Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2019-2021:

Integrated Team Care Funding

Country WA PHN

Approved by the Australian Government Department of Health, July 2019 (Version 1)

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

Proposed Activity	
ACTIVITY TITLE	**ITC 1: Enhancing Care**
Program Key Priority Area	Indigenous Health
Needs Assessment Priority	**Priority** • CGP1.7 Work with Local Hospital Networks, primary care providers, other health service providers and Aboriginal groups to reduce disease trends in Aboriginal communities. (p.97) **Possible Option** • Strategies to develop integrated care pathways in partnership with local hospital networks, health services, general practices and other clinicians. (p.94) **Priority** • CGP1.5 Promote the effectiveness of digital health technologies to optimise patient care (telehealth). (p.96) **Possible Option** • Ensure commissioned service providers utilise and encourage uptake of telehealth services. (p.96)
Aim of Activity	The aim of the Enhancing Care activity is to build on previous successes of the ITC program to grow the programs integration, effectiveness and outcome focused service model to meet the aims and objectives of the ITC Program. The PHN will continue to work with ITC teams to: • strengthen links, program integration patient outcomes, and • workforce development • enhance the capacity of the ITC workforce to support a client's ability to self-manage their chronic condition/s; • support ITC providers to embed a Quality Improvement framework to support ongoing quality and performance of the ITC activity; • improve program reporting with the aim of improved patient/clinical outcomes, improved patient experience, improved system integration and improved safety and quality (including staff experience).
Description of Activity	Activities to achieve the aims and objective of the ITC program and to build an effective and sustainable ITC Program in WA were identified from the Curtin Evaluation "Project Illuminate" Stage 2 Report. Recommendations from the Evaluation that will guide activities are: • Contract Relationship Management ensuring delivery of services in line with the ITC Implementation Guidelines and submitted budget. This includes the assessment of provider reports ensuring key elements of the program are on tracked as per program Activity Plan submitted by providers e.g. care coordination, building culturally competent GPs and supporting service integration with the program. Contract relationship meetings are also an opportunity for the identification of both program

	barriers and enablers to delivery of the ITC program, as well as progress discussion on planned activity. • Supporting ongoing investigation and implementation of the Curtin evaluation activity undertaken with ITC program in WA. • Convening regular program meetings with Placed Based teams on ITC implementation activity. • Maintaining and promoting the 'ITC Community of Practice' hub on Primary Health Exchange as a communication tool between WAPHA and ITC providers. • Continuing to employ 2.0 FTE Indigenous Health Project Officers (referred within the PHN as Aboriginal Health Coordinators) in Perth North, South and Country WA PHNs. • Developing and maintaining on the WAPHA website an ITC Provider Location Map accessible by ITC providers, GPs and consumers; • Further investigation of delivery of an ITC Outcomes Map. • Attend and feedback on any available national ITC/Aboriginal health network/s. Activities to support the development of the ITC workforce will include: • Conducting a second ITC workforce training needs analysis to inform the ITC workforce training plan. Current skills development options identified include data collection, use and reporting; supporting clients to self-manage their chronic disease; use of Supplementary Services Fund; supporting ITC clients with mental health and interpreting the new ITC Guidelines/reporting template. • Using training needs analysis to inform the ITC workforce training activity. • Increasing ITC staff (IHPO) knowledge and use of local data and planning tools to enhance/develop ITC program planning activity. Identify best approaches and outcomes in data capture, collection and reporting and utilise to review/improve ITC program delivery. WAPHA implementing a reporting dashboard to support ITC providers to share learnings across regions and promote consistency in program delivery. • Increasing knowledge and skills of ITC staff to support ITC clients better understand their chronic condition/s and how to manage it via resource promotion, training, etc., with a view to enhance ITC client outcomes; support increased client flow through the ITC program, etc. • Delivering training sessions on how to effectively and efficiently use Supplementary Services Funding Pool to ensure good use of SS funds. • Developing and promoting ITC workforce on how to access Medicare to increase sustainability of ITC program. • Promoting professional development opportunities to support training to ITC providers, to both better support ITC clients requiring mental health support, but to also support resilience in the ITC workforce; • Delivering training to both ITC teams and PHN staff in the interpreting of the new ITC Guidelines and reporting template to ensure best in class program delivery and client outcomes. • Supporting any commissioning/decommissioning activity relating to the ITC program, including any project develop/management/implementation. As the project is rolled- out, current good practice will be documented and shared on a state-wide basis and beyond across the PHN network.

