PHN Activity Work Plan

Summary View
2020/2021 – 2023/24

Integrated Team Care

Perth South PHN

Presented to the Australian Government Department of Health

WA Primary Health Alliance
Better health, together

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PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

Contents

ITC 1000 - Enhancing Care

Activity Title

Enhancing Care

Activity Number

1000

Existing, Modified or New Activity

Existing

Program Key Priority Area

Aboriginal and Torres Strait Islander Health

Aim of Activity

To build on previous successes of the Integrated Team Care (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 work with ITC teams to:

- Strengthen links and program integration across WA PHNs to improve patient outcomes.
- Support workforce development.
- Enhance the capacity of the ITC workforce to support a client's ability to self-manage their chronic condition through use of Flinders My Health Story care planning.
- Support ITC providers to embed a Quality Improvement framework to support ongoing quality and performance of the ITC activity.
- Improve program reporting will aim to improve patient/clinical outcomes, improved patient experience, system integration and 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 in the Curtin University Evaluation report - "Project Illuminate" Stage 2.

1. Recommendations from the Curtin University Evaluation report that will continue to guide activities include:
   - Contract Relationship Management ensuring delivery of services in line with the ITC Implementation Guidelines and submitted budget using relationship meetings to identify both program barriers and enablers to delivery of the ITC program, as well as progress discussion on planned activity.
   - Convening regular program meetings between Place Based Teams focusing on ITC

service implementation activities.
- Maintaining and promoting the 'ITC Community of Practice' hub on Primary Health Exchange as a communication tool between the WA Primary Health Alliance and ITC providers.
- Developing and maintaining the WA Primary Health Alliance website ITC Provider Location Map, accessible by ITC providers, GPs, and consumers.
- Attending and providing feedback on any available national ITC/Aboriginal health network/s.

2. WA Primary Health Alliance will continue to work with ITC providers to build capacity, with the intent to:
   - improve corporate and clinical governance.
   - improve data collection and outcomes focused reporting.
   - improve integration with other service providers (mainstream and Aboriginal Community Controlled Health Service).
   - improve the patient journey to ensure stepped care model is applied.
   - apply continuous quality improvement.
   - support workforce development.

The ITC Program workforce are contractually obliged to adhere to and implement the ITC Implementation Guidelines (4-6). In addition:

- ITC workforce will adhere to ITC Standardised Processes. These support consistency across the 14 provider regions, which in turn supports ITC clients to access the program in a consistent manner across WA PHNs. e.g., Where it is necessary to travel from country to metropolitan Perth for health care.
- Care Coordinators will utilise 'Flinders My Health Story' care planning to assist patients to become self-managing.
- Indigenous Health Project Officers will assist developing and mapping referral pathways that incorporate available services at the local, regional, and jurisdictional level and ensuring such information is provided to WA Primary Health Alliance for inclusion in HealthPathways.
- Indigenous Health Project Officers will increase capacity of mainstream health service providers to deliver culturally appropriate primary care services.
- Outreach workers will encourage clients to register for and utilise a My Health Record.

3. Activities to support the development of the ITC workforce will include:
   - Development of an ITC Handbook to support consistent and efficient provision and reporting of the program. This is inclusive of care coordination (including self-management) supplementary services processes, as well as quality activity planning and quality of reporting, further enhancing quality improvement activities. The ITC handbook will also provide clarity on interpretation of the ITC Guidelines. eg: the support of clients to transition from the ITC Program into Aged Care or a National Disability Insurance Scheme package.
   - Conduct ITC workforce training needs analysis to inform the ITC workforce training plan. Current skills development identified include:
     - data collection use and reporting.

    - supporting clients to self-manage their chronic disease.
    - use of Supplementary Services funds.
    - supporting ITC clients requiring mental health care.
    - interpreting the new ITC guidelines and reporting template.
- Increasing ITC staff knowledge and use of local data and planning tools to enhance/develop ITC program planning activity, including identifying the best approaches and outcomes in data capture, collection and reporting and utilising to review/improve ITC program delivery. WAPHA will implement a reporting dashboard to support ITC providers to share learnings across regions and promote consistency in program delivery.
- Improve collaboration between the ITC Indigenous Health Project Officers and WA Primary Health Alliance practice support staff according to specific areas of expertise.
- Increasing knowledge and skills of ITC staff to support ITC clients to better understand their chronic condition/s and how to manage via resource promotion, training, etc. with a view to enhance ITC client outcomes; support increased client flow through the ITC program.
- Delivering training sessions on how to effectively and efficiently use the Supplementary Services (SS) Funding Pool to ensure good use of SS funds.
- Increasing knowledge accessing Medicare Benefit Schedule Items 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 to support resilience in the ITC workforce.
- Delivering training to both ITC teams and PHN staff in interpretation of the ITC guidelines and reporting template to ensure program delivery and client outcomes.
- Supporting any commissioning/decommissioning activity relating to the ITC program, including any project develop/management/implementation.

The PHN will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

WAPHA Needs Assessment Priorities

Priorities	Page reference
PSGP1.1 Increase access to General practice and improve the management of chronic disease management.	87
PSGP1.7 Engage with Primary Health Care providers and Local Hospital Networks to improve transitions of care, care coordination and service linkages.	90
PSGP1.3 Increase access to allied health services and chronic disease management programs provided by allied health practitioners.	88

Coverage

The whole Perth South PHN region.

