Australian Government
Department of Health

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An Australian Government Initiative

Primary Health Networks:
Integrated Team Care Funding

Activity Work Plan 2016-2017:

- **Annual Plan 2016-2017**

Adelaide PHN

This template was used to submit the Primary Health Network's (PHN's) Activity Work Plan to the Department of Health (the Department) on 15 July 2016.

Contents

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.

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

The APHN Integrated Team Care (ITC) Activity Work plan is underpinned by the population and health status profile of Aboriginal and Torres Strait Islander people identified in the Adelaide PHN (APHN) Population Needs Assessment.

The strategic vision of the Adelaide PHN is to achieve better health for Adelaide Aboriginal and Torres Strait Islander people. It is recognised that the Aboriginal and Torres Strait Islander population in Adelaide experience poorer health and greater exposure to risk factors than other South Australians, and there is a need for the APHN to work with multiple providers across the region to improve the health outcomes of this population group.

Strategic planning for the ITC program will continue as part of APHN's comprehensive stakeholder engagement structure involving Clinical Councils, Community Advisory Councils and Health Priority Groups, in particular the Aboriginal Health Priority Group. Aboriginal health services and mainstream health providers as well as community groups and consumers are active participants on these groups.

APHN will continue its collaborative work with SAMHRI's Aboriginal Research Unit (Wardliparingga) on the implementation of programs and initiatives for culturally appropriate best practice management of a range of chronic conditions for Aboriginal and Torres Strait Islander people. Commissioned agencies will be required to build the outcomes of this research into translating chronic disease management programs and approaches.

APHN strategy for ongoing provision of ITC programs is focused on minimising disruption to services for clients, maintaining the continuity of the workforce, and continued referral pathways for GPs and Aboriginal health services.

The regional and local Closing the Gap (CTG) services operating across metropolitan Adelaide PHN, located within areas of highest Aboriginal and Torres Strait Islander need, will be continued.

During the 2015-16 Transition year, to minimise disruption to service delivery and ensure the program is fully commissioned, the existing provider of the northern Closing the Gap program will continue to be contracted to provide the northern ITC program. The APHN, led by both the Western and Southern Closing the Gap teams identified the Northern Health Network to be the lead agency for both the south and west Closing the Gap service. The contracted lead agency is required to deliver the ITC services in line with national ITC guidelines. The commissioned service includes all Care Coordination and Supplementary services and Aboriginal and Torres Strait Islander Outreach worker activity and a range of Indigenous Health Project Officer activities. Supplementary Service funding will be provided, with specific contract and reporting requirements in place to ensure compliance with national Supplementary Service guidelines.

All Closing the Gap staff have a role to play in program promotion and advocacy for culturally sensitive service provision, practice support and primary care development around culturally appropriate services.

As the ITC program is being commissioned to an external agency, the ITC budget will be fully utilised for operational service provision. APHN will not retain an administrative component, rather utilise the ITC budget to maximise service delivery capacity.

APHN will work collaboratively with Country SA PHN (CSAPHN) to ensure that Aboriginal and Torres Strait Islander people moving between rural and metro areas are supported.

To ensure the continuation of improved capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people, the APHN will ensure that education is delivered as a component of the program including: Cultural awareness training, education and support to register for the Practice Incentives Program - Indigenous Health Incentive (PIP IHI), Aboriginal health specific and Chronic Disease management MBS items, development of GP management plans and team care arrangements.

APHN and previously the Medicare Locals have always managed the Care Coordination Supplementary Service and Improved Indigenous Access to Mainstream Primary Care (IIAMPC) programs as an integrated service, and the ITC structure will enable our current service delivery model to continue.

The contracted agency will be required to work within the parameters of the Primary Health Network and Aboriginal Community Controlled Health Organisation Guiding Principles 2016, and the National Continuous Quality Improvement Framework for Aboriginal and Torres Strait Islander Primary Health Care 2015—2025.

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

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-17. These activities will be funded under the IAHP Schedule for Integrated Team Care.

