WA Primary Health Alliance PHN Integrated Team Care Country WA 2024/25 - 2027/28 Activity Summary View

Approved by the Australian Government Department of Health, Disability and Aged Care, July 2025

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Activity Metadata

Applicable Schedule

Integrated Team Care - Country WA

Activity Prefix

ITC

Activity Number

1000

Activity Title

ITC 1000 - Integrated Team Care Program

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Aboriginal and Torres Strait Islander Health

Aim of Activity

To grow the Integrated Team Care (ITC) programs' integration, effectiveness, and outcome focused service model to meet the aims and objectives of the ITC Program.
To consider the Priority Reforms of the National Agreement on Closing the Gap in ITC service delivery and explore ways in which ITC can drive:
• Genuine shared decision making and partnerships
• Aboriginal community controlled comprehensive primary care
• Sustained Aboriginal workforce growth
• Identification and elimination of racism.
The ITC program is made up of a team including Care Coordinator, Aboriginal and Torres Strait Islander Outreach Worker (referred to in WA as Aboriginal Outreach Worker (AOW)) and Aboriginal and Torres Strait Islander Health Project Officer (referred to in WA as Aboriginal Health Project Officer – (AHPO)).

The ITC team works together to:
• Contribute to improving health outcomes for Aboriginal people with chronic health conditions through better access to care coordination, and multidisciplinary care, and to support self-management.
• Improve access to culturally appropriate mainstream primary care services (including but not limited to mainstream/private general practice, allied health, and specialists) for Aboriginal people by supporting community-controlled services, while also maintaining client choice with mainstream options.

Description of Activity

ITC program objectives include:
• Contribute to better treatment and management of chronic conditions for Aboriginal people enrolled in the program.
• Improve access to appropriate health care through care coordination and provision of supplementary services for eligible for Aboriginal people with chronic disease.
• Foster collaboration and support between mainstream primary care and the Aboriginal health sector.
• 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 specific Medicare Benefits Schedule (MBS) items, including Health Assessments for Aboriginal people and follow up items.

The PHN contracts appropriate organisations to deliver the ITC program across the Country WA PHN regions of South West, Great Southern, Midwest, Goldfields, Wheatbelt, Pilbara, Kimberley. The PHN supports ITC teams by:
• Implementing the WAPHA Aboriginal Cultural Competency and Capability Framework, which will be: embedded into the procurement process; enable the PHN to assess and make improvements to the management of the ITC Program; and assist in ensuring ITC organisations provide cultural safety to their Aboriginal workforce and clients.
• Strengthening links and program integration across WA PHNs (Primary Health Networks) to improve client outcomes.
• Encouraging commissioned services to enhance and continuously improve the capacity of their ITC workforce to support a client's ability to self-manage complex chronic care needs.
• Ongoing support with data collection and outcomes focused reporting.
• Improving program reporting with the aim to improve patient experience, health outcomes, cost efficiency, provider experience and health equity.
• Developing quality improvement initiatives, communities of practice and peer support opportunities within the ITC sector.
• Appointing an individual from the ITC workforce (AHPO, Care Coordinator, Aboriginal Outreach Worker) to take the lead in improving the cultural safety of mainstream primary care services.
• Endeavour to facilitate mutual access to data and information by collaborating on areas such as identifying general practices which may benefit from capacity to uplift in cultural awareness training.

Commissioned ITC service providers implement two ITC activities.
1. Care Coordination and Supplementary Services – delivered by the Care Coordinator and Aboriginal Outreach Worker and supported by the Aboriginal Health Project Officer.
2. Culturally competent mainstream services – led by the Aboriginal Health Project Officer and supported by the Aboriginal Outreach Worker and Care Coordinator.
Care Coordination and Supplementary Services – Enhancing Care
WAPHA developed the WA ITC Program Model of Care from the Flinders Chronic Condition Management Framework and the Department of Health ITC Program Guidelines. The Flinders Chronic Condition Management framework supports the objective of the ITC Program as a short-term care coordination activity designed to support people with chronic conditions, to collaborate in care planning with a view to self-management. The ITC Model of Care supports delivery of the program and management of chronic health conditions, with a view to self-management.

The ITC Model of Care includes seven (7) stages:
1. GP (General Practitioners) referral and client screening.
2. Intake assessment/Registration and Consent.
3. Care Coordination Planning.
4. Care Management.