Activity Duration

Activity Start Date 1 July 2019

Activity End Date 30 June 2024

Activity Planned Expenditure

Funding Stream	FY 20 21	FY 21 22	FY 22 23	FY 23 24	Total
Interest - ITC	$0.00	$0.00	$0.00	$0.00	$0.00
Integrated Team Care Funding	$2,516,616.92	$2,394,801.62	$2,643,962.58	$2,686,846.54	$10,242,227.66
Total	$2,516,616.92	$2,394,801.62	$2,643,962.58	$2,686,846.54	$10,242,227.66

ITC 2000 - Culturally competent mainstream services

Activity Title

Culturally competent mainstream services

Activity Number

2000

Existing, Modified or New Activity

Existing

Program Key Priority Area

Aboriginal and Torres Strait Islander Health

Aim of Activity

To improve access to culturally competent mainstream primary care services (including but not limited to general practice, allied health, and specialist services) for Aboriginal and Torres Strait Islander people.

Description of Activity

Activity undertaken by the ITC program to build the cultural competency of mainstream general practice is supported by a number of nationally released resources and policies. These are frameworks based on sound evidence and consultation, informed by both Aboriginal and other key stakeholders.

The following national resources will inform PHN ITC activity:

1. National ITC Implementation Guidelines: current data (Aboriginal people who are active patients of GP services).
2. National Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026.
3. National Safety and Quality Health Services Standards – User guide for Aboriginal and Torres Strait Islander Health.
4. National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023.

WAPHA will continue to work with the primary health care network to improve cultural competence by promoting models of good practice, assisting primary health care providers to adopt culturally appropriate models of care for Aboriginal people, supporting increased uptake of Aboriginal specific chronic disease packages including PIP IHI and relevant MBS items, supporting increased access to cultural awareness training that meets PIP IHI requirements, promoting the ITC program to primary care providers and community, and promoting the ITC Program as a culturally safe resource for primary care providers to partner with in their care of Aboriginal people with complex chronic disease management

needs.
In addition to implementing 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.

This will be achieved by providing subject matter expertise to staff across the three WA PHNs, to improve integration of the ITC program with other PHN commissioned activity, providing a targeted approach supporting practices with higher numbers of Aboriginal patients, or practices that have registered their interest in improving cultural competence, and improving collaboration between PHN practice support staff and externally employed ITC Indigenous Health Project Officers.

The PHN will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

WAPHA Needs Assessment Priorities

Priorities	Page reference
PSGP1.1 Increase access to General practice and improve the management of chronic disease management.	87
PSGP1.7 Engage with Primary Health Care providers and Local Hospital Networks to improve transitions of care, care coordination and service linkages.	90
PSGP1.9 Reduce non-urgent Emergency Department attendances and improve access to alternative services.	91

Coverage

The whole Perth South PHN region.

Activity Duration

Activity Start Date 1 July 2019

Activity End Date 30 June 2024

Activity Planned Expenditure

Funding Stream	FY 20 21	FY 21 22	FY 22 23	FY 23 24	Total
Interest - ITC	$0.00	$0.00	$0.00	$0.00	$0.00
Integrated Team Care Funding	$420,712.33	$215,018.38	$215,018.38	$215,018.38	$1,065,767.47
Total	$420,712.33	$215,018.38	$215,018.38	$215,018.38	$1,065,767.47

ITC 3000 - ITC Country to City - Improving Patient Transitions Project

Activity Title

ITC Country to City (C2C) - Improving Patient Transitions Project

Activity Number

3000

Existing, Modified or New Activity

Existing

Program Key Priority Area

Aboriginal and Torres Strait Islander Health

Aim of Activity

The Integrated Team Care (ITC) Country to City (C2C): 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 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.
2. Understand the good practice happening and to share relevant learnings on a state-wide basis.
3. 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 ITC activity aims to improve coordination of health and other care elements and improve the health journey of ITC clients across WA.
Over the duration of this Activity Work Plan, the PHN aims to support providers to apply continuous quality improvement to the Country to City – Improving Patient Transitions Project, including but not limited to the service model, standardised processes and improving communication, information sharing and discharge planning.

Description of Activity

Activities to implement the Project align with recommendations from the ITC Country to City: Improving Patient Transitions (2018) Report published by WAPHA. The report focuses on practical solutions that can be implemented across WA to improve processes, promote consistency, and increase integration between organisations. The report concluded with 14 recommendations.

The Recommendations that will be addressed, prioritised, and enhanced during this period include (but not limited to):

Recommendation 1: Establish and implement a standardised intake, allocation, transfer, and discharge process for ITC.

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.

Recommendation 3: Work with health service providers to explore ways of using digital health services to avoid unnecessary travel and facilitate care between regions.

Recommendation 6: Develop a service model for the provision of primary health and social services support for patients in Perth for treatment.

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.

Recommendation 11: Hold regular forums for ITC providers and key stakeholders to network, facilitate consistency, share innovation and jointly problem solve.

Recommendation 12: Promote uptake of My Health Record by ITC providers and the Aboriginal community.

Recommendation 13: Embed use of My Health Record into ITC workflows.

The PHN will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

WAPHA Needs Assessment Priorities

Priorities	Page reference
PSGP1.7 Engage with Primary Health Care providers and Local Hospital Networks to improve transitions of care, care coordination and service linkages.	90
PSA4.2 Increase access to Aboriginal specific services with an Aboriginal approach to cultural wellbeing, healing, and community empowerment.	107

Coverage

The whole Perth South PHN region.

Activity Duration

Activity Start Date 1 July 2019

Activity End Date 30 June 2022

Activity Planned Expenditure

Funding Stream	FY 20 21	FY 21 22	FY 22 23	FY 23 24	Total
Interest - ITC	$0.00	$0.00	$0.00	$0.00	$0.00
Integrated Team Care Funding	$386,332.52	$194,340.00	$0.00	$0.00	$580,672.52
Total	$386,332.52	$194,340.00	$0.00	$0.00	$580,672.52