<table>
<tr><td></td><td>
Provider Performance:

The PHN will continue to develop and maintain close working relationships with contracted ITC service providers and will formally review services at six- and twelve-month intervals using a diverse range of data collection methods (i.e. provider reports, referrer feedback, patient feedback) to determine:

How well targeted and efficient services are, and
How effective services and systems are in relation to:

Patient experience
Patient health outcomes
Service / system integration
Service sustainability including provider experience / governance.

<table>
<tr><th>Workforce Type</th><th>FTE</th><th>AMS</th><th>MPC</th><th>PHN</th></tr>
<tr><td>Indigenous Health Project Officers</td><td>8</td><td>2</td><td>5</td><td>1</td></tr>
<tr><td>Care Coordinators</td><td>15</td><td>4.5</td><td>10.5</td><td>0</td></tr>
<tr><td>Outreach Workers</td><td>10.35</td><td>3</td><td>7.35</td><td>0</td></tr>
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</td></tr>
<tr><td>Target population cohort</td><td>Aboriginal and Torres Strait Islander people with a diagnosed chronic condition.</td></tr>
<tr><td>Indigenous specific</td><td>Yes</td></tr>
<tr><td>Coverage</td><td>Country WA PHN</td></tr>
<tr><td>Consultation</td><td>During this commissioning cycle, the PHN has worked closely with identified stakeholders to support the commissioning of ACCHOs to deliver the ITC program. It is the aim of the PHN to ensure that Aboriginal and Torres Strait Islander people are provided with a range of options in the delivery of the ITC program and their other health care services.

Regular contract and wider programmatic discussion meetings are convened between PHN staff and ITC service providers. These meetings are regularly scheduled and include identification of the barriers and enablers to delivery of the ITC program, as well as progressing discussion on planned activity and supporting information sharing with ITC providers regarding local system activity impacting on the ITC program.

Regular Forums with ITC providers have informed the priorities for the coming period.

The WA Primary Health Alliance (WAPHA) Aboriginal Strategic Aboriginal Health and Wellbeing Advisory Group (SAHWAG) will continue to meet regularly throughout the year. One of the SAHWAG priorities is to further inform the ITC programs capability in the delivery of activity that grows culturally competent primary health care. SAHWAG members include rural and metro representatives including WAPHA Board, Research and Academia, Aboriginal Elders, Aboriginal youth, Area Health Services (metro and country), Aboriginal workforce, PHN staff and others co-opted as required. They provide a valuable consultation forum from which to inform ITC and other aspects of work with relevance to Aboriginal communities.</td></tr>
<tr><td>Collaboration</td><td>The PHN works closely in the regions to ensure the ITC program is connected with local services providers ensuring ITC providers participate in local activity</td></tr>
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	such as NAIDOC week, health and networking events. Consultation continues with the following key stakeholders: • WA Country Health Service • ITC Providers • Aboriginal consumers • Aboriginal Health Council of WA • local service providers • other PHNs Recently WAPHA entered into a Memorandum of Understanding (MoU) with the Aboriginal Health Council of WA (AHCWA). A workplan is currently under development to support implementation of the MoU, with this document including approaches in the delivery of commissioned services and supporting care pathways between AMSs and mainstream services. WAPHA is the lead PHN for the Aboriginal and Torres Strait Islander theme on SharePoint. WAPHA will source and upload locally developed ITC relevant resources for use by the wider PHN network and other stakeholders. Cross PHN collaboration is anticipated as the ITC program is commissioned in all jurisdictions. It is anticipated that activity will include information sharing; cross-pollination of ITC best practice and other activity that supports PHN delivery of the ITC program.
Activity milestone details	Activity start date: 1/07/2019 Activity end date: 30/06/2021 Service delivery start date: July 2019 Service delivery end date: June 2021
Commissioning method and approach to market	☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. ☐ Open tender ☐ Expression of Interest ☐ Other approach 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	In terms of ongoing performance management of the ITC program in WA, information will be sought from the following: • Aboriginal and Torres Strait Islander People who access the ITC program • Organisations commissioned to deliver the ITC activity • Broader health and community services system engaging with the ITC program.

	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.

