Australian Government
Department of Health

phn
An Australian Government Initiative

# Activity Work Plan 2018-2021:
# Integrated Team Care Funding

The Activity Work Plan template has the following parts:

1. The Integrated Team Care Annual Plan 2018-2021 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.

***Perth South PHN***

Approved by the Australian Government Department of Health, September 2018 (Version 1)

# Overview

This updated Activity Work Plan covers the period from 1 July 2018 to 30 June 2021. To assist with PHN planning, each new activity nominated in this work plan should be proposed for a period for 12 months.

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

The WA Primary Health Alliance (WAPHA) exists to facilitate a better health system for all Western Australians. The strategic vision for Integrated Team Care is an essential component of, and substantial contributor to WAPHA's overarching vision of improved health equity in Western Australia.

The primary health care system in WA is fragmented and lacks strong, integrated general practitioner (GP) led care at its core. Through collaboration with the three WA PHNs, WAPHA is committed to addressing the many access barriers that exist for people trying to navigate the current system – particularly those at risk of poor health outcomes.

The Perth South PHN Needs Assessment highlights the current barriers and constraints experienced by Aboriginal people with chronic conditions and those who support them. The PHN is committed to ensuring that the health and well-being of our most vulnerable people and communities is improved in a coordinated and patient-centred manner.

The Perth South PHN is committed to ensuring that there is full and ongoing participation of Aboriginal people in all levels of decision making affecting their health needs. The ITC commissioning activity has been informed by the PHN Baseline Needs Assessment, Aboriginal representation on our Clinical Commissioning Committee and Community Engagement Committee and an ITC Stakeholder workshop which included representation from key Aboriginal community members including Elders, a representative from the WA Grant Services Division of the Australian Department of Health, the Aboriginal Health Council of Western Australia, other key stakeholders and PHN / WAPHA team members.

Significant focus on the development and implementation of dedicated stakeholder engagement has been the key element of the WA PHNs' Integrated Team Care (ITC). This engagement focuses on sustained and meaningful collaboration within the WA Aboriginal[1] and mainstream health sectors. It is integral to achievement of the ITC aims and objectives and the stakeholder groups have valuable perspectives that inform the regional response of the PHN.

**Equity in Access and Cultural Competence**

The inequitable burden experienced by Aboriginal people living with complex chronic conditions is predominantly due to lack of access to both formal and informal care, health literacy, and a general lack of resources outside of the health system.

Cultural competence of service providers (organisations and individual providers) is intimately related to the cultural security of services[2] which affects access by Aboriginal people. Supporting the delivery of culturally secure health services to Aboriginal people in Western Australia is central to ensuring equity in access for Aboriginal people in Western Australia.

[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.

[2] McCalman J, Jongen C, Bainbridge R. Organisational systems' approaches to improving cultural competence in healthcare: a systematic scoping review of the literature. International Journal for Equity in Health. 2017;16(1):78.

The Perth South PHN's strategic vision for ITC is to focus on building a clear pathway along the course of care to the point of completion for Aboriginal people at the risk of isolation due to socioeconomic disadvantage or vulnerability. To ensure a solid foundation in the pathway, the PHN will focus on service providers' organisational cultural competency and the capability of ITC staff to deliver culturally secure services to Aboriginal people living with complex chronic conditions during the 2018-19 financial year. In accordance with Section 3 of ITC Program Implementation Guidelines, the PHN will also work with ITC providers to influence mainstream providers to reflect on the cultural competence of their organisations.

**Provider Support and Improving Patient Journey**

Workforce development and capacity building for ITC providers is a key support function of the PHN and will ensure that the local networks of providers are enabled to deliver place-based, culturally appropriate, coordinated care to Aboriginal people. Provider networks will be supported by the PHN to improve communication and collaboration across the sector. This is integral to the provision of optimal co-ordinated and wrap-around care.

In 2018-19, the Perth South PHN will also facilitate improvements in ITC clients' journeys through the health care system at a program delivery level by providing online tools, and at systems level by facilitating collaboration between Commonwealth and State-funded programs. The vision for the ITC patient journey is seamless transition between acute and primary care, and between metro and regional areas.

