# Activity Work Plan 2019-2021:

## Integrated Team Care Funding

This Integrated Team Care Activity Work Plan template has the following parts:

1. The Activity Work Plan for the financial years 2019-20 and 2020-2021. Please complete one table for each activity to be undertaken in accordance with the Indigenous Australian's Health Programme Schedule, Item B3 – Integrated Team Care:
    a) Care coordination and supplementary services; and
    b) Culturally competent mainstream services.

***Adelaide PHN***

***This Activity Work Plan has been endorsed by the CEO.***

***Submitted 28 March 2019***

# Overview

This Core Activity Work Plan covers the period from 1 July 2019 to 30 June 2022. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of up to 36 months. Regardless of the proposed duration for each activity, the Department of Health will require PHNs to submit updates to the Activity Work Plan on an annual basis.

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

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2021. These activities will be funded under the IAHP Schedule for Integrated Team Care.

| **Proposed Activity 1** | |
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| ACTIVITY TITLE | ITC1 – Care coordination and supplementary services |
| Program Key Priority Area | Indigenous Health |
| Needs Assessment Priority | Improve Aboriginal and Torres Strait Islander people's access to high quality, culturally appropriate health care, including care coordination services. |
| Aim of Activity | Contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to care coordination, multidisciplinary care, and support for self-management. |
| Description of Activity | *Provide a description of the ITC model for this activity, including how the activity and core coordination services will be delivered. Please also include a description of the work to be undertaken by Indigenous Health Project Officers, Care Coordinators and Outreach Workers, including the anticipated FTE.*<br>*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*, mainstream primary care service or PHN:*<br><br>Services will work within the Adelaide PHN region, across both Aboriginal and Torres Strait Health and mainstream primary care sectors. Integrated Team Care service activity will focus on providing care coordination services to eligible people with chronic conditions who need assistance to access primary health care services to improve their health status.<br><br>Care coordination and Aboriginal and Torres Strait Islander Outreach Worker support will improve access for Aboriginal and Torres Strait Islander people to culturally appropriate mainstream primary care.<br><br>Common to all Integrated Team Care staff roles will be:<br><br>○ promotion of mainstream primary care providers to Aboriginal and Torres Strait Islander people as a valid, trustworthy and accessible first point of health care<br>○ developing and disseminating resources for Aboriginal and Torres Strait Islander people about accessing services and managing chronic disease<br>○ developing referral pathways that incorporate available services, both locally and in collaboration with other Integrated Team Care services, across metropolitan Adelaide and also into rural SA areas.<br>○ assisting mainstream primary care providers to manage specific Aboriginal and Torres Strait Islander health needs and issues; |

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| | - supporting mainstream primary care providers to encourage Aboriginal and Torres Strait Islander people to identify their Indigenous status when accessing mainstream primary care services.<br>- client advocacy in relation to health care needs and to improve inter-agency collaboration.<br>- promoting the wellbeing benefits of regular Aboriginal Health Assessments, to Aboriginal and Torres Strait Islander people and to general practices involved in Integrated Team Care client care.<br><br>Aboriginal and Torres Strait Islander Outreach Workers (ATSIOW) will work with 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 social support agencies as well as community-based support programs. Aboriginal Outreach Workers ATSIOW will work with other Integrated Team Care 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.<br><br>Care Coordinators (CC) support eligible clients to access the services needed to treat their chronic conditions according to General Practitioner (GP) management plans. The Care Coordinator (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 accessed by Care Coordinators to assist eligible clients access specialist, allied health and other support services |

