

# Adelaide - Integrated Team Care 2024/25 - 2027/28 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 \*

Existing



### 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.

The Integrated Team Care (ITC) program delivers clinical care coordination, cultural advocacy and self-management support for Aboriginal and Torres Strait Islander peoples with chronic conditions who:

- Have multiple chronic conditions and comorbidities.

- Are at greater risk of experiencing avoidable hospital admissions.
- Require support to overcome barriers to access the range of community services they require.
- Require support to enable effective management of their chronic conditions.
- Have poor health literacy and would benefit from more intensive education/support.

Activities that are integral to all ITC program roles include:

- Developing and disseminating resources for Aboriginal and Torres Strait Islander people to facilitate service access and management of chronic conditions.
- Developing referral pathways to local culturally safe services across metropolitan Adelaide.
- Supporting mainstream primary care providers to respectfully 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.
- Support the development of consumer 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 Aboriginal Health Project Officer (AHPO) 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 AHPO 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 – Aboriginal Medical Service (AMS), MSP (Mainstream Service Provider) or PHN:

- Aboriginal Health Project Officer: 1.0FTE (Adelaide PHN)
- Care Coordinators: 5.5 FTE (MSP)
- Aboriginal Outreach Workers: 4.5 FTE (MSP)
- Project Support Officer: 0.8FTE (MSP)

Adelaide PHN ensures the ITC program budget includes an allocation of funds to support workforce development, and monitors

reporting on staff attendance at appropriate continuing professional development events. Workforce development provided for staff under this activity includes:

- Mandatory participation in Aboriginal and Torres Strait Islander cultural learning activities.
- Various education opportunities supported by the provider and the Adelaide PHN.

## Needs Assessment Priorities \*

### Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

#### Priorities

Priority	Page reference
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate services for chronic conditions management and early interventions	90
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate workforce and primary health care services	90



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



## 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 our inaugural Innovate Reconciliation Action Plan. This Innovate RAP spanned a period of two years from July 2020 – July 2022 and was led by and 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 Strengthening and maintenance of our relationships with Aboriginal communities and organisations.
- o Commissioned services are culturally safe, responsive and respectful, and 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.
  - Adelaide PHN hosts and attends sector events and community events to engage broadly with stakeholders.
  - Adelaide PHN board and consumer advisory council includes Aboriginal and Torres Strait Islander representation from across the region.
  - 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.

Adelaide PHN is currently planning the development of a third RAP and continues to consult broadly with Aboriginal communities

and service providers to understand needs and ensure primary care services, including the ITC program are responsive to identified needs.

### Collaboration

The ITC program has been delivered for an extended period of time, resulting in well-established referral pathways to support program implementation. This includes following collaboration activity with service providers:

- Local Health Networks (LHN) - referral pathways for clients accessing LHN primary and acute care services.
- Mainstream general practices - ITC Care Coordinators engage with general practices and clients to enable integrated care coordination and chronic disease self-management.
- ACCHOs - referral pathways between services ensuring appropriate shared care arrangements.
- Aboriginal Hospital Liaison Units – referral pathways 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 pathways and assistance for ITC clients, supporting consumer 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?

No

**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

**Co-design or co-commissioning comments**

n/a



## ITC-Op - 1000 - ITC Operational



### Activity Metadata

**Applicable Schedule \***

Integrated Team Care

**Activity Prefix \***

ITC-Op

**Activity Number \***

1000

**Activity Title \***

ITC Operational

**Existing, Modified or New Activity \***

Existing

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### Activity Priorities and Description

**Program Key Priority Area \***

**Other Program Key Priority Area Description**

**Aim of Activity \***

**Description of Activity \***

**Needs Assessment Priorities \***

**Needs Assessment**

**Priorities**

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## Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type \*

Indigenous Specific \*

Indigenous Specific Comments

Coverage

Whole Region



## Activity Consultation and Collaboration

Consultation

Collaboration



## Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



## Activity Commissioning

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**Co-design or co-commissioning comments**