Public Accountability	
What are the sensitive components of the PHN's Annual Plan? Please list	List the Annual Plan components that the PHN considers sensitive and does not wish to upload onto its website. With the exception of Budget information, the department assumes anything that is not listed here will be uploaded by the PHN onto its website, after the Activity Work Plan is approved by the department. Nil

Proposed Activities	
Six-month transition phase	Provide a description of your provider arrangements and plans to transition to commissioning if your organisation will utilise the six-month transition phase to 31 December 2016. The service delivery components of APHNs Integrated Team Care program will be commissioned to an external agency from July 1, 2016.

	The existing Closing the Gap program will be transitioned in the new format as the Closing the Gap Integrated Team Care (CTG ITC) program, to a single organisation with experience managing the program and workforce to ensure continuity, coverage and equity across the Adelaide PHN region. The Northern Health Network, which has been contracted by APHN to provide the Closing the Gap service in the north during 2015-16, will be re-funded to continue in the north and expand to the West and Southern area under the new ITC guidelines. APHN will provide initial practical support to the provider agency to transition existing CTG ITC staff and establish any further governance, reporting or client support protocols and processes. Education, training and primary care/general practice support components of the ITC guidelines will be supported by APHN as a focussed activity and also commissioned to NHN as the A*boriginal Health Awareness Education and Support* program.
Anticipated start date of ITC activity	1 July 2016. NHN as a commissioned agency has committed to providing smooth delivery of services during the transition phase to the revised ITC guidelines with minimal disruption or impact to client management and care. Existing, active Closing the Gap clients and referring agencies and primary health organisations will be advised of the new ITC program format and new service management arrangements by 30 July 2016. The *Aboriginal Health Awareness Education and Support* program will commence by December 2016.
Will the PHN be working with other organisations and/or pooling resources for ITC?	Please describe arrangements if the PHN plans to collaborate or pool resources with other organisations, including other PHNs. APHN will not be pooling resources with other organisations, including other PHNs, for ITC service delivery in 2016-17.

	The Adelaide PHN will continue to consolidate and extend collaborative working relationships with Aboriginal health and medical services, as well as primary and state based health and support agencies providing services to Aboriginal and Torres Strait Islander peoples. Adelaide PHN and Country SA PHN will also be working collaboratively to ensure that a state-wide support and education network is developed for Closing the Gap staff that is inclusive of shared training, support and networking opportunities.
Service delivery and commissioning arrangements	Provide a description of the service delivery and commissioning arrangements for the ITC Activity. Briefly outline the planned commissioning method and if the process will involve an approach to market, direct engagement or other approach for the activity. List the type of organisations to be commissioned (e.g. AMS or mainstream primary care organisation). APHNs Needs Assessments and consultation processes identified the geographic areas of highest Aboriginal and Torres Strait Islander populations and those with poorest health outcomes. This analysis positioned the need for Closing the Gap services to remain accessible in northern, western and southern metropolitan Adelaide regions. Accordingly, no changes to the existing Closing the Gap program locations are planned for 2016-18. Currently, there are three Closing the Gap teams delivering the program in Adelaide's north, central/west and south areas and commissioning processes have therefore been structured to continue these programs. For the 2016-18 period, Northern Health Network, will be directly engaged to continue provision of the CTG ITC program for Aboriginal and Torres Strait Islander people in the northern metropolitan area. Northern Health Network is a mainstream primary health care organisation. The western/central and southern CTG programs have been provided by APHN during the 2015-16 transition year. Agencies with established working relationships with the Closing the Gap program were approached to canvas their interest in managing the programs. Two alternative agencies were approached using a direct procurement model, however were unable to manage the program due to various reasons. As the existing provider of the northern CTG program Northern Health Network was