5. Monitoring and Review.
6. Discharge Planning.
7. Client discharged back to their GP.

The PHN developed and implemented a set of ITC Standardised Processes to support a consistent approach to care coordination and continues to work with providers to achieve the desired objectives of the program. The Care Coordinator will lead the following activities, with support from the Aboriginal Outreach Worker:
• Develop and maintain a close working relationship with clients' GP and practice.
• Arrange the required services outlined in the client's GP Management Plan (replaced by GP Chronic Condition Management Plan from Jul 2025).
• Provide one-on-one care coordination to assist clients to manage complex chronic care needs.
• Support the client to access a range of services such as appointments with specialist and allied health providers. Enabling access may include arranging transport, completing forms, coordinating appointments, or arranging payment of services.
• Support client access to allowable medical aids and equipment.
• Provide education to empower clients to understand and manage their chronic health conditions, and if appropriate, involve the client's family and carer.
• Utilise care planning to assist clients to become self-managing.
• Implement the WAPHA ITC Standardised Processes.
• Encourage clients to register for (and utilise) a My Health Record.

Whilst all Aboriginal people with a chronic condition are eligible for ITC support, priority will be given to people:
• Who have complex needs, and require multidisciplinary coordinated care for their chronic disease/s. This includes, but is not limited to, clients with:
o Diabetes
o eye health conditions associated with diabetes
o mental health conditions
o cancer
o cardiovascular disease
o chronic respiratory disease
o chronic kidney disease
• Who require more intensive care coordination than is currently able to be provided by mainstream/private general practice and/or Aboriginal Community Controlled Health Service.
• Who are unable to manage a mix of multidisciplinary services.
• Who are at greater risk of experiencing otherwise avoidable hospital admissions.
• Who are at risk of inappropriate use of services, such as hospital emergency presentations.
• Who are not using community-based services appropriately or at all.
• Who need help to overcome barriers to access services. This includes those at risk of, or experiencing, homelessness.

Culturally competent mainstream services
WAPHA will continue to work with the primary health care network to improve cultural competence by:
• Implementing the WAPHA Aboriginal Cultural Competency and Capability Framework, which will enhance efforts to ensure clients of the ITC Program and patients of mainstream/private practices receive high quality and culturally competent care.
• Assisting primary health care providers to adopt culturally appropriate models of care for Aboriginal people.
• Supporting increased uptake of key Aboriginal health initiatives including Practice Incentive Program Indigenous Health Incentive (PIP IHI), PBS CoPayment and relevant MBS items.

• Supporting increased access to cultural awareness training that meets PIP IHI requirements.

• 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.

Aboriginal Health Project Officers (HPO) will work to increase capacity of mainstream health service providers to deliver culturally appropriate primary care services and improve integration with other service providers (mainstream and ACCHS).

The Aboriginal Health Project Officer role, supported by the Aboriginal Outreach Worker will:
• Promote local credible cultural awareness training to mainstream primary care providers and services.
• Encourage the uptake of Aboriginal MBS items such as 715 health checks and follow up services, to both mainstream/private general practice, Aboriginal Community Controlled Health Services and Aboriginal community members.
• Assist practices to create a more welcoming environment for Aboriginal people i.e.: Aboriginal Artwork, posters, Aboriginal flags, flyers relevant to Aboriginal people.
• Support, as required, primary health care providers to recognise significant days in the Aboriginal calendar.
• Develop and disseminate resources for Aboriginal people about accessing services and managing chronic disease.

The PHN promotes the ITC program through various networks and community engagement events.
Activities are aligned to the National agreement on Closing the Gap and its priority reforms.

The PHN will:
• Work in partnership with stakeholders to prioritise local activities (commissioning and general practice support) that address the leading causes of mortality for Aboriginal people. This includes coronary heart disease, diabetes, chronic respiratory conditions, cancer, and as it relates to Target 1 of the National Agreement on Closing the Gap – Everyone enjoys long and healthy lives.
• Enhance focus of WAPHA's population health initiatives that address improving immunisation and cancer screening rates for Aboriginal people. Further work with primary care providers to focus on activity that relates to Target 2 of the National Agreement on Closing the Gap – Children are born healthy and strong.
• Undertake preliminary transition planning to support potential action associated with Priority Reform 2 – Building the Community Controlled Sector and Clause 55 from the National Agreement on Closing the Gap.
• Implement the WAPHA Cultural Competency Framework to improve both the PHN and WAPHA-commissioned service providers' cultural competency and contribute to Priority Reform 3 – Transforming Government Organisations (and their funded agencies).

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

Care Coordination and Supplementary Services - Aboriginal people with an existing chronic condition.
Culturally competent mainstream services - Mainstream general practice, Aboriginal Community Controlled Health Services, allied health providers and specialists.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

IITC Service Review 2022 - In December 2021, WAPHA engaged IPS Management Consultants to review the ITC program's delivery and measure the extent to which service providers were delivering the program in alignment with the implementation guidelines. Engagement with ITC clients was out of scope for the review and, as such, claims relating to the client experience, value and success of the program are subjective, and further engagement is required to substantiate some of these claims.
The aims of the review were to assess:
• Alignment of contractual obligations to the Department of Health, Disability and Ageing ITC Program Implementation Guidelines.
• Program fidelity to the ITC Program Implementation Guidelines.
• Role of Aboriginal Health Project Officers (AHPO):
o Alignment to ITC Program Implementation Guidelines
o Best positioning for AHPOs

The recommendations were based on findings and intended to provide guidance to improve alignment to the implementation guidelines, improve service delivery, and ensure the program is best placed to meet future needs. A copy of the executive summary and recommendations can be located at https://www.wapha.org.au/about-us/our-priorities/aboriginal-health/.