**Stakeholder Engagement**

Stakeholder engagement has enormous value in the identification and management of risks, support, change management and transitioning priorities for the PHN. An important shift is occurring in the PHN's ITC activity from an environment of single-service funding that encourages fragmented, episodic and output focused care to an outcomes-based, locally responsive approach. The PHN will communicate regularly and consistently with stakeholders regarding the evidence-based, robust and transparent process that will be applied throughout the PHN's phased approach to the ITC activity.

The engagement strategy will be complemented by due recognition of the need to integrate mainstream primary care in providing a collaborative and supportive response to improving the health outcomes of Aboriginal people.

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

**Monitoring and Evaluation**

Monitoring and evaluation are of utmost importance to ensure the ongoing development and sustainability of the ITC activity. The PHN will work with our research partner, Curtin University, and provider networks to identify the challenges, barriers and enablers associated with the ITC activity. Regular communication with providers will be a priority of the PHN to facilitate relationship development supporting two-way engagement.

# 1. (b) Planned activities funded by the Indigenous Australians' Health Program Schedule for Integrated Team Care Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2018-2021. These activities will be funded under the IAHP Schedule for Integrated Team Care.

| **Public Accountability** | |
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| What are the sensitive components of the PHN's Annual Plan? Please list | No components. |

| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity | |
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| Existing, Modified, or New Activity | Modified to incorporate Departmental approval of underspend proposal. |
| Start date of ITC activity as fully commissioned | 1 January 2017 |
| Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed? | Perth South PHN works closely with both the Perth North PHN and Country WA PHNs to share planning, commissioning and workforce development activities where possible to achieve efficient and innovative ITC service delivery models across Western Australia.<br><br>The WA PHNs are supported by WA Primary Health Alliance (WAPHA) shared resources that undertake a range of services such as engagement with Peak Bodies and state-wide service providers in metropolitan Perth; the shared Primary Health Exchange (*PHExchange*), an online engagement tool, and the WAPHA centralised contracting department.<br><br>*PHExchange* will be utilised by WA ITC providers as a shared IT platform to share knowledge and information relating to the ITC. The platform will also be a consistent mechanism for PHN staff to communicate with all ITC providers.<br><br>The Perth South, Perth North and Country WA PHNs continue to employ a total of 2.0 FTE Aboriginal Health Coordinator (AHC) roles to provide leadership, coordination and support for PHN teams, external ITC providers and ITC stakeholders. |

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| Service delivery and commissioning arrangements | ITC is delivered in three regions in the PHN South PHN:<br><br>1. Perth South West (Mandurah, Waroona, Murray).<br>2. Perth South West.<br>3. Perth South East.<br><br>Two mainstream primary health care providers with links to Aboriginal community were commissioned from 1 January 2017 to deliver ITC in the Perth South East and Perth South West (Mandurah, Waroona and Murray) region, no changes beyond June 30, 2018.<br><br>The Perth South West is commissioned via a sub-contracting arrangement for the period from January 1st, 2017 to June 30, 2018. It is planned that this subcontracting arrangement will transition to the current subcontracted organisation; an Aboriginal Community Controlled primary healthcare provider.<br><br>This transition is in alignment with WAPHA's intention to support Aboriginal Community Controlled organisations to participate in WAPHA's commissioning activity.<br><br>In the Perth South PHN the Aboriginal Health Coordinator (AHC) (Metro) works both internally and externally to support delivery of the ITC program in the PHN.<br><br>In the Perth South PHN the AHC supports external delivery of key activities relating to the ITC including, but not limited to:<br>• Supporting capacity growth of the ITC workforce in the Perth South PHN.<br>• Supporting ITC providers to build cultural responsiveness of GP services.<br>• Supporting implementation of identified ITC Country to City: Patient transitions project recommendations.<br>• Supporting networking between ITC providers and with other stakeholders.<br>• Connecting with other ITC program stakeholders in recognition that the ITC program is premised on good integration across the health and social care systems.<br><br>As well as external activity, the AHC works internally with WA PHN staff to support the delivery of the ITC program in various ways including, but not limited to:<br>• Informing the ITC pathway on the WAPHA *HealthPathways* tool.<br>• Supporting knowledge and skills of WAPHA State-wide and Placed-based teams to support them implement the ITC program.<br>• Providing ITC programmatic guidance and updates.<br>• Supporting implementation of the ITC Country to City: Patient transitions project.<br>• Supporting PHN staff across the three WA PHNs to provide opportunity for best practice and integration of the ITC program with other PHN commissioned activity. |

