activities funded by the IAHP Schedule for Integrated Team Care Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-17. These activities will be funded under the IAHP Schedule for Integrated Team Care.

Proposed Activities	
Six-month transition phase	*Provide a description of your provider arrangements and plans to transition to commissioning if your organisation will utilise the six-month transition phase to 31 December 2016.* From 1 July – 31 December 2016 service delivery will continue through existing service providers. Six month contracts will be offered to existing CCSS and IIAMPC providers allowing time for commissioning activity with these new services to begin January 1st 2017. The transitional contracts utilise the same principles of the previous contracts but include opportunities for providers to begin work on identifying ways their service can deliver increased outcomes based activity in alignment with local needs and at the PHN and regional levels. Between July and December 2016, the PHN will undertake a procurement process for new services to begin January 1st 2017. Details of the commissioning approach are outlined elsewhere. To inform this commissioning approach, workshops and 1:1 meetings have been held in July in each region involving community members and existing service providers in July. Regional Clinical Commissioning Committees have also been consulted regarding regionally appropriate commissioning. Feedback from the workshops and meetings has been used in the development of the procurement approach.

Anticipated start date of ITC activity	Transition phase - 1 July 2016 – 31 December 2016 for service continuity contracts August/September – advertising for PHN based Aboriginal Health Coordinator position Commissioned ITC Activity – 1 January 2017
Will the PHN be working with other organisations and/or pooling resources for ITC?	*Please describe arrangements if the PHN plans to collaborate or pool resources with other organisations, including other PHNs.* Country WA PHN will coordinate with the Perth North and Perth South PHNs to ensure a consistent approach to the development of services whilst ensuring regional and local needs and priorities are met as identified in the PHN Comprehensive Needs Assessment (CNA). Consortia models will be desired, working with stakeholders including WA Country Health Service (as the Area Health Service), Non-Government Organisations, Aboriginal Community Controlled Health Organisations (ACCHOs), Regional Planning Forums, Peak bodies and the community itself. Desirable attributes of successful applicants include: • Evidence of the provision of culturally secure services; • Existing relationships and a track record of successful service delivery within the specific region; • Demonstrated experience and success in working with Aboriginal and Torres Strait Islander people; and • A commitment to an outcomes focussed delivery model that ultimately aims to reduce potentially preventable hospitalisations. As WACHS plays a key role in the provision of primary care services in many communities WAPHA has committed to work collaboratively with them in the planning and development of services, especially those addressing chronic health conditions. In working with WACHS we are (where possible) utilising frameworks and principles developed for WA in consultation with communities. This includes the *Chronic Conditions Strategy* and the *WA Health and Wellbeing Framework*. The latter acknowledges the importance of: • Culture as a determinant of health and wellbeing of Aboriginal people • Aboriginal people's definition of health and the strength of community • Partnerships between services and community to encourage new ways of working.

	Country WA PHN is supported by WAPHA 'backbone' resources including a cultural advisor, engagement with Peak bodies and state wide service providers undertaken in metropolitan Perth, the shared *PHExchange* online engagement tool, and the WAPHA centralised contracting department. All WA PHNs will be accessing the support of AHCWA and the Aboriginal Health Leadership Forum in the assessment process with each of these groups providing representatives for the assessment panels. The WA PHNs are working towards the completion of an ITC Implementation Plan that sets out the annual work plan for each PHN, and in the case of Country WA PHN the work plan for each Region. We will seek to align these plans with the PHN and National Aboriginal and Community Controlled Health Organisation (NACCHO) *Guiding Principles 2016.*
Service delivery and commissioning arrangements	*Provide a description of the service delivery and commissioning arrangements for the ITC Activity.* *Briefly outline the planned commissioning method and if the process will involve an approach to market, direct engagement or other approach for the activity. List the type of organisations to be commissioned (e.g. AMS or mainstream primary care organisation).* The service delivery and commissioning approach of Country WA PHN has three elements: 1. Service continuity contracts to existing providers of the CCSS/IIAMPC programs from 1 July – 31 December 2016 2. Country WA PHN will appoint an Aboriginal Health Coordinator (1.0 FTE) to provide PHN-wide coordination of the ITC activity and alignment with the ITC services being delivered in the community and to work with the Perth North and Perth South PHNs to promote synergies and to ensure smooth transitions of Aboriginal Clients who need to move from Country to Metro. 3. An open market Expression of Interest (EOI) approach to commission place-based services across each region from 1 January 2017. This will ensure and open and transparent approach whilst allowing for regional tailoring, based on the advice of the Regional Clinical Commissioning Committees and other stakeholders. Aligning with stakeholder feedback about the current ITC service model, any EOI will encourage a consortia approach to service development and delivery.

