Adelaide - Integrated Team Care
2022/23 - 2026/27
Activity Summary View

ITC - 1000 - ITC1 – Care coordination and supplementary services

Activity Metadata

Applicable Schedule *

Integrated Team Care

Activity Prefix *

ITC

Activity Number *

1000

Activity Title *

ITC1 – Care coordination and supplementary services

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aboriginal and Torres Strait Islander Health

Other Program Key Priority Area Description

Aim of Activity *

Contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to dedicated care coordination, multidisciplinary care, and support for self-management.

Description of Activity *

Integrated Team Care services are delivered across the Adelaide PHN region, working in partnership with both Aboriginal and Torres Strait Islander health and mainstream primary care sectors.

Integrated Team Care (ITC) service activity focuses on providing clinical care coordination, cultural advocacy and self-management support for Aboriginal and Torres Strait Islander peoples with chronic conditions who:

• Are at greater risk of experiencing avoidable hospital admissions
• Require support to overcome barriers to accessing the range of community services they require
• Do not comply with medical recommendations
• Have poor health literacy and would benefit from more intensive education/support

Activities that are integral to all ITC roles include:
• Developing and disseminating resources for Aboriginal and Torres Strait Islander people to facilitate service access and management of chronic disease
• Developing referral pathways to locally available services across metropolitan Adelaide
• Supporting mainstream primary care providers to respectful enquire about Aboriginal and Torres Strait Islander identify when consumers access services
• Provision of client advocacy in relation to health care needs
• Building the capacity of mainstream primary care providers to improve cultural safety and responsiveness
• Supporting inter-agency collaboration
• Promoting the well-being benefits of regular Aboriginal and Torres Strait Islander Health Assessments with both the community and general practices involved in Integrated Team Care client care.

Care Coordinators (CC):
• Support clients to access the services required to manage their chronic conditions according to General Practitioner (GP) Management Plans.
• Provide relevant clinical care, education and assistance for clients to support participation in regular reviews with their primary care providers.
• Work with clients to assist the development of chronic condition self-management skills.
• Coordinate client appointments with allied health and specialist providers.
• Engage client GPs and Practice Nurses to assist in maximising access to Team Care Arrangements and additional services requiring Supplementary Service funding.
• Utilise Supplementary Services funds where relevant to expedite client access to urgent and essential allied health or specialist services (where public services are not available in a clinically acceptable timeframe), and transport to attend services when required.

Aboriginal and Torres Strait Islander Outreach Workers (ATSIOW) undertake a range of non-clinical tasks and will work with clients to:
• Improve access to health services
• Connect clients with social support agencies and community-based support programs
• Promote the principles of culturally competent service provision with all agencies they engage with
• 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
• Provide practical assistance for clients: taking clients to attend appointments, including GP care planning, follow-up care, specialist services and community pharmacies.

The Indigenous Health Project Officer ensures there is a focus on promoting Aboriginal and Torres Strait Islander Health with mainstream general practices and works to improve the integration of care across the region. The IHPO is primarily responsible for the following activities:
• Identifying and addressing barriers faced by Aboriginal and Torres Strait Islander people when accessing mainstream primary care services.
• Promoting and providing information to increase the uptake of PIP IHI registration, CTG co-payments, Aboriginal Health Assessments, and participation in cultural learning activities and education.

Summary of ITC Workforce (including FTE breakdown by position, and commissioned service provider type - AMS, MSP or PHN)

Please Note:
AMS = Aboriginal Medical Service
MSP = Mainstream Service Provider

Workforce Breakdown
- Indigenous Health Project Officer: 1.0FTE (PHN from 24/25)

- Care Coordinators: 5.2 FTE (MSP)
- Outreach Workers: 5.8 FTE (MSP)
- Project Support Officer: 0.8FTE (MSP)

Please provide a description of workforce development provided for staff under this activity:
• All staff continue to participate in mandatory cultural learning activities
• Various education opportunities are supported by the provider and the Adelaide PHN
• Adelaide PHN ensures the program budget includes an allocation of funds to support ITC workforce development, and monitors reporting on staff attendance at appropriate continuing professional development events.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2022/23 - 2024/25: 2023 Update

Priorities

Priority	Page reference
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate services for chronic conditions management and early interventions	84

Activity Demographics

Target Population Cohort

Aboriginal and Torres Strait Islander people with a diagnosed chronic condition

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

The commissioned agency will work in partnership with Adelaide PHN and Aboriginal State peak bodies to consolidate and extend collaborative working relationships with Aboriginal Community Controlled Health Organisations, primary and acute health services, and a range of community support services.