	able to offer a solution that included both western and southern based teams, this agency has been commissioned using a direct procurement approach. The rationale for the direct procurement approach to the Northern Health Network was the need to ensure stability of existing teams and ensure the transition of service management was seamless for clients. Furthermore, the procurement approach was led and supported by both the West and South CTG teams, with assistance from the APHN. Selection criteria for the Northern Health Network included the capacity to maintain the provision of both services in the western and southern Adelaide region, current working relationships, agency understanding and knowledge of the program, reducing the impact of having to relocate the service, agencies ability to manage Aboriginal staff in a culturally appropriate way, as well as knowledge of managing community based, mobile teams. Based on these criteria, a consensus decision was made by the CTG teams and a recommendation made to APHN management that the Northern Health Network be commissioned as the agency to provide the service for the next two years. The Northern Health Network is a mainstream primary care organisation that has experience in providing Aboriginal specific health and support services. Adelaide PHN will require the Northern Health Network to maintain and strengthen their engagement with the Aboriginal health and support service sector, and to enable integration across sectors and service deliverers. Already established relationships will be continued and encouraged.
Decision framework	Making specific reference to the needs assessment, market analyses, clinical and consumer input (including through the PHN's Clinical Councils and Community Advisory Councils), describe how this framework led to the service delivery and commissioning arrangements outlined above. As part of APHNs Needs Assessment processes, consultation and engagement with service providers has been undertaken through APHNs membership groups, including Clinical Councils, Community Advisory Councils and Aboriginal Health Priority Group. This process generated significant information, input and feedback in relation to specific issues, gaps in services, high prevalence

	chronic conditions, potentially preventable hospital admissions, inappropriate Emergency Department presentations, lack of integration across sectors and regions [including geographic areas]. This Needs Assessment feedback, population health data, and the existing service provision profile in the region were triangulated to establish the most relevant location, activities and focus for CTG ITC services. The current model of CTG service delivery has had a strong focus on working with mainstream primary health to improve their capacity to provide culturally sensitive and welcoming primary care services. Analysis of the current model supported the fidelity of the current CTG model. There is one Aboriginal Community Controlled Health Service in metropolitan Adelaide with service delivery sites in the northern and central (Central Business District) areas of Adelaide. This Aboriginal Medical Service works closely with existing CTG programs to extend the reach of coordinated care services for Aboriginal and Torres Strait Islander people. Due diligence of the approached organisation was undertaken to confirm the veracity of their business model, organisational stability, and ability to deliver culturally relevant primary health care services. There is confidence that the Northern Health Network infrastructure and workforce will successfully provide the ongoing management and implementation of the program. Along with the administration of the ITC program, a range of other funded programs will have activities imbedded within them, to ensure Aboriginal and Torres Strait Islander Health is considered and addressed beyond the ITC program. [Please refer to the Adelaide PHN Activity Plan 2016/17 for more details].
Decision framework documentation	Has the decision framework outlined above been documented? Yes
Description of ITC Activity	Provide a summary (or attach) your PHN's 2016-17 ITC implementation plan, which includes the work to be done by IHPOs, Care Coordinators, and Outreach Workers in the PHN region.

	The Northern Health Network will deliver the integrated service model across 3 sites. CTG ITC staff members will be directly employed by this agency. Each service delivery site will include Care Coordinators and Aboriginal and Torres Strait Islander Outreach Workers working closely together to engage with clients referred to the program and develop coordination and support plans that will assist and encourage clients to improve their ability to better manage their chronic health conditions. A culturally safe working environment, including appropriate working space and administrative support for the CTG programme will be provided by the Northern Health Network . Northern Health Network will have responsibility for CTG ITC program oversight, including recruitment and retention of team members, oversight on clinical governance and adherence to the program guidelines to ensure seamless program activity. Northern Health Network will also support resource development, mapping referral pathways and program and service coordination. Appropriate and ongoing peer support, professional guidance and mentoring will be provided for the CTG ITC team. This will include professional networking opportunities, liaison with other ITC Closing the Gap service providers to enhance skills, sharing information and facilitating peer support, cultural support for Aboriginal team members, and clinical mentoring including discussions on case studies or models of care. The Program will have the capacity to revise the role of the Indigenous Health Project Officer (IHPO) to reflect the expanded scope allowable under the new ITC guidelines. As there are currently team members employed as IHPO's, this will be done in line with contracted Service Provider's Human Resource management principles and negotiation with current employees. In addition to the service promotion role that IHPOs have, all CTG ITC team members will continue to play a role in engaging with general practice, including allied health providers, and the range of health care agencies across the health care continuum that are involved in meeting clients health care needs.