	A range of service providers will be engaged in the commissioning process and are expected to participate in the EOI process, either as lead agencies or as consortia members. Mainstream and AMS providers will be encouraged to explore partnership opportunities within their regions. The EOI documents, and any subsequent Tender documents will prioritise areas and populations of significant need, as identified in the 2016 CNA, within which a more comprehensive targeted approach to Aboriginal health is required. Respondents will be required to specifically identify how they will address each identified area or population group – not simply extend services from one location to another thus avoiding a one size fits all approach. A collaborative multi-agency approach is supported by the CNA which identified fragmentation of services and lack of clear referral pathways for Aboriginal People as critical issues. The 2014 report *"A Promising Future: WA Aboriginal Health Programs[2]"* highlighted the need for improved integration at a regional level and promoted joint service ventures. Expressions of interest will be encouraged from the AMS sector, but will not be limited to this group. **Timeline** <u>March 2016 – comprehensive needs assessment undertaken</u> This identified a number of priority needs for the PHN to address including people with chronic and complex conditions, and people from vulnerable and hard to reach groups, including Aboriginal people. It also identified those areas with high Aboriginal populations. <u>June/July 2016 - Consultation with stakeholders</u> The PHN will work with key stakeholders including the Aboriginal community; current ITC providers and other key stakeholders to share experience and learnings on the most effective and culturally safe ways to meet the needs of

[2] Holman Review- A Promising Future: WA Aboriginal Health Programs. An external review of Western Australia's State funded Aboriginal Health Programs was undertaken in 2014.

	Aboriginal and Torres Strait Islander people accessing the ITC program. These conversations with stakeholders will inform the details of the local commissioning approach and contribute to wider primary health planning for Aboriginal and Torres Strait Islander people. A survey was also posted on the PHNs' online community engagement forum, *PHExchange*, to gather feedback from the community and other stakeholders. These conversations with stakeholders inform the details of the local commissioning approach and contribute to wider primary health planning for Aboriginal people. <u>August 2016</u> 1. Recruitment for PHN-based Aboriginal Health Systems Coordinator 2. Expressions of Interest request open Service providers interested in being considered for funding will be able to respond to a formal request through the WA Primary Health Alliance (WAPHA) website. <u>September 2016 - Evaluation of responses and selection of preferred respondents</u> Independent input may be sought to assist with the assessment of the EOI responses and select the providers demonstrating capability to deliver a collaborative integrated service. Respondents will be assessed according to a the following criteria: • Pre-qualification criteria – including the requirement to have experience in providing health and well-being services/programs for Aboriginal people in the relevant region • Disclosure and compliance • Organisational capacity, experience and capability • ITC service model, including consortia partners <u>September/October 2016 – dialogue (or open tender if required)</u> Successful respondents selected via the EOI process will be invited to progress to stage two of the process which will include further development of the model for the particular region and will explore, preferably through dialogue:

	• ITC workforce
	• Budget
	• Risk management
	• Governance – robust and appropriate corporate and clinical governance processes are in place in the organisation
	• Evidence of experience of working with the local Aboriginal community and health care providers in the planning and design of shared care arrangements for Aboriginal people with complex health care needs.
	• Organisation's current service provision activities within the region and how these may complement and support the delivery of a culturally safe and effective regionally targeted ITC program
	• A service model that responds to the identified areas and populations of significant need within the particular PHN region. The model will include:
	  ○ Proposed engagement with, and support to, general practice
	  ○ Provision of clear referral pathways for specialist and allied health care
	  ○ Staffing levels that will meet service demand
	  ○ Anticipated client numbers per care coordinator/indigenous outreach worker and anticipated activity of the IHPO role
	  ○ Approach to professional development and performance management of their ITC workforce
	  ○ Mechanisms to support the ongoing development of cultural and clinical competencies, responsive to the needs of Aboriginal people.
	