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| | **Monitoring and evaluating**<br>Regular meetings are convened between Perth South PHN staff and ITC service providers. These meetings are scheduled to include identification of the barriers and enablers to delivery of the ITC program, as well as progressing discussion on planned activity.<br><br>WAPHA works with our research partner, Curtin University, current providers, other WA PHNs and stakeholders to develop a tailored Outcomes Framework for the ITC program based on the quadruple aim strategy that measures outcomes by:<br>• Health gains – individuals and populations<br>• Client experience – across the service and health systems<br>• Efficiency and effectiveness of services in addressing needs<br>• Clinician experience and improvements in quality and safety.<br><br>An activity funded by the Core Flexible Funding Stream under the Schedule – Primary Networks Core Funding Health System Improvement activity in 2017-2018 was the baseline assessment and evaluation of the ITC program. The evaluation has provided an independent assessment of the PHNs implementation, commissioning and delivery of the ITC program to achieve program objectives. The study evaluated the uptake, effectiveness and outcomes of the ITC program. Study objectives included:<br><br>1. Evaluate that the ITC program has been delivered with fidelity.<br>2. Evaluate the reported outputs and outcome for ITC clients.<br>3. Explore client experiences on the effectiveness of the ITC program.<br>4. Explore the costs associated with delivering the ITC program.<br>5. Provide recommendations for future program commissioning of the ITC program.<br><br>This was important to conduct because the ITC program is significant investment for the WA PHNs and our aim is to ensure that the program continues to meet the needs of the community and the programs partners. The evaluation complimented the Commonwealths evaluation and provided more local state-based information with a focus on how WAPHA could improve the support provided to ITC teams in WA across areas such as workforce development, program and policy refinement and enhancing collaborative approaches of the ITC program.<br><br>The local evaluation also informs WAPHAs commissioning and ongoing program monitoring approach ensuring the ongoing success and sustainability of the ITC program.<br><br>The impact of the ITC evaluation will now be mapped back to the WAPHA Outcomes Framework assessing:<br>• The impact of the ITC program in these outcome domains<br>• If the program has met its overall objectives to contribute to improving health outcomes for Aboriginal people with chronic health conditions through better access to coordinated and multidisciplinary care, and to contribute to closing the gap in life expectancy. |

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| | The ITC evaluation was the first whole of state evaluation of a specific chronic disease intervention for Aboriginal people and will be used to guide program change to improve health outcomes.<br><br>Evaluation findings will be used (at a minimum) to:<br>• Integrate and coordinate services within the ITC primary health care sector and across the wider health system. This will allow the sector to work together to ensure the delivery of services to best achieve health outcomes.<br>• Build a robust and responsive ITC client centred primary healthcare system through innovative and meaningful partnerships.<br>• Narrow the cultural distance gap between healthcare professionals and their Aboriginal clients.<br><br>The evaluation was in 2 Stages, commencing December 2016 and concluding August 2018.<br><br>Stage 1 of the evaluation involved qualitative analysis of data collected from in-depth interviews with ITC services providers.<br><br>Stage 2 of the evaluation focused on the desktop analysis of the 6 monthly service provider reports for the period from July to December 2017. Data visualisation models will accompany the evaluation report to enhance communication of the range of ITC activity and finance data. The visualisation models will support ITC program improvement enlightened by evidence, to inform ITC workforce training needs and service development, thereby leading to service improvement.<br><br>The findings and recommendations from Stage 2 evaluation will be used to support ITC program improvements. |
| Decommissioning | One contracted provider who subcontracted an Aboriginal Community Controlled Organisations (ACCO) to deliver ITC in the period January 2017 to June 2018 will be decommissioned and direct contracting will occur with the ACCHO.<br><br>In terms of ongoing Performance Management of the ITC program in WA, information will be sought from the following:<br>• People who access the ITC program.<br>• Organisations commissioned to deliver the ITC activity.<br>• Broader health and community services system engaging with the ITC program.<br>• Curtin University evaluation.<br><br>Depending on the outcomes from the performance management activities and the availability of funding, the PHN may re-shape, decommission, and/or commission new services. The procurement approach will depend on what is to be procured and the supply available. |
| Decision framework | WAPHA is in the process of developing a high-level decision support framework, the Prioritisation Framework (Framework) which uses an agreed set of criteria to operationalise strategic priorities. The Framework will incorporate three building blocks to support reflection on proposed or commissioned activities against their strategic fit, potential to optimise |