	The CTG ITC services will be provided for Aboriginal and Torres Strait Islander people within the Adelaide PHN catchment area who meet CTG ITC eligibility criteria. Service sites will continue to be located in Aboriginal population areas with highest need. Northern Health Network will maintain existing staff employment contracts**.** Services will work within the Adelaide PHN region, across both Aboriginal and Torres Strait Health and mainstream primary care sectors. CTG ITC service activity will focus on providing care coordination services to eligible people with chronic disease(s) who need assistance to access primary health care services to improve their health status**.** Care coordination and Aboriginal and Torres Strait Islander Outreach Worker support will also improve access for Aboriginal and Torres Strait Islander people to culturally appropriate mainstream primary care. Adelaide PHN's CTG services currently use an integrated team model that aligns with the reformatted approach in the new ITC Guidelines. This model will be continued by the Northern Health Network. Common to all Closing the Gap ITC staff roles will be: • promotion of mainstream primary care providers to Aboriginal and Torres Strait Islander people as a valid, trustworthy and accessible first point of health care • developing and disseminating resources for Aboriginal and Torres Strait Islander people about accessing services and managing chronic disease • developing referral pathways that incorporate available services, both locally and in collaboration with other CTG ITC services, across metropolitan Adelaide and also into rural SA areas. • assisting mainstream primary care providers to manage specific Aboriginal and Torres Strait Islander health needs and issues; • supporting mainstream primary care providers to encourage Aboriginal and Torres Strait Islander people to identify their Indigenous status when accessing mainstream primary care services. • client advocacy in relation to health care needs to improve inter-agency collaboration.

	• promoting the wellbeing benefits of regular Aboriginal Health Assessments, inclusive of eye health checks, to both Aboriginal and Torres Strait Islander people and to general practices involves in CTG ITC client care. The **Indigenous Health Project Officer (IHPO)Team Leader** will provide program leadership at the local level within the ITC CTG program. As team leaders they will ensure there is a focus on Aboriginal and Torres Strait Islander Health and work to improve the integration of care across the region. The role of the IHPO and/or team leader will also include identifying and addressing barriers faced by Aboriginal and Torres Strait Islander people when accessing mainstream primary care services, including primary care, pharmacy, allied health and specialists. The role also includes coordinating quality improvement activities and strengthening the integrated team-based approach to Aboriginal and Torres Strait Islander health within the service. The **Aboriginal and Torres Strait Islander Outreach Workers (ATSIOW)** will work with program clients to access health services and promote the principles of culturally competent service provision with all agencies they engage with. Their role will include linking clients into support and welfare agencies as well as community based support programs. ATSIOW will work with other CTG ITC team members to assist local Aboriginal and Torres Strait Islander people make better use of available health care services, especially mainstream health services. ATSIOWs, under supervision, will undertake a range of non- clinical tasks. This will include liaison with local cultural support organisations, community liaison, establishing links with local Aboriginal and Torres Strait Islander communities to promote the importance of improving health outcomes and encourage and support the increased use of health services. They will also provide practical assistance for clients, taking clients to appointments and services including for GP care planning, follow-up care, specialist services and community pharmacies. They will also promote the use of primary health care services and encourage Aboriginal and Torres Strait Islander people to identify their Aboriginal and/ or Torres Strait Islander status when attending health care services. A key component of the role of the ATSIOWs will be distributing information to Aboriginal and Torres Strait Islander people about the national CTG program, particularly the subsidised medication scheme. **Care Coordinators (CC)** support eligible clients to access the services needed to treat their chronic

