Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks:
Integrated Team Care Funding

Activity Work Plan 2016-2017:

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

Western NSW PHN - 107

Introduction

Overview

The aims of Integrated Team Care are to:

- contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care; and
- contribute to closing the gap in life expectancy by improved access to culturally appropriate mainstream primary care services (including but not limited to general practice, allied health and specialists) for Aboriginal and Torres Strait Islander people.

The objectives of Integrated Team Care are to:

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

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

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

The Activity Work Plan template has the following parts:

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

Activity Planning

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

- ITC aims and objectives;
- Item B.3 in the Integrated Team Care Activity in the IAHP Schedule;
- Local priorities identified in the Needs Assessment;

- ITC Implementation Guidelines; and
- Requirement to work with the Indigenous health sector when planning and delivering the ITC Activity.

Annual Plan 2016-2017

Annual plans for 2016-2017 must:

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

Activity Work Plan Reporting Period and Public Accessibility

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

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

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

Useful information

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

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

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

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

Western Health Alliance Limited, which operates the Western NSW PHN (WNSW PHN), is a consortium model based on a unique Aboriginal Health partnership focusing on improving poor health[1]. The application proposed that solutions to lift Aboriginal Health will be driven through Aboriginal-owned General Practice clinics and services, and through the spread of integrated health, social, and cultural capacity across mainstream General Practice and primary care networks.

WNSW PHN's vision for Integrated Team Care (ITC) is premised on this key point of difference proposed in the application for funding.

A key strategic priority for the WNSW PHN is to**:**

"Realise the value of effective partnerships with Aboriginal Communities"

This will be achieved by:

i.) Working in collaboration with Aboriginal health partners, which are the foundations of the PHN, through the Aboriginal Health Council.

ii.) Supporting Aboriginal Community Health Services spread the delivery of innovative, high performing Aboriginal health services across all communities in our region.

iii.) Supporting Aboriginal Communities and service providers to those communities to increase Aboriginal ownership of health services, empowerment and self-navigation for improved health outcomes.

The WNSW PHN's proposed approach to Integrated Team Care will focus working in collaboration with the Aboriginal Community Controlled Health Services (ACCHS) in the region to improve health outcomes for Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander peoples (A&TSI) participation in and control of primary health care services has been identified at both a state and national level as an effective action to improve health outcomes for A&TSI people and contribute to closing the gap in health outcomes between A&TSI people and other Australians. The Western NSW PHN's Aboriginal Health Council has been established to ensure A&TSI community involvement in the planning, management and delivery of local primary health care services, in this case the ITC program.

Primarily using ACCHSs to provide the chronic disease brokerage service would have the practical benefit of decreasing the overhead costs associated with the ITC program, through a more effective sharing of resources, resulting in an increase in the investment in frontline services.

The WNSW PHN's vision of collaboration with ACCHS closely compliments the ITC objectives specifically improving the treatment and management for Aboriginal and Torres Strait Islander people with chronic disease conditions and fostering collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors.

A key outcome of the Single Provider or Most Capable Provider (MCP) Approach, based on goals and outcomes agreed between WNSW PHN and ACCHS, will be closer collaboration and support between mainstream primary care providers and the Aboriginal and Torres Strait Islander health sectors. There will be a requirement for linkages with the two Local Health Districts in the region, particularly through the Integrated Care Strategy demonstrator sites.

[1] Western NSW Primary Health Network: application for funding (24 January 2015)

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

Proposed Activities	
Six-month transition phase	WNSW PHN has extended the funding for the services provided by the Care Coordination and Supplementary Services (CCSS) and the Improving Indigenous Access to Mainstream Primary Care (IIAMPC) providers during 2015/16, by four months to 31 October 2016. A transition plan will be prepared by Maari Ma Health Aboriginal Corporation for the establishment of the ITC program from 1 November 2016. Information will be provided by WNSW PHN to GPs, Practice Managers and patients. The PHN has sent letters to GPs and practices on 22 September 2016 informing them of the changes and asked that this be provided to clients, an information sheet and a Q&A was also placed on our website. The new provider has set up a generic email address active now and an 1800 number which will be available from the 21st of October for enquiries from Practices. The new providers are working with the ceasing providers and have developed a plan to ensure a smooth transition. The new providers have outlined the model to ceasing providers this being a brokerage model that enables the GP to provide the clinical care supported by a care coordinator and the provision of supplementary services. This model is further discussed in the service delivery and commissioning arrangement section.
Anticipated start date of ITC activity	1 November 2016