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| | health system performance and the proposed provider's organisational cultural competence. Once developed, this set of criteria will be reviewed periodically to reflect changes in the health sector.<br><br>WAPHA strategic priorities, also incorporated in WAPHA's Prioritisation Framework, are:<br>• Health Equity and Access.<br>• Person Centred Models of Care.<br>• Integrated and Outcomes Focused Commissioning.<br>• Strong Partnerships.<br>• Primary Care Capability.<br><br>The Framework also prompts reflection on whether the proposed or commissioned activity aligns with local priorities identified in the Needs Assessment. The following priorities from the Perth South PHN Core Needs Assessment Report 2017 (pages 36 – 43) apply:<br><br>P1: Orient primary health care towards people experiencing high socio-economic disadvantage especially in regions where there are lower levels of primary care providers<br><br>P2: Orient primary health care towards vulnerable people supporting primary health care providers to adopt appropriate approaches for targeted groups<br><br>P3: Primary care providers work with Aboriginal people and groups to plan and design strategies that address localised priorities<br><br>P4: Improve transitions between services by supporting effective care pathways, care coordination and service linkages<br><br>P5: Orient primary health care to ensure that risk factors for poor health outcomes are addressed or modified as early as possible<br><br>P6: Support local communities to be connected to primary care, in and out of hours<br><br>P7: Build the capacity for patient self-management, particularly for patients with co-occurring and multiple morbidities, through the support of appropriate primary care providers<br><br>P8: Build community awareness of when and where to seek non-urgent health care<br><br>P9: Reduce rates of PPHs by working with primary care providers and GPs to target specific areas where there are higher than state rates<br><br>P10: Promote the effectiveness of digital health technologies to optimise patient care<br><br>P11: Invest in services that have demonstrated health outcomes by commissioning to a validated Outcomes Framework in order to demonstrate services are efficient and effective |

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| Indigenous sector engagement | Perth South PHN will continue to build new and strengthen existing relationships with the Aboriginal health sector and Aboriginal communities.<br><br>Existing formal relationships and partnerships include:<br>• WA Aboriginal Health Partnership Forum.<br>• National PHN ITC collaboration network.<br>• State-wide Aboriginal Health Network.<br>• The AHCWA MAPPA Steering Committee.<br>• WAPHA convened in 2017 and will maintain and review in 2018, the WAPHA Aboriginal Health & Wellbeing Advisory Group. Membership includes state health, education and research areas, Aboriginal community members and the PHN.<br>• Attendance at AHCWA CEO/Board meetings.<br>• Establishment of an Aboriginal Health Community of Practice, open to GPs, other primary care clinicians, hospital and community sector clinicians and other staff with an interest in Aboriginal Health.<br>• WA Department of Health convened District Aboriginal Health Action Group in the Perth metro area: attend upon invitation. |
| Decision framework documentation | The WAPHA Prioritisation Framework (Framework) will be documented using a password protected online survey tool. This survey tool will capture individual decision maker's assessments and the results of individual assessments will be collated to inform the final decision.<br><br>This tool will also be used to help prioritise options considered in the continuous needs assessment, and this decision framework will be separately documented in the needs assessment reports.<br><br>The Needs Assessment report and the corresponding activity work plans will be published on the WAPHA website to allow public access. Dialogues taking place during the decision-making process will be documented in clinical and consumer committee meeting notes. |
| Description of ITC Activity | The aim of this activity is to ensure Perth South ITC providers are:<br>• Meeting the ITC program aims and objectives as set out in the ITC Program Guidelines.<br>• Delivering the ITC program in a way that is currently and/or planning to address the local needs of Aboriginal clients accessing the program.<br><br>To support this, the three WA PHNs have developed an ITC Implementation Plan 2018-19.<br><br>The ITC Implementation Plan aims to ensure the ITC workforce is undertaking activities aligned to the aims and objectives of the ITC program.<br><br>The ITC program has two components:<br>1. To provide care coordination services to eligible Aboriginal people with chronic disease/s who require coordinated, multidisciplinary care, and improve access to Aboriginal people to culturally appropriate mainstream primary care.<br>2. A Supplementary Services Funding Pool when access to a GP-approved medical aid, or an urgent and essential allied health or specialist |