	disease according to General Practitioner (GP) management plans. The CC role includes providing relevant clinical care, education and assistance for clients to participate in regular reviews by their primary care providers. A significant element of CC role includes working with clients to assist developing chronic condition self-management skills. It includes coordinating client appointments with allied health and specialist providers. Care Coordinator roles include engagement and ongoing liaison with GPs and Practice Nurses to assist in maximising access to Team Care Arrangements and additional services requiring Supplementary Service funding. Care Coordinators will use Supplementary Services funds where relevant to expedite client access to urgent and essential allied health or specialist services, necessary transport to services, where this is not available in a clinically acceptable timeframe. The Supplementary Services funding will be used by Care Coordinators to assist eligible clients access specialist, allied health and other support services in line with their care plan, and specified medical aids needed to maximise management of chronic conditions. Purchase of medical aids will be in accordance with ITC Supplementary Service guidelines. All currently employed Care Coordinators are qualified health workers. Most are Registered Nurses with Australian Health Practitioner Regulation Agency (AHPRA) registration. Commissioned Service Providers have flexibility to employ appropriately qualified and skilled people, including Aboriginal Health Workers and Aboriginal Health Practitioners. Care Coordinators and Aboriginal and Torres Strait Islander Outreach Workers will work closely together to ensure all health care and wellbeing supports are accessible. Both CCs and ATSIOWs will take on 'lead worker' roles, based on client health care and cultural need complexity. Care coordination services for eligible people will focus on the Indigenous Chronic Disease Program conditions – diabetes, cardiovascular disease, chronic respiratory disease, chronic renal disease or cancer. Care provided will be in line with the clients' chronic disease management plan. CTG ITC clients with a mental health condiiton will be linked into appropriate mental health services. CTG ITC team members will liaise with mental health services working with these complex clients to ensure that chronic disease and mental health treatments are well coordinated and complement each other. Northern Health Network will be required to actively recruit Aboriginal and Torres Strait Islander

	people to work in CTG ITC roles, in particular Aboriginal and Torres Strait Islander Outreach Worker positions. Aboriginal and Torres Strait Islander Outreach Workers have strong links and established relationships with the community in which they work. Adelaide PHN will retain responsibility for general oversight of the program, including support with capacity building and workforce development across the broader primary healthcare sector. Promotion of the aims and objectives of the ITC program to the primary healthcare sector including general practice will be incorporated into the activity undertaken by Adelaide PHN through information on web sites, stakeholder newsletters and promotion at local community and provider events, and via general practice support. Adelaide PHN will also facilitate working relationships and communication exchange between mainstream organisations, Aboriginal Medical Services and peak bodies, and other health and support services through established advisory and governance structures. The commissioned agency will be required to deliver the CTG ITC program in accordance with relevant sections of the AG DoH ITC Activity Implementation Guidelines 2016-2017 to 2017-2018. Other program delivery informing documents include the National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care 2015 – 2015 prepared by the Lowitja Institure. Service providers will work collaboratively with other CTG programmes across both metropolitan and country SA areas to ensure all eligible Aboriginal and Torres Strait Islander people have access to a CTG ITC programme and there is seamless transition for clients moving between geographic areas. All CTG ITC services will comply with relevant national Safety and Quality Health Service Standards. An accurate and current database of all CTG ITC clients, care coordination, supplementary service and outreach worker activity will be maintained using utilising ISA Healthcare Solutions web-based software program MMEx. Client records will be securely maintained in accordance with Australian Privacy Principles.
ITC Workforce	Indicate number of Indigenous Health Project Officers, Care Coordinators and Outreach Workers that are to be engaged. Specify which positions will be engaged by the PHN or commissioned

	organisation(s). If engaged at a commissioned organisation, specify whether it is an AMS* or mainstream primary care service. All CTG ITC workforce will be employed by the commissioned agency to deliver the services across three sites where there is the highest number of Aboriginal and Torres Strait Islander residents within the Adelaide PHN region. The ITC workforce currently employed in CTG roles will have their employment continued. It is anticipated that any recruitment opportunities that arise during this Activity Plan period may impact on the numbers of staff employed within each role. Current employed staff numbers: • Care Coordinators: 6.86 FTE across the 3 services • Aboriginal Outreach Workers : 6.7FTE across the 3 services • Indigenous Health Project officers: 1.8FTE across the 3 services. Approximately 60% of staff currently employed in CTG roles are Aboriginal and Torres Strait Islander.