Will the PHN be working with other organisations and/or pooling resources for ITC?	The ITC program will be aligned with other WNSW PHN activities, including practice support initiatives and other programs, and with the two Local Health Districts. WNSW PHN has a key involvement in the implementation of the NSW Integrated Care Strategy particularly in the Western NSW demonstrator sites, where there is a particular focus on improving care for Aboriginal and Torres Strait Islander peoples, with chronic disease conditions. The collaboration between the demonstration sites and the ITC program is critical in improving the integration of care. The future program will focus on improving the effectiveness of the ITC funding by working in collaboration with ACCHSs to share resources and increase the capacity at a regional level of supporting Aboriginal and Torres Strait Islander peoples with chronic disease conditions, to improve their community's health and wellbeing. WNSWPHN's believe this new model and key partnerships between the IHPO/Transition Manger (Maari Ma), IHPO Manager (WNSW PHN), Care Coordinators and the PHN practice support team (WNSW PHN) will lead to successfully implementation of this project.
Service delivery and commissioning arrangements	WNSW PHN will directly engage with Bila Muuji Aboriginal Health Services Incorporated and Maari Ma Health Aboriginal Corporation. Bila Muuji comprises Aboriginal Community Controlled Medical Services from Brewarrina, Bourke, Coomealla, Coonamble, Dubbo, Forbes, Orange, Wellington and Walgett, and Maari Ma services communities in the far west region of New South Wales. Maari Ma Health Aboriginal Corporation, in conjunction with Bila Muuji Aboriginal Health Services Inc. will work together to implement the ITC program from 1 November 2016 in the Western NSW PHN region with their newly created Indigenous Health Support Service (IHSS). Operating as a brokerage service, the IHSS will introduce its service to General Practices in Western NSW currently caring for Aboriginal people under Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care. A central phone number and direct email contact for IHSS Care Coordinators will be communicated to all mainstream health providers and AMSs once these have been established. GPs with an Aboriginal patient eligible for the ITC program will work with the relevant Care Coordinator to continue the management of current patient support services.

	IHSS will provide support to both mainstream health providers and Aboriginal community controlled sectors to ensure patient access to a comprehensive array of services. Further information will be available on the WNSW PHN website. A particular focus of the service delivery model by ACCHS will be ensuring that access is improved to culturally appropriate mainstream primary care services. This will be a requirement for the consortium providers. WNSW PHN is developing a Cultural Safety framework which will be the basis for future service delivery arrangements and will be applied to ITC providers. The new model for clients is a brokerage service, Indigenous Health Support Service (IHSS), that supports the patient care provided by the patient's GP in both General Practices and Aboriginal Medical Services. The IHSS brokerage service is not a parallel clinical service. The IHSS will liaise between the client's primary care provider (e.g. general practice or AMS), the client and the service they need and provide information back to the client's primary care provider. The IHSS will facilitate the client receiving the care that is deemed necessary by their GP according to their care plan. The IHSS will introduce its service to all of the General Practices and ACCHS in Western NSW which care for Aboriginal and Torres Strait Islander people. Any practice with an Aboriginal client eligible for the service can make contact with the relevant Care Coordinator. The Care coordinator will discuss the needs of the client with the referring practice and the client, and put plans in place to address these needs (e.g. Assist in completion of necessary paperwork, arranging payment of specialist gap fees, arranging travel and accommodation logistics around a specialist appointment, organising local transport). This new model promotes clinical care being provided by the GP to prevent disconnected patient information and service delivery, and promotes better integrated and patient centred-care. The organisation of the chronic care services prescribed by the patient's GP will be supported by care coordinators. There will be a mix of both part-time and full-time staff strategically placed based on the level of need in the community. The transition process will be measured in line with standard quarterly reporting requirements. Effective change management and service satisfaction will be measured using the Quadruple Aim: improving the patient experience which will be measured through patient satisfaction surveys, and improving provider satisfaction will be measured through GP satisfaction surveys. Based on information from the ceasing providers, the new provider envisage that this new model and the 50/50

	split across staff, infrastructure costs and services, will facilitate significantly more funds being spent on direct service provision. WNSWPHN have contacted all GPs in the region informing them of the changes to the program and created resources to ensure patients understand and are informed regarding their ongoing care. Under this new model the role of the GP is to manage the clinical care of the client and the care coordinator will facilitate this care through arranging external services and aids. There will be a strong link between the IHPO PHN/IHPO Maari Ma and the PHN practice support team. This partnership will ensure Aboriginal clients in both mainstream and Aboriginal Medical services with chronic disease are supported to choose and adopt culturally appropriate healthy lifestyle and have improved access to key service providers to support better health outcomes. The WNSWPHN and new provider acknowledge these relationships are crucial to ensure effective change management. The Department will be aware of the challenges in transitioning services to new providers, particularly over such a large geographical footprint as Western NSW. The experienced project team implementing the transition plan, supported by the WNSW PHN staff, have a focus on ensuring the transition of services is as smooth as possible.
Decision framework	There is significant disadvantage across a large range of social, economic and cultural factors impact of the health of the aboriginal people.[2] The following information is outlined in the WNSW PHN Needs Assessment 2016 : From HealthStats NSW, for 2015 (latest NSW ERPs available), WNSW PHN had the highest Aboriginal population (11.8%) of all NSW PHNs. There is significant disadvantage across a large range of social, economic and cultural factors impact of the health of the aboriginal people. From HealthStats NSW Aboriginal people have poorer health than the non-Aboriginal population for many measures. According to the 2012-13 National Aboriginal and Torres Strait Islander Health Survey conducted by the ABS, for residents of the WNSW PHN 40.7% of respondents aged 15 yrs. + were current daily smokers; 59.5% of participants aged 2 yrs. and over were overweight or obese; and 76.7% had at least 1 long term health condition. The needs assessment proposed a priority of effective partnerships with Aboriginal communities. This would include the need to develop redesign options that enhance access to CCSS-type services (care