Funding Source	2019-2020	2020-2021	Total
Planned Commonwealth Expenditure – Integrated Team Care Funding	$4,206,124	$4,275,815	$8,481,939
Funding from other sources			
Funding from other sources			

Proposed Activity	
ACTIVITY TITLE	**ITC 2: Culturally competent mainstream services**
Program Key Priority Area	Indigenous Health
Needs Assessment Priority	**Priority** • CA4.4 Assist Primary Health Care Providers to adopt culturally appropriate models of care for Aboriginal populations, Culturally and Linguistically Diverse groups. (p.109) **Possible Option** • Ensure commissioned services have undertaken cultural competency training and promote cultural competency training to other health service providers. (p.109)
Aim of Activity	The aim of this activity is to improve access and quality care 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.
Description of Activity	<table><tr><th>Workforce Type</th><th>FTE</th><th>AMS</th><th>MPC</th><th>PHN</th></tr><tr><td>Indigenous Health Project Officers</td><td>8</td><td>2</td><td>5</td><td>1</td></tr><tr><td>Care Coordinators</td><td>15</td><td>4.5</td><td>10.5</td><td>0</td></tr><tr><td>Outreach Workers</td><td>10.35</td><td>3</td><td>7.35</td><td>0</td></tr></table> Activities planned to improve access to culturally appropriate mainstream primary care services for Aboriginal people include: • Identifying and promoting evidenced based GP resources that support the increase uptake of Aboriginal specific chronic disease package MBS; Practice Incentive Payment Indigenous Health Incentive (PIP IHI) and PBS Script Annotation. • Identifying, documenting and comparing across ITC the current Cultural Awareness Training provided to GPs. • Identifying and promoting evidenced based approaches to support improved identification of Aboriginal patients in general practice; • Identifying and promoting to GPs, culturally appropriate chronic disease self-management programs.

	• Promoting the ITC program via existing WAPHA newsletters/publications to grow understanding of the ITC program aims and objectives with GPs and other primary health care providers. Activity undertaken by the ITC program to build the cultural competency of mainstream general practice is supported by a number of nationally released resources/policy. These are frameworks based on sound evidence and consultation, informed by both Aboriginal and other key stakeholders. It is anticipated that these (see below) will inform PHN ITC activity. • National Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026. • National Safety and Quality Health Services Standards – User guide for Aboriginal and Torres Strait Islander Health. • National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023. In addition to rolling out the above activity across the PHN, the PHN based Indigenous Health Project Officer (referred to in WAPHA as the Aboriginal Health Coordinator (AHC)) will work both internally and externally to support delivery of culturally competent services: • Developing and supporting implementation of standardised ITC policy and process supporting culturally safe services. • Monitoring the Primary Health Exchange ITC Community of Practice webpage that provides resources that support ITC providers to build cultural competency of general practice. • Supporting ITC networking events. • Leading implementation of the ITC Country to City project activity to build culturally safe discharge process. • Informing the ITC pathway on the WAPHA *HealthPathways* tool for use by general practice and grow their capability. • Supporting staff across the three WA PHNs to provide opportunity for best practice and integration of the ITC program with other PHN commissioned activity to build access to culturally safe primary health. • Supporting cultural awareness of PHN ITC contract managers, and • Supporting the PHN's general practice support team to identify practices in their regions with higher numbers of Aboriginal patients, with the aim of improved collaboration with ITC IHPOs to support these practices. ITC IHPO can then promote optimal engagement between care coordinators and practice staff for client care coordination with the aim of increasing access to culturally safe care.
Target population cohort	Engagement and communication with the following key stakeholder groups has been identified as a priority: • IHPOs • General Practitioners • Practice Nurses • Aboriginal Health Workers • Health Service Providers.
Indigenous specific	Yes
Coverage	Country WA PHN