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| | 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 Integrated Team Care Supplementary Service guidelines. All currently employed Care Coordinators are qualified health workers. Most are Registered Nurses with Australian Health Practitioner Regulation Agency (AHPRA) registration. The Commissioned Service Provider has the flexibility to employ appropriately qualified and skilled people, including Aboriginal Health Workers and Aboriginal Health Practitioners.<br><br>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 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.<br><br>The Indigenous Health Project Officer will ensure there is a focus on promoting Aboriginal and Torres Strait Islander Health with mainstream practices and work to improve the integration of care across the region. The role of the Indigenous Health Project Officer will 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 includes promoting initiatives to increase PIPIHI registration, CTG co-pay and support, the promotion of Aboriginal Health Checks and promoting access to cultural awareness activities and training.<br><br>Workforce Type \| FTE \| AMS \| MPC \| PHN<br>Indigenous Health Project Officers \| 1 \| \| 1 \|<br>Care Coordinators \| 5.2 \| \| 1 \|<br>Outreach Workers \| 8 \| \| 1 \|<br><br>*Please provide a description of workforce development provided for staff under this activity.*<br>All staff have and will continue to participate in cultural learning activities. Various interagency forums are supported by the provider and Adelaide PHN. Adelaide PHN are working with the provider to implement a workforce development plan to ensure staff have access to up to date accredited training and access to conferences and forums.<br>**AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services* |
| Target population cohort | Aboriginal and Torres Strait Islander people with a diagnosed chronic condition |
| Indigenous specific | Yes |
| Coverage | Entire Adelaide PHN Region |
| Consultation | *Please provide details of stakeholder engagement and consultation activities undertaken or to be undertaken to support this activity.* |

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| | Adelaide PHN has undertaken community engagement workshops across Adelaide to discover community issues involved in accessing culturally appropriate and safe health services. This is informing Adelaide PHN on actions and measures that need to be included in Adelaide PHN agreements and workplans with commissioned service providers.<br>The formation and integration of an Aboriginal Community Advisory Council in the Adelaide PHN membership structure was also recommended. The establishment of this Council has drawn on broad community representation from across the region and is now an integral part of Adelaide PHN membership structure. The Aboriginal Community Advisory Council provides advice:<br>• To Adelaide PHN Board<br>• To Adelaide PHN to understand locally relevant Aboriginal community perspectives in relation to health<br>• On community experience of health care, and how services can be delivered<br>• On interpretation of local health data, about the health and service needs of the community<br><br>The Adelaide PHN will consult the Aboriginal Community Advisory to develop local strategies to improve the health care system and co-design activities for Aboriginal Health.<br><br>The commissioned service provider has established an Aboriginal Reference Group in February 2018 to provide guidance and consultancy for services provided through the ITC program. |
| | *List stakeholders that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services. Describe the role of each party.*<br><br>The Adelaide PHN will continue to build on partnerships with Aboriginal State peak bodies, consolidate and extend collaborative working relationships with Aboriginal Community Controlled Health Organisations, primary health and acute services, as well as primary and state-based health and support agencies who provide services to Aboriginal and Torres Strait Islander peoples.<br><br>Adelaide PHN is a partner on the South Australian Medical Health Research Institute's (SAMHRI) Aboriginal Chronic Disease Consortium and 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.<br><br>The ITC commissioned agency will be required to build the outcomes of this research into translating chronic disease management programs and approaches.<br><br>Adelaide PHN and Country SA PHN will continue to work collaboratively to ensure that a state-wide support and education network is developed for |

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| | Integrated Team Care staff that is inclusive of shared training, support and networking opportunities. |
| Activity milestone details | Activity is valid for full duration of AWP |
| Commissioning method and approach to market | 1. Please identify your intended procurement approach for commissioning services under this activity:<br>☐ Not yet known<br>☒ Continuing service provider / contract extension<br>☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.<br>☐ Open tender<br>☐ Expression of Interest (EOI)<br>☐ Other approach (please provide details)<br><br>2a. Is this activity being co-designed?<br>Yes<br><br>2b. Is this activity this result of a previous co-design process?<br>Yes<br><br>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?<br>No<br><br>3b. Has this activity previously been co-commissioned or joint-commissioned?<br>No |
| Decommissioning | Outline any decommissioning that this activity may result in and potential implications.<br>N/A |