[2] WNSW PHN Needs Assessment (March 2016)

	navigation) leading to a broader range of service options for Aboriginal clients and improved management of chronic conditions. A population/ needs based allocation formula will be utilised for the decision framework on where ITC services should be located. This will be based on population size, chronic disease status, socio-economic deprivation, remoteness, and unavailability of services. The WNSW PHN 2016 needs assessment identified Aboriginal Health as the top priority. Data collected for the needs assessment will be utilised in the population/ needs based allocation formula. WNSW PHN is undertaking a review of the CCSS programme, up to 30 June 2016, and, as part of this process, is conducting a GP survey to identify areas where the programme is working successfully and areas where CCSS programme may be enhanced. The WNSW PHN's Aboriginal Health Council (AHC) supports and advises the WNSW PHN Board of Directors on strategic directions and opportunities to improve the health and wellbeing of Aboriginal people living in Western NSW[3]. The AHC's role confirms the strategic intent of the WNSW PHN to build innovation and collaboration with the Aboriginal Community Controlled Health Services (ACCHS) sector, to assist the development of a locally responsive patient centred system of primary health care that will deliver better outcomes for the communities of the Western region and specifically recognise the needs of Aboriginal people. The WNSW PHN's Aboriginal Health Council has had a key involvement in the provision of advice to the PHN Board and Management on the future direction of the ITC program.
Decision framework documentation	The ITC decision framework adopted by WNSW PHN originates in the successful application to operate the Western NSW PHN, submitted by a consortium in January 2015, that proposed that "solutions to lift Aboriginal Health will be driven through Aboriginal-owned General Practice clinics and services, and through the spread of integrated health, social, and cultural capacity across mainstream General Practice and primary care networks".

[3] WNSW PHN Aboriginal Health Council terms of reference, 2015

Description of ITC Activity	WNSW PHN has extended the funding for the services provided by the Care Coordination and Supplementary Services (CCSS) and the Improving Indigenous Access to Mainstream Primary Care (IIAMPC) providers during 2015/16, by four months to 31 October 2016. Based on the proposal in this plan WNSW PHN will undertake a commissioning process for the implementation of the ITC program from 1 November 2016. This process will be undertaken in line with WNSW PHN's Procurement policy and procedures. The negotiations will include identification of the location for the Care Coordinators and Outreach Workers based on the population/ needs based allocation formula, and opportunities for synergies with ACCHS organisations. The commissioning of services will be undertaken in line with WNSW PHN Commissioning and Procurement policies. A key component of the ITC arrangements will include maintaining and extending relationships with mainstream health services. The WNSWPHN, with advice from its Aboriginal Health Council, is working on the development of a Culturally Safety framework to ensure that the service providers working in mainstream primary care have appropriate competences in place. The IHPO employed by the WNSW PHN will focus over the 2016/18 period on whole of region Aboriginal Health planning, service development and coordination; engagement with ACCHS and Aboriginal communities; Commonwealth, State and non-government organisations; leading the implementation of the Cultural Safety framework; and overseeing and monitoring the contract relationship with the ACCHS organisations delivering ITC. The IHPO/s to be employed by consortium partners will focus on overseeing the delivery of ITC services by the Care Coordinators and Outreach Worker roles, and liaising closely with WNSW PHN's IHPO through program reporting and monitoring. Both IHPO roles will have a significant involvement in building relationships between ACCHS and mainstream primary health care services. The Care Coordinators and Outreach Worker roles will manage patients from 1 November 2016, through a transition plan.
ITC Workforce	To assist in its coordination of ITC and Aboriginal Health planning and engagement activities, WNSW PHN will employ one Indigenous Health Project Officer (IHPO) from the funding provided in the 2016/17 and 2017/18 financial years. The justification for this relates to the significant Aboriginal

	population in the WNSW PHN region and the need for effective PHN coordination of primary health care services for Aboriginal people. The IHPO officer would work closely with the Aboriginal Health Council and with the ITC provider. It is proposed that the ITC provider workforce will be comprised of the following roles and locations: 1 x IHPO/Transition Manager (FTE -covering the whole WNSW PHN region) 4 x Care Coordinators roles (FTE – resources allocated across the region) 8.5 x IOW roles (FTE - resources allocated across the region) There will be flexibility in the form the roles will take in individual communities, based on need, whether the roles will be located in a General Practice/ ACCHS, and workforce availability.