	<u>October/November 2016 - Contracts finalised and issued to successful respondents</u>
	
	<u>November/December 2016 – service transition (if required)</u>
	
	<u>January 2017 - Services commence under new ITC funding agreement</u>
	
	<u>Monitoring and evaluating</u>

	The 6 monthly reporting activity is expected to include identification of the barriers and enablers to delivery of the ITC program. We will work with our research partner, Curtin University, current providers and other stakeholders to develop a tailored outcomes framework for the ITC program based on the Quadruple Aim of improved patient/clinical outcomes, improved patient experience, improved efficiency/effectiveness and improved safety and quality (including staff experience). This will reflect the WAPHA Outcomes Framework currently in development. Curtin University will work with the successful providers and PHN staff to undertake a baseline assessment and regular evaluation throughout the program. This will enable the PHN to contribute to the evidence base about place-based approaches to care coordination for Aboriginal people and building capacity in mainstream primary care. The principles of collective impact, plus outcome measures and indicators, including those outlined in the WA Aboriginal Health and Wellbeing Framework 2015 – 2030 will be utilised together with Patient Reported measures (PREMs and PROMs) in program monitoring and evaluation.
Decision framework	*Making specific reference to the needs assessment, market analyses, clinical and consumer input (including through the PHN's Clinical Council and Community Advisory Committee), describe how this framework led to the service delivery and commissioning arrangements outlined above.* The Country WA PHN Comprehensive Needs Assessment identified five key priorities: • Keeping people well in the community • People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions • Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage • System navigation and integration to help people get the right services at the right time and in the right place

	• A Capable workforce tailored to these priorities. ITC addresses all the above priorities. The CNA also highlighted: • Aboriginal people in WA are a younger population and have a dramatically reduced life expectancy compared to non-Aboriginal Western Australians. Both Aboriginal males and females have life expectancies significantly below the national Aboriginal averages • In 2011, the median age at death for Indigenous males in WA was 52.2 years, 25.2 years less than that for non-Indigenous males (77.4 years). The median age at death for WA Indigenous females was 54.2 years, 30.2 years less than that for WA non-Indigenous females (84.4 years)[3] • Across Country WA there are some regions with significantly larger Aboriginal populations, for example the Kimberley population is more than 40% Aboriginal. Overall Aboriginal people comprise approximately 10% of the population of Country WA PHN. In some regions of Country WA Aboriginal people live in very remote communities, for example, 48% of the Kimberley Aboriginal population and 30.2% of the Goldfields Aboriginal population live in permanent remote Aboriginal communities. <u>Market Analysis</u> Market analysis in Country WA reveals that care coordination in most areas is being provided by a very limited number and type of organisations. Linkage to Aboriginal people with chronic conditions and the integration with other services is variable across the regions and is particularly poor in remote areas. Country WA will be seeking to improve access to and coordination of care through the use of a more regionally target approach which building on existing services and makes maximum use of technologies available to support service delivery.

[3] Australian Indigenous HealthInfoNet. (2013). Overview of the health of Indigenous people in Western Australia 2013

	Within the seven regions of the Country WA PHN there is often a need to address Aboriginal health issues on a sub-regional (or place based) basis given the distances between regional 'hubs' and differences between communities. Engagement with Aboriginal people has also identified the difficulties they experience with the propensity of fly-in-fly-out or drive-in-drive-out services such as irregular schedules, lack of cultural understanding and changing staff. There are 71 public hospitals across Country WA. These hospitals are operated by WACHS and in some instances provide General Practitioner/primary care under the COAG Section 19 (2) Exemption for Non-admitted Services, playing an important role in chronic disease management. In all regions there are non-clinical Aboriginal Health and Wellbeing services provided by a range of organisations but as identified in the CNA a significant gap exists across rural and remote WA with a need to better integrate regional governance systems, plans, clinical registers, workforce reforms and joint service provision. *Consumer Analysis* • It is estimated that there are approximately 53,286 Aboriginal people in Country WA PHN with the regional breakdown as follows: o Kimberley – 17,022 or 19.3% of the total WA Aboriginal population (8,167 in remote communities) o Pilbara – 9,926 or 11.2% of the total WA Aboriginal population (1,492 in remote communities) o Midwest – 8,472 or 9.6% of the total WA Aboriginal population (386 in remote communities) o Goldfields – 6,851 or 7.8% of the total WA Aboriginal population (2,068 in remote communities) o South West – 4,178 or 4.7% of the total WA Aboriginal population o Great Southern – 2,577 or 2.9% of the total WA Aboriginal population o Wheatbelt – 4,260 or 4.8% of the total WA Aboriginal population • Despite improvements in recent years in Aboriginal and Torres Strait Islander health, Aboriginal and Torres Strait Islander people experience poorer health and have worse general health outcomes than other Australians. They have a burden of disease two to three times greater than the general Australian population and are more likely to die at younger ages, experience disability and report their health as fair