Consultation	The WAPHA Aboriginal Strategic Aboriginal Health and Wellbeing Advisory Group will inform the PHN's strategic approach to the delivery of culturally competent primary health care in WA. Members include AHCWA, Elders, WA Country Health Services, metropolitan Area Health Services, WA Dept. of Health, Aboriginal health workforce, research and academia, and PHN representatives. The group has clear terms of reference to direct activity in 2019, and beyond, across the three WA PHNs. Regular Forums with ITC providers have informed the priorities for the coming period.
Collaboration	WAPHA recently signed an MoU with the Aboriginal Health Council of WA (AHCWA). A workplan is currently under development to support implementation of the MoU with this document, including approaches to growing access to culturally competent primary health care. The PHN will continue to collaborate with area health services to improve the discharge process of ITC clients into primary health care. The PHN will seek to investigate the delivery of a standardised cultural awareness training package across WA in collaboration with agencies such as NATSIHWA, RACGP, ITC providers, ITC consumers and other key stakeholders.
Activity milestone details	Activity start date: 1/07/2019 Activity end date: 30/06/2021 Service delivery start date: July 2019 Service delivery end date: June 2021
Commissioning method and approach to market	☒ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement ☐ Open tender ☐ Expression of Interest ☐ Other approach 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	In terms of ongoing performance management of the ITC program in WA, information will be sought from the following: • Aboriginal and Torres Strait Islander People who access the ITC program • Organisations commissioned to deliver the ITC activity • Broader health and community services system engaging with the ITC program. 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.

Funding Source	**2019-2020**	**2020-2021**	**Total**

Planned Commonwealth Expenditure – Integrated Team Care Funding	$771,824	$771,824	$1,543,648
Funding from other sources			
Funding from other sources			

Proposed Activity	
ACTIVITY TITLE	**ITC 3: ITC Country to City (C2C) - Improving Patient Transitions Project**
Program Key Priority Area	Indigenous Health
Needs Assessment Priority	**Priority** • PSGP1.7. Engage with Primary Health Care providers and Local Hospital Networks to improve transitions of care, care coordination and service linkages. (p.96) **Possible Option** • Strategies to develop integrated care pathways in partnership with Local Health Networks, health services, general practices and other clinicians. (p.96) Promote digital health technologies such as My Health Record to optimise patient care. (p.96)
Aim of Activity	The Integrated Team Care (ITC) Country to City: Improving Patient Transitions Project (the Project) was initiated in response to feedback relating to the difficulties of supporting Aboriginal patients who were off-Country and staying in metropolitan areas for health treatment. The feedback identified that the patient journey for Aboriginal people from country to Perth can be fragmented, inconsistent and may result in poor health and well-being. The Integrated Team Care Country to City: Improving Patient Transitions Report, is available for review. The objectives of the Project are to: 1. Understand the extent of the issues and concerns regarding the transition of ITC clients, and those eligible for ITC, across WA. In addition, to understand the good practice happening and to share relevant learnings on a state-wide basis. 2. Work with the health sector to develop solutions that will improve the experience and care of Aboriginal people with chronic conditions, promoting integrated, seamless care and optimal health outcomes for Aboriginal people. The Project aims to improve coordination of health and other care elements and improve the health journey of ITC clients across WA through: • developing and disseminating culturally appropriate communication resources that support client knowledge about pre-admission and discharge from hospital; • improving access to health and other services when away from home and receiving acute care; • improving integration between ITC providers and other health care providers.

Over the next three years the PHN aims to:

- Develop, trial and evaluate a Country to City service model to support ITC patients off-Country to access primary health, social, emotional and cultural services;
- Implement standardised client transfer and inter-region support processes;
- Continue to liaise with ITC Providers and hospital staff to assist in improving communication, information sharing and discharge processes.

As the project is rolled- out, current good practice will be documented and shared on a state-wide basis and beyond, across the PHN network.

Description of Activity

Workforce Type	FTE	AMS	MPC	PHN
Indigenous Health Project Officers	0.33			0.33
Care Coordinators				
Outreach Workers				

Activities to implement the Project align with recommendations from the Integrated Team Care Country to City: Improving Patient Transitions Report published by the WA Primary Health Alliance. The Recommendations that will inform activities during this period include:

Recommendation 2: *Develop resources to support clients in preparing for travel, such as a checklist for journey planning, patient stories and videos. Promote and educate patients, community and health professionals on the availability and use of the resources*. - The most common theme highlighted in stakeholder consultation was that Aboriginal people did not want to travel for healthcare treatment due to a fear of Perth (the unknown) and the perception that people who travel to Perth do not return home. This is exacerbated for Aboriginal people from remote communities where English is not their first lanuage, there is minimal health education, and/or a more traditional lifestyle is followed. Feedback also highlighted that the Aboriginal person often had a more positive experience and achieved improved health and wellbeing outcomes when an organisation took responsibility for preparing the patient for travel. The C2C Steering Committee, established to provide strategic direction to theProject will guide development, promotion and training of the travel resources. The resources will be developed in print, video, or audio, be culturally appropriate, and locally tailored for different regions and language groups. Training and education will be provided on use of the resources. The resources will be located on websites accessible to patients, community, service providers and health professionals.