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Norwood - Payneham - St Peters	40105
Mitcham	40303
Holdfast Bay	40301
Burnside	40103
Tea Tree Gully	40205
Prospect - Walkerville	40106
Marion	40302
Charles Sturt	40401
Port Adelaide - East	40203
West Torrens	40403
Port Adelaide - West	40402
Unley	40107
Playford	40202
Adelaide City	40101
Salisbury	40204
Onkaparinga	40304

Activity Consultation and Collaboration

Consultation

After two years of consultation with the Aboriginal community, local Elders, our membership groups, stakeholders and staff, Adelaide PHN received final endorsement from Reconciliation Australia for its inaugural Innovate Reconciliation Action Plan. This Innovate RAP spanned a period of two years from July 2020 – July 2022 and was led by an internal working group with representation from all portfolios across the organisation.

Following consultation with the above stakeholder groups the Adelaide PHN launched our second Innovate RAP for July 2023-2025, endorsed by Reconciliation Australia. Through this RAP, the Adelaide PHN has planned the next phase of our path towards reconciliation ensuring:
o The strengthening and maintenance of our relationships with Aboriginal people, communities and organisations, and
o The services we commission are culturally safe, responsive and respectful, working effectively with Aboriginal people and communities to achieve better health outcomes
• Organisational resources are committed to regularly inform stakeholders about the program and to improve the cultural responsiveness of mainstream primary care providers.
• Key stakeholders including the Aboriginal and Torres Strait Islander community are aware of commissioned services and activities providing culturally safe service delivery.
• Together with the provider, the Adelaide PHN hosts and attends sector events and community events to engage broadly with stakeholders.
• The Adelaide PHN membership structure includes Aboriginal and Torres Strait Islander representation. The Adelaide PHN has established an Aboriginal Community Advisory Council, drawing on broad community representation from across the region to form a now integral part of the Adelaide PHN membership structure. The Aboriginal Community Advisory Council provides advice to the Adelaide PHN to understand local Aboriginal community perspectives in relation to health, experience of health care, how

service delivery can be improved, interpretation of local health data, and the health and service needs of the community. The Adelaide PHN Board now also includes Aboriginal and Torres Strait Islander representation with inclusion of the CEO of the state Aboriginal Community Controlled Health Service peak body.
• The commissioned service provider delivering the ITC program has established an Aboriginal Reference Group to provide guidance and consultancy for services delivered through the ITC program.

Collaboration

As the ITC program has been delivered for a length of time, referral pathways for implementation of the program have been well established.

• Local Health Networks: Assist ITC staff to establish referral pathways for clients accessing their Primary Health Care and acute services.

• Mainstream general practices: ITC Care Coordinators engage with general practices and clients to enable integrated care coordination and chronic disease self-management.

• ACCHOs: Support and collaborate to implement referral pathways between services ensuring appropriate shared care arrangements.

• Aboriginal Hospital Liaison Units: Both teams work closely to ensure appropriate referrals are made to enable integrated and coordinated care for ITC clients between primary and acute care services.

• Community and social support services such as Housing, Centrelink, Aged Care and emergency relief funding are all key stakeholders of the program, providing pathways and assistance for ITC clients, supporting their capacity for self-management of chronic conditions.

• Joint community events and forums with the above stakeholders take place throughout the year to support collaboration and provide consistent health messages to the community.

Activity Milestone Details/Duration

Activity Start Date

30/06/2021

Activity End Date

29/06/2025

Service Delivery Start Date

July 2021

Service Delivery End Date

June 2025

Other Relevant Milestones

Activity valid for the full duration of this AWP

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

Yes

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

n/a

ITC-Op - 1000 - ITC Operational

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Other Program Key Priority Area Description

Aim of Activity *

Description of Activity *

Needs Assessment Priorities *

Needs Assessment

Priorities

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Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region

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Consultation

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Decommissioning

Decommissioning details?

Co-design or co-commissioning comments