	to poor. The reasons for the differences include disparities in social and economic factors, in health behaviours and in access to health services. [4] • Further to this: ○ Hospitalisations for Aboriginal people in WA are 3.8 times higher than non-Aboriginal people, mainly due to care involving dialysis, diseases of the respiratory system and endocrine, nutritional and metabolic conditions. ○ The hospitalisation rate for potentially preventable chronic conditions was 4.3 times higher for Aboriginal people than for non-Aboriginal people. From 2008 – 2012, 48.6% of all potentially preventable hospitalisations for Aboriginal people were due to chronic conditions[5]. The CNA indicated that the differences in potentially preventable hospitalisations between Aboriginal and non-Aboriginal people are particularly pronounced in Remote and Very Remote areas. In Remote areas (2011 – 2013) there were 254 separations per 1,000 Aboriginal people and 35 separations per non-Aboriginal people; in Very Remote areas the rate was 118 per 1,000 for Aboriginal people and 34 per 1,000 for non-Aboriginal people. Most of the health gap for Aboriginal people is due to chronic disease and can be attributed to specific diseases The major contributors are: - Heart diseases - Diabetes - Liver diseases - Chronic lower respiratory disease - Cerebrovascular diseases, such as stroke - Cancer ○ Approximately two in three Aboriginal and Torres Strait Islander people (67 per cent) reported that they had at least one long-term condition in 2012–13[6]; and ○ One-third (33 per cent) of Aboriginal and Torres Strait Islander people reported having three or more long-term conditions[7].

[4] National Strategic Framework for Chronic Conditions May 2016

[5] WA Aboriginal Health and Wellbeing Framework 2015 – 2030. Department of Health 2015.

[6] Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

[7] Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

	○ Applying this approximation of the levels of chronic conditions to the Aboriginal population in the Country WA PHN equates to approximately 35,702 Aboriginal people with at least one long term chronic condition and approximately 17,584 with three or more long term conditions. Achieving long-lasting sustainable impact in Aboriginal health across Country WA will require a 'whole-of-health-system' approach that includes support from the mainstream general practice and other health services, ACCHO services, specialists, allied health and hospitals. <u>Clinical and consumer input</u> Community and clinical input was sought through community/provider workshops and meetings and through discussions at the PHN's Regional Clinical Commissioning Committees and members of Aboriginal Health Planning Forums. Several Country WA stakeholders also attended a Perth based workshop. Feedback from the community/provider workshops identified a number of key desired outcomes, key strengths of the existing program, as well as opportunities for improvement in future. Desired outcomes of the program were: • Services are appropriate and accessible for the community; • Reduced financial barriers to consumers accessing services; • Reduced cultural barriers to consumers accessing services; • Increased consumer knowledge of where to go to access support; • Contribution to consistent and purposeful data collection; • Enhanced peer and/or professional support to the workforce to deliver program outcomes; • Improved collaboration between health services; • Improved self-management of chronic conditions (inside and outside the ICT program); and • Feedback highlighted the lack of collaboration and coordination between service providers, attributed to the current contracting environment. This has led to difficulties for some consumers in accessing suitable services in their local area. Clinical and consumer input confirms the limited scope and reach of many existing programs and the possibility of better outcomes through partnerships. The difficulties for Aboriginal people in accessing mainstream health

	services is magnified by socioeconomic disadvantage, geographic location, limited availability of mainstream providers in many regions, high mobility, and a lack of culturally appropriate mainstream health services. All involved are looking for sustained improvement and good outcomes. Consideration of these factors has led the PHN to determine an approach to market via an open Expression of Interest process will be necessary to achieve the level of innovation and improvement required. The appointment of an Aboriginal Health Coordinator for the Country WA PHN, to work collaboratively with IHPO and other ITC staff in regions and with Metro PHN staff to promote system wide change is also seen as a priority. Note the PHN position will be funded through allowable administration funds.
Decision framework documentation	*Has the decision framework outlined above been documented?* • The baseline needs assessment has been published for internal use. A public version of the document is being prepared; • The market analysis is documented in internal meeting notes; and • Clinical and consumer input is captured in meeting notes. The decision matrix for the program was prepared, indicating a need to move to an open market testing process. This is attached for information.
Description of ITC Activity	*Provide a summary (or attach) your PHN's 2016-17 ITC implementation plan, which includes the work to be done by IHPOs, Care Coordinators, and Outreach Workers in the PHN region.* The Country WA PHN ITC approach is intended to deliver wrap-around and co-ordinated care to support vulnerable Aboriginal people to live well in their local community by accessing the right care in the right place at the right time. **Key areas of the Country WA PHN Implementation Plan 2016-2017 include:**