Recommendation 3: *Work with health service providers to explore ways of using digital health services to avoid unnecessary travel and facilitate care between regions* - This activity will involve the provision of information and digital health resources (including infrastructure) to ITC Providers to promote and embed the use of digital health services, including Telehealth, as an alternative service delivery method and support mechanism within the program. To further increase the utilisation of digital health services within the ITC Program, additional workforce training and development will be conducted in collaboration with other organisations (such as WA Country Health Services Telehealth Services). Additionally, embedding digital health within the Country to City service model will support clients to improve self-management of their chronic condition.

	The outcomes of the digital health element will include: • Increased confidence and improved knowledge and skills in the utilisation of digital health services within the ITC Program. • Increased confidence and improved implementation of self-management practices across the ITC Program. • Improved condition management in the community potentially reducing in un-necessary travel of regional/remote Aboriginal people requiring access to healthcare treatment. • Improved health and social wellbeing outcomes for regional/remote Aboriginal people. • An increase in the number of Aboriginal people within the community with an ability to self-manage their chronic condition/s. • Increased ability to measure and assess client outcomes within the ITC Program across WA. **Recommendation 10***: Advocate for improved discharge processes and continuity of care* – where a patient has travelled to Perth or a regional centre due to an acute hospital admission, stakeholders identified several challenges with discharge: • discharge planning may not consistently occur with enough notice to implement or refer to services such as ITC. • discharge summaries may not be sent to ITC providers, particularly if they are not part of an Aboriginal Community Controlled Health Service. • ITC providers may not be aware their client has been hospitalised and are not involved in discharge planning. Outcomes of improving the discharge process will be to: • Improve notice of discharge to no more than 24 hours' notice. • Better identification of Aboriginal patients so they can be supported appropriately by Aboriginal Hospital Liaison Officers and hospital staff. • Assist public hospitals to develop a policy regarding supply of discharge medications for Aboriginal patients to ensure consistency across sites. • Inclusion of the ITC Care Coordinator in discharge planning and communication for admitted ITC clients. • There will have been scoping of the benefit of listing ITC providers as recognised providers on the Notification and Clinical Summaries system, enabling ITC Providers to be sent discharge summaries appropriate with client consent. **Recommendation 12:** *Promote uptake of My Health Record by ITC providers and the Aboriginal community*; and **Recommendation 13***: Embed use of My Health Record into ITC workflows* – the PHN will continue to build on previous My Health Record promotion to ITC providers and Aboriginal communities. The outcomes of promoting My Health Record will include: • Important health information will be stored and accessed by health professionals. • All ITC Providers will be recorded as "Healthcare Providers Organisation"; • ITC clients not with My Health Record will be assisted to register. • Persons are identified as an ITC client on the "event summary" on their My Health Record.