Collaboration

WAPHA will continue to collaborate with the Aboriginal Health Council of WA (AHCWA) to support Aboriginal Health initiatives and to improve access to primary health care services and improve health and wellbeing outcomes for Aboriginal people

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Activity Milestone Details/Duration

Activity Start Date

30/06/2016

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2016

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Work Plan - Review the multiyear AWP and submit any amendments
Due 28/05/25
Performance Report – 12-month Performance Report
Due 30/09/25
Financial Acquittal – Audited income & Expenditure Statement and Declaration
Due 30/09/25
Needs Assessment – Confirm the Needs Assessment is current
Due 15/11/24

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Integrated Team Care Funding	$4,962,288.27	$5,115,729.75	$0.00	$0.00	$0.00	$10,078,018.02
Total	**$4,962,288.27**	**$5,115,729.75**	**$0.00**	**$0.00**	**$0.00**	**$10,078,018.02**

ITC 3000 - ITC Country to City (C2C) - Improving Patient Transitions Project

Activity Metadata

Applicable Schedule

Integrated Team Care - Country WA

Activity Prefix

ITC

Activity Number

3000

Activity Title

ITC 3000 - ITC Country to City (C2C) - Improving Patient Transitions Project

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Aboriginal and Torres Strait Islander Health

Aim of Activity

To improve coordination of health and other care elements and improve the health journey of ITC clients across WA and 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.
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.

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 ITC Country to City: Improving Patient Transitions (2018) Report concluded with 14 recommendations.

Recommendations that will continue to 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. Completed and implemented, due for review.

Recommendation 3: Work with health service providers to explore ways of using digital health services to avoid unnecessary travel and facilitate care between regions. In progress.
Recommendation 6: Develop a service model for the provision of primary health and social services support for patients in Perth for treatment. The resulting service model was/is currently commissioned to an ITC Provider based in Perth metro that supports ITC clients from Country PHN while they are in Perth North and Perth South PHNs for healthcare.
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. Ongoing in the form of Communities of Practice.
Recommendation 12: Promote uptake of My Health Record by ITC providers and the Aboriginal community.

It is envisioned that several of the recommendations will be transferred to into business-as-usual activities for the PHN as part of ongoing plans in Regional Integration and with Quality Improvement Initiatives in partnership ITC service providers and Local Health Networks.
Funding for service delivery of the Country to City Service will cease on 30 June 2026. The PHN will continue discussions with WA Country Health Service and the service provider to ensure Aboriginal clients who are coming off-country for treatment are supported in their care whilst in the city and when returning home.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal people living with chronic disease and build capacity for patient self-management (Metro).	44
Enable access to culturally appropriate alternative options to Emergency Departments for Aboriginal people (Metro).	44

Activity Demographics

Target Population Cohort

Aboriginal people with an existing chronic condition.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN will engage with the following organisations in communicating changes to this activity:
- Aboriginal Health Council of WA (AHCWA).
- Local Health Networks.
- ITC service providers.

Activity Milestone Details/Duration

Activity Start Date

20/10/2021

Activity End Date

29/06/2025

Service Delivery Start Date

21/10/2021

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Work Plan - Review the multiyear AWP and submit any amendments
Due 28/05/25
Performance Report – 12-month Performance Report
Due 30/09/25
Financial Acquittal – Audited income & Expenditure Statement and Declaration
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Needs Assessment – Confirm the Needs Assessment is current
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Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Integrated Team Care Funding	$156,858.66	$356,808.42	$0.00	$0.00	$0.00	$513,667.08
Total	**$156,858.66**	**$356,808.42**	**$0.00**	**$0.00**	**$0.00**	**$513,667.08**

ITC 1000 - ITC Operational

Activity Metadata

Applicable Schedule

Integrated Team Care - Country WA

Activity Prefix

ITC-Op

Activity Number

1000

Activity Title

ITC-Op 1000 - ITC Operational

Existing, Modified or New Activity

Existing

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
ITC Operational	$536,745.11	$569,609.30	$0.00	$0.00	$0.00	$1,106,354.41
Total	**$790,716.21**	**$569,609.30**	**$0.00**	**$0.00**	**$0.00**	**$1,360,325.51**