	• Service continuity; • Aboriginal Health Coordination role within the PHN; • Procurement of services; • Development of an outcomes framework in collaboration with stakeholders; and • Testing and implementation of clinical, cultural and organisational standards. IHPOs, Care Coordinators and Outreach Workers in the PHN regions will undertake work as outlined in the ITC Implementation Guidelines. EOI documentation and specifications will articulate the requirement for Aboriginal and Torres Strait Islander people to be engaged to work in all roles where possible. The PHN plans to employ an Aboriginal health "system coordinator" position (1.0 FTE) to work in the across the PHN and to collaborate with the Perth North and Perth South PHN to effect system wide improvement. The role would be positioned to collaborate closely with the ITC providers in the regions in service capacity building and workforce development. The PHN would utilise allowable administration and workforce capacity building funds for this position. This role will work with ITC providers in partnership on activities such as: • The design, and then trial for implementation of a set of standards for culturally appropriate care in a clinical setting. This will reference work already undertaken by AHCWA; • ITC workforce development activity, and • An external evaluation of the ITC program across the PHN. Workforce Development activity will be planned with existing and new suppliers and staff members. Activity could include carrying out a training needs analysis and developing and delivering tailored training programs for ITC staff; coordinating a network of ITC staff across the PHN regions and across Country and Metro WA (in collaboration with Perth North and Perth South PHNs); organising a forum for ITC staff.

	The desired outcome of points above is consistency in a model of care which is both clinically and culturally responsive to the needs of Aboriginal people and their carers/families, and be able to measure, analyse and evaluate the program with the aim of demonstrating the success or areas of improvement for the service model.
ITC Workforce	*Indicate number of Indigenous Health Project Officers, Care Coordinators and Outreach Workers that are to be engaged. Specify which positions will be engaged by the PHN or commissioned organisation(s). If engaged at a commissioned organisation, specify whether it is an AMS* or mainstream primary care service* *AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services Ensuring service continuity the ITC commissioning process will seek to maintain the current level of ITC workforce in the sector which is currently; • 6.6 Full-time Equivalent Indigenous Health Project Officers (IHPOs) • 8.8 Full-time Equivalent Indigenous Outreach Workers • 13.4 Full-time Equivalent Care Coordinators Currently all staff work within mainstream organisations and the new models will seek to distribute the workforce amongst mainstream providers, AMSs and other Aboriginal Community Controlled Organisations. The placement of staff will be identified in the EOI documentation and based on areas with high numbers of Aboriginal people and limited service access. Respondents will also be encouraged to identify how they might extend the reach of the programs through the utilisation of a range of tele-health options such as the Diabetes and Respiratory Tele-health hubs. Final details regarding placement of staff will be negotiated with successful EOI respondents. As previously mentioned, the Country WA PHN will employ an Aboriginal Health Coordinator (AHC) in the PHN to identify systemic improvement opportunities and work with the ITC provider/s, their partners and the health sector more broadly to achieve the aims and objectives of the ITC program.

	Some of the benefits of this approach include: • Closer working relationship with and between IHPOs than currently experienced; • Provider IHPO would provide the PHN links to services and the patients/partners with which they engage; • PHN AHC could support network opportunities for the provider IHPOs with a range of stakeholders; • PHN AHC can provide data/information sets relevant to the Provider IHPOs catchment area; • PHN AHC can connect directly the Provider IHPOs with other Country WA PHN funded programs • Direct connection with Provider IHPO may support easier implementation of ITC and other Aboriginal health improvement strategies/activities; and • Increased capacity in the PHN to facilitate system change initiatives to address Aboriginal health issues.	
Planned Expenditure 2016-2017 (GST exc)	$5,367,457.28	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, state and territory governments)

COUNTRY WA PHN – INTEGRATED TEAM CARE COMMISSIONING DECISION MAKING PROCESS

ATTACHMENT 1