Target population cohort	Aboriginal and Torres Strait Islander people with a diagnosed chronic condition who travel to Perth or a regional centre due to an acute hospital admission.
Indigenous specific	Yes
Coverage	Country WA PHN
Consultation	The WA Primary Health Alliance (WAPHA) consulted with a range of stakeholders across WA to better understand the issues that can impact the health outcomes of Aboriginal people travelling between regions for health care. Consultation was undertaken by holding a 2-day workshop with over 70 stakeholders attending, and by speaking to individual ITC providers and their clients, Perth metropolitan and regional hospitals, Aboriginal Community Controlled Health Services, government bodies and non-government organisations. As part of the consultation, stakeholders identified what worked well, what could be improved and what they would like to see changed; which informed the ITC Country to City: Improving Patient Transitions Project Report and 14 Recommendations. Key stakeholders across WA (by region) that were consulted include: • Metropolitan Perth North and Perth South Regions – Arche Health – ITC staff and clients • Mooditj Koort – ITC staff and clients • GP Down South – Nidjalla Waagan Mia • AHCWA • WACHS – Aboriginal Health Improvement Unit and PATS • Health Consumer's Council • GPs – Dr Wood, Dr Krishnan, Dr Dolan and Dr Wozencroft • Fiona Stanley Hospital – pharmacists, ALOs, complex care coordinators, clinical nurse specialist, cardiologist • Royal Perth Hospital – pharmacists, ALOs, nurses, specialists • Sir Charles Gairdner Hospital - pharmacists, ALOs • Allawah Grove. • Kimberley Region - Boab Health Services staff and clients; Broome Regional, Derby Regional and Fitzroy Crossing Hospitals Aboriginal Liaison Officers (ALO), Patient Assistance Travel Scheme (PATS) officers, medical and nursing staff and community health providers. • Pilbara Region – Mawankarra Health Service ITC staff and clients, PATS officer, Senior Medical Officer and Perth based outreach officer and Puntukurnu Aboriginal Medical Service staff members. • Goldfields Region – Hope Community Services ITC staff and clients and Aboriginal community members in Leonora and Laverton. • Midwest Region – Carnarvon Medical Service Aboriginal Corporation – ITC staff and clients, CMSAC General Manager • Geraldton Regional Aboriginal Medical Service – ITC staff and clients • Geraldton Hospital – ALO and Telehealth Coordinator. • Great Southern Region - Amity Health ITC staff and clients • Katanning Hospital – nursing staff • WACHS Great Southern Aboriginal Health • Pioneer Health Albany GP Practice. • South West Region - GP Down South – ITC staff and clients • South West Aboriginal Medical Service – ITC staff and clients • Breakaway Aboriginal Corporation • Spencer Street Family Practice • Bunbury Regional Hospital – Chronic Disease Project Officer. • Wheatbelt Region - Amity Health – ITC staff and clients • Wheatbelt Health Network – ITC staff and clients • Wheatbelt Aboriginal Health Service.

Collaboration	The Project emphasises the shared responsibility across regional and metropolitan services, acknowledging the significant demands placed on metropolitan providers when endeavouring to provide a service to people from outside their ITC providers' catchment. The shared responsibility of providing the best possible care to Aboriginal people travelling between regions for health care involves extensive collaboration with a variety of stakeholders including, the Aboriginal Health Council of WA, ITC Service Providers, GP and allied health service providers, South and East Metropolitan Area Health Services, Aboriginal Strategic Aboriginal Health and Wellbeing Advisory Group and local and regional stakeholder networks. The role of stakeholders: • Aboriginal Health Council of WA – an MoU was signed recently with WAPHA that includes developing a workplan to support implementation of the MoU including approaches to growing access to culturally competent primary health care. • GP and allied health providers – by participating in local engagement opportunities to identify and respond to areas of need, avoid duplication and leverage existing mechanisms to improve the patient journey. • Aboriginal Strategic Aboriginal Health and Wellbeing Advisory Group - provides a valuable consultation forum from which to inform ITC and other aspects of work with relevance to Aboriginal communities. • Local and regional stakeholder networks - participation ongoing to support development and improved referral pathways, identify coordinated responses to address needs and build local workforce capability. The C2C Steering Committee established to provide strategic direction to the Project and ensure organisational commitment, is inclusive of the following members: • WAPHA – Chairperson • WA Country Health Services • Aboriginal Health Council of WA • Representation from each of the 7 country regions (ITC provider, hospital, Aboriginal elder or Aboriginal patient) • Metropolitan ITC representative • North Metropolitan Health Service, East Metropolitan Health Service, South Metropolitan Health Service • Fiona Stanley, Sir Charles Gairdner and Royal Perth Hospitals, • Aboriginal Hostels Limited • GP representative • Health Consumers council • Rural Health West.
Activity milestone details	Activity start date: 1/07/2019 Activity end date: 30/06/2021 Service delivery start date: July 2019 Service delivery end date: June 2021
Commissioning method and approach to market	Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement

	☒ Open tender* ☒ Expression of Interest ☐ Other approach 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No *The PHN released an open tender for the commissioning of the service model to be delivered as a recommendation of the ITC Country to City: Improving Patients Transitions Project.
Decommissioning	No

Funding Source	**2019-2020**	**2020-2021**	**Total**
Approved – 17/18 Unspent Funds	$529,549	$250,000	$779,549
Planned Commonwealth Expenditure – Integrated Team Care Funding			
Funding from other sources			

Funding from other sources	