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| | service, or the necessary transport to access the service needs to be expedited.<br><br>Not all those presenting with a chronic condition will require assistance through the ITC Program.<br><br>The PHN will continue to work with ITC providers and the programs partners to ensure priority is considered for clients who have complex needs, and require multidisciplinary coordinated care for their chronic disease, in particular those:<br><br>• Who require more intensive care coordination than is currently able to be provided by general practice and/or ACCHO staff.<br>• Who are unable to manage a mix of multidisciplinary service.<br>• Who are at greatest risk of experiencing otherwise avoidable hospital admissions.<br>• Who are at risk of inappropriate use of services, such as hospital emergency presentations.<br>• Who are not using community-based services appropriately or at all.<br>• Who need help to overcome barriers to access services.<br><br>To increase access, connectivity and collaboration between key ITC stakeholders including consumers, ITC providers and other parts of the local/wider health systems, the PHN intends to offer:<br><br>• Networking and increased collaboration opportunities between WA ITC providers, and local and wider health and social service providers.<br>• Appropriate resources designed to improve consumers' health literacy.<br>• A skills and training needs analysis to inform the development of the ITC workforce.<br>• Support for the identification and implementation of local ITC policy and process improvements including alignment with the revised ITC guidelines.<br>• Increase knowledge and access to digital health options e.g. My Health Record and telehealth.<br>• Access to IT platforms for patient management and communication between and with ITC providers.<br>• Resource to primary care providers to assist in the building of culturally safe mainstream services, and<br>• Support across the ITC program systems/processes that ensure the program captures:<br>o Patient experience<br>o Patient health outcomes.<br><br>PHNs will continue to work with ITC providers to ensure flexibility of the ITC program to suit the needs of the local community whilst considering the objectives of the ITC Program, and ensuring the Program Guidelines are being met by:<br>• Designing and contracting services to address the needs of Aboriginal people with complex chronic disease/s unable to effectively manage their condition/s, and<br>• Shaping the structure of supply to:<br>o Increase access to treatment and support, particularly vulnerable and hard to reach populations |

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<tr><td></td><td>
<ul>
<li>Enable better collaboration and integration between service providers</li>
<li>Support opportunities to better self-management</li>
<li>Sustain engagement with GPs/other primary health care professionals</li>
<li>Develop the capacity of the workforce.</li>
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<tr><td>ITC Workforce</td><td>
<table>
<tr><th></th><th>PHN</th><th>Mainstream</th><th>ACCHO</th><th>Total</th></tr>
<tr><td>IHPOs</td><td>0.5</td><td>3.5</td><td>1.0</td><td>5.0</td></tr>
<tr><td>Care Coordinators</td><td></td><td>3.65</td><td>4.25</td><td>7.9</td></tr>
<tr><td>Outreach Workers</td><td></td><td>2.6</td><td>2.5</td><td>5.1</td></tr>
<tr><td>Total</td><td>0.5</td><td>9.75</td><td>7.75</td><td>18.0</td></tr>
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<tr><td>Planned Expenditure 2018-19 (GST Exc) –<br>Commonwealth funding</td><td>$3,096,284.05</td></tr>
<tr><td>Planned Expenditure 2018-19 (GST Exc) –<br>Funding from other sources</td><td>$0</td></tr>
<tr><td>Planned Expenditure 2019-20 (GST Exc) –<br>Commonwealth funding</td><td>$3,075,815.10</td></tr>
<tr><td>Planned Expenditure 2019-20 (GST Exc) –<br>Funding from other sources</td><td>$0</td></tr>
<tr><td>Planned Expenditure 2020-21 (GST Exc) –<br>Commonwealth funding</td><td>$3,116,776.52</td></tr>
<tr><td>Planned Expenditure 2020-21 (GST Exc) –<br>Funding from other sources</td><td>$0</td></tr>
<tr><td>Funding from other sources</td><td>$0</td></tr>
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