Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2018-2021:
Integrated Team Care Funding

The Activity Work Plan template has the following parts:

1. The Integrated Team Care Annual Plan 2018-2021 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 Budget for Integrated Team Care funding for 2018-2021 (attach an excel spreadsheet using template provided).

Adelaide PHN

This Activity Work Plan has been endorsed by the CEO

Submitted on 25 June 2018.

Overview

This updated Activity Work Plan covers the period from 1 July 2018 to 30 June 2021. To assist with PHN planning, each new activity nominated in this work plan should be proposed for a period for 12 months.

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

Please outline, in no more than 500 words, an overview of the PHN's strategic vision for the 12 month period covering this Activity Work Plan. The strategic vision should demonstrate how the PHN will achieve the Integrated Team Care objectives, with reference to Needs Assessment as applicable.

As the Integrated Team Care program is being commissioned to Sonder an external agency, the budget will be fully utilised for operational service provision. Adelaide PHN will not retain an administrative component, rather utilise the Integrated Team Care budget to maximise service delivery capacity.

The regional Integrated Team Care Service operating across metro Adelaide PHN, located within areas of highest Aboriginal and Torres Strait Islander need, will be continued.

The commissioned service provider will deliver all Care Coordination, 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.

Sonder 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 Health and Safety Quality Standards (6 new actions for Aboriginal Health)

Adelaide PHN and Sonder 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.

Aboriginal and Torres Strait Islander Health is a key priority area for the Adelaide PHN as part of our work to ensure the community can receive the right care in the right place at the right time.

To address the priorities in this area, the Adelaide PHN have clear strategies in place to ensure we are addressing local needs and supporting the health system to better meet the needs of the Aboriginal and Torres Strait Islander community.

This includes:

- Recognising Aboriginal and Torres Strait Islander health needs in population health planning.
- Working in partnership with Aboriginal Health organisations and services in responding to population health needs including the disparity in health outcomes between Aboriginal and Torres Strait Islanders and other Australians.
- Ensuring Aboriginal and Torres Strait Islander health is focus in all planning for commissionable services and activities, and embedding a continuous quality improvement

element within all service commissioning. Adelaide PHN is working with commissioned service providers on their contractual and reporting obligations. This will monitor activities with the aim to provide culturally safe services

- 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.
  The Adelaide PHN are currently commissioning a cultural learning program: An introduction to cultural safety. Face to face sessions will be delivered to Adelaide PHN commissioned services providers, and more broadly to primary health care providers across the Adelaide PHN region.
- Coordinating integration activities working together with all primary health care service providers including the Integrated Team Care Program, to support the connection of services to improve referral pathways and patient experience.
- Adelaide PHN are committed to working with our stakeholders to understand and address needs of the Aboriginal and Torres Strait Islander community.
- The development of a Reconciliation Action Plan (RAP) as a commitment to working towards the organisation's vision for reconciliation: to respect and acknowledge the unique connection that Aboriginal and Torres Strait Islander people have, to the land on which Adelaide PHN is situated and to build genuine, respectful relationships with Aboriginal and Torres Strait Islander communities and peoples.

(b) 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 2018-2021. 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.* *N/A*

Proposed Activities	
Existing, Modified, or New Activity	*Existing Activities* *Please attach any Department approvals of underspend proposals when submitting the Activity Work Plan.* *N/A*
Start date of ITC activity as fully commissioned	July 2018 Sonder (formerly known as the Northern Health Network) is the commissioned agency who are committed to the delivery of services for this next financial year and implement the revised Integrated Team Care guidelines with minimal disruption or impact to client management and care. Existing and active clients and referring agencies including primary health organisations will be advised of any changes to the Integrated Team Care Guidelines service management arrangements by July 30, 2018.
Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?	*Please describe arrangements if the PHN is collaborating or pooling resources with other organisations, including other PHNs.* APHN will not be pooling resources with other organisations, including other PHNs, for Integrated Team Care service delivery in 2018-19. The Adelaide PHN will continue to establish partnerships, 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. Adelaide PHN and Country SA PHN will continue to work collaboratively to ensure that a state-wide support and education network is developed for Integrated Team Care 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).* The service delivery components of Adelaide PHNs Integrated Team Care program will continue to be commissioned to an external agency from July 2018 Through a direct approach to market, Sonder has been contracted by Adelaide PHN to continue to provide the Integrated Team Care Gap service across Adelaide metropolitan region. The Indigenous Health Project Officer role, which includes education, training and primary care/general practice support components of the Integrated Team Care has been supported with additional resources by Adelaide PHN as a focussed activity. This has been commissioned to Sonder. **AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services*
Decommissioning	*Outline any decommissioning that this activity may result in and potential implications.* *N/A*
Decision framework	*Making specific reference to the needs assessment, market analyses, clinical and consumer input (including through the PHN's Clinical Council and Community Advisory Committee), describe how this framework led to the service delivery and commissioning arrangements outlined above.* As part of Adelaide PHNs Needs Assessment processes, consultation and engagement with commissioned and broader service providers has been undertaken through Adelaide PHNs membership groups, including Clinical Councils, Community Advisory Councils and Aboriginal Health Priority Group. This process has generated significant Information, input and feedback in relation to specific issues, gaps in services, the high prevalence chronic conditions, potentially preventable hospital admissions, inappropriate Emergency Department presentations, lack of integration across sectors and regions. 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 Integrated Team Care services. A recommendation from the Adelaide PHN membership, specifically the Aboriginal HPG, as part of the Adelaide PHN ongoing engagement strategy, the Adelaide PHN has undertaken community engagement workshops across Adelaide to discover community irritants and issues involved in accessing culturally appropriate and safe health services. This community engagement is informing Adelaide PHN on standards, actions, performance indicators and measures that need to be included in