| Proposed Activity 2 | |
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| ACTIVITY TITLE | ITC2 – Culturally competent mainstream services |
| Program Key Priority Area | Indigenous Health |
| Needs Assessment Priority | Improve Aboriginal and Torres Strait Islander people's access to high quality, culturally appropriate health care, including care coordination services. |
| Aim of Activity | Improve 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 |
| Description of Activity | *Provide a description of the ITC model for this activity. Please also describe the work to be undertaken as part of this activity, including the anticipated FTE. 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*, mainstream primary care service or PHN.*<br><br>Adelaide PHN have commissioned a cultural learning program, partnering with Linking Futures and AOGP who are delivering and facilitating face to face sessions to all Adelaide PHN commissioned service providers, and more broadly to primary health care providers in the Adelaide regions. This activity is integrated with the ITC program.<br><br>Training sessions are and will continue to be delivered targeting mainstream primary health care providers: GPs, allied health, pharmacy and general practice staff. This program aligns with the cultural safety criteria set by the RACGP National Faculty of Aboriginal and Torres Strait Islander Health and will be evaluated by Adelaide PHN. This program will support the delivery of all Adelaide PHN commissioned services and work closely with the Integrated Team Care program.<br><br>This program will assist in improving the experience of Aboriginal people in accessing culturally safe primary health care, as identified by our Adelaide PHN Aboriginal Health Network members.<br><br>The Indigenous Health Project Officer provides specific face to face information and education sessions with the aim to increase cultural safety to deliver appropriate services for Aboriginal and Torres Strait Islander peoples across the Adelaide metropolitan region. This includes:<br><br>Working with General Practice and other mainstream primary health care providers and Aboriginal health services to improve the delivery of culturally safe primary health care through promoting improved identification and recording of Aboriginal consumers, supporting cultural learning, and the promotion of MBS item numbers for services for people of Aboriginal and Torres Strait Islander descent.<br><br>Providing and facilitating access to cultural learning training for primary health care providers.<br><br>Coordinating integration activities working together with all primary health care |

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| | service providers including the Integrated Team Care Program, to support the connection of services to improve referral pathways and patient experience.<br><br>Workforce Type / FTE / AMS / MPC / PHN:<br>Indigenous Health Project Officers: FTE 1; MPC 1<br>Outreach Workers: FTE 8; MPC 1<br>Consultants: FTE 1<br>Other: specify<br><br>*Please provide a description of workforce development provided for staff under this activity.*<br>The Adelaide PHN works with the provider in a capacity building role, implementing activities to support workforce, such as participating in regular workforce network meetings and providing an IT platform and discussion forum to share and discuss relevant program, training, professional development events and information.<br>Various interagency forums are supported by the provider and Adelaide PHN. Adelaide PHN are working with the provider to implement a workforce development plan to ensure staff have access to up to date accredited training and access to conferences and forums.<br><br>*AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services |
| Target population cohort | Aboriginal and Torres Strait Islander people with a diagnosed chronic condition |
| Indigenous specific | Yes |
| Coverage | Entire Adelaide PHN region |
| Consultation | Please provide details of stakeholder engagement and consultation activities undertaken or to be undertaken to support this activity.<br><br>Ongoing engagement with the Cultural Learning Provider, reviewing attendance, and participant evaluations.<br><br>Adelaide PHN will continue to provide program evaluations to the Aboriginal Community Advisory Council for ongoing consultation. |
| Collaboration | List stakeholders that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services. Describe the role of each party.<br><br>The Adelaide PHN will continue to build on partnerships with Aboriginal State peak bodies, consolidate and extend collaborative working relationships with Aboriginal Community Controlled Health Organisations, primary health and acute services, as well as primary and state-based health and support agencies who provide services to Aboriginal and Torres Strait Islander peoples. |
| Activity milestone details | Activity is valid for full duration of AWP |
| Commissioning method and | 1. Please identify your intended procurement approach for commissioning services under this activity:<br>☐ Not yet known |

Nested workforce table (from the first row above):

| Workforce Type | FTE | AMS | MPC | PHN |
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| Indigenous Health Project Officers | 1 | | 1 | |
| Outreach Workers | 8 | | 1 | |
| Consultants | 1 | | | |
| Other: specify | | | | |

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| approach to market | ☒ Continuing service provider / contract extension<br>☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.<br>☐ Open tender<br>☐ Expression of Interest (EOI)<br>☐ Other approach (please provide details)<br><br>2a. Is this activity being co-designed?<br>Yes<br><br>2b. Is this activity this result of a previous co-design process?<br>Yes<br><br>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?<br>No<br><br>3b. Has this activity previously been co-commissioned or joint-commissioned?<br>No |
| Decommissioning | Outline any decommissioning that this activity may result in and potential implications.<br>N/A |