	Adelaide PHN agreements and workplans with commissioned service providers. The Adelaide PHN is in the process in establishing an Aboriginal Community Advisory Council, as a significant outcome identified from community workshops. Through a direct approach to market, Sonder has been contracted by Adelaide PHN to continue to provide the Integrated Team Care Gap service across Adelaide metropolitan region. Sonder is an organisation that has experience in managing the program for a period of 3 years with established partnerships, referral pathways and a trained Aboriginal workforce, this will ensure continuity, coverage and equity across the Adelaide PHN region. The model of Integrated Team Care service delivery has had a strong focus on working with all primary health care and mainstream services to improve their capacity to provide culturally sensitive and welcoming environments. There is one Aboriginal Community Controlled Health Service in metropolitan Adelaide with service delivery sites in the northern and central CBD areas of Adelaide. Sonder works closely with existing Integrated Team Care programs to extend the reach of coordinated care services for Aboriginal and Torres Strait Islander people
Indigenous sector engagement	*Detail your plans for ongoing engagement with the Indigenous health sector.* The Adelaide PHN will continue to establish 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. 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. The commissioned agency will be required to build the outcomes of this research into translating chronic disease management programs and approaches.
Decision framework documentation	*Has the decision framework outlined above been documented?* Yes
Description of ITC Activity	*Provide a summary (or attach) your PHN's ITC implementation plan, which includes the work to be done by Indigenous Health Project Officers, Care Coordinators, and Outreach Workers in the PHN region.* Sonder will deliver the integrated service model across three sites in metropolitan Adelaide. All Integrated Team Care 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 Integrated Team Care program will be provided by Sonder. Sonder has the responsibility for the Integrated Team Care program oversight, including recruitment and retention of team members, oversight on clinical governance and adherence to the Integrated Team Care program guidelines. Sonder will 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 Integrated Team Care workforce. This will include professional networking opportunities, liaison with other Integrated Team Care 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 support the role and activities of the Indigenous Health Project Officer to support the expanded scope allowable under the expanded guidelines. In addition to the service promotion role that Indigenous Health Project Officers have, all Integrated 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 Integrated Team Care services will be provided for Aboriginal and Torres Strait Islander people within the Adelaide PHN catchment area who meet Integrated Team Care eligibility criteria. Service sites will continue to be located in Aboriginal population areas with highest need. 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 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. Common to all Integrated Team Care 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 Integrated Team Care 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 Integrated Team Care client care. The Indigenous Health Project Officer 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 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 also includes coordinating quality improvement activities and strengthening the integrated team-based approach to Aboriginal and Torres Strait Islander health within the service. 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 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.

	Care Coordinators (CC) support eligible clients to access the services needed to treat their chronic disease 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 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. 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 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. Integrated Team care clients with a mental health conditions will be linked into appropriate mental health services. 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. Sonder will be required to actively recruit Aboriginal and Torres Strait Islander people to work in Integrated Team Care 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 Integrated Team Care 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. Sonder will work collaboratively with other Integrated Team Care program across both metropolitan and country SA areas to ensure all eligible Aboriginal and Torres Strait Islander people have access to the Integrated Team Care program and there is seamless transition for clients moving between geographic areas. A database of all Integrated Team Care clients, care coordination, supplementary service and outreach worker activity will be maintained using utilising ISA Healthcare Solutions web-based software program MMEx.
ITC Workforce	*Indicate number of Indigenous Health Project Officers, Care Coordinators and Outreach Workers. 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* **AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services* 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. There will be continuity of the Integrated Team Care workforce currently employed with Sonder. 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: 1.8 FTE across the 3 services. Approximately 60% of staff currently employed in Integrated Team Care roles are Aboriginal and Torres Strait Islander.
Funding from other sources	*N/A*