Integrated Team Care Funding Activity Work Plan

2019-2021

phn COUNTRY SA

An Australian Government Initiative

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SA Rural Health Network Limited trading as Country SA PHN
ABN 27 152 430 914

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

<table>
<tr><th colspan="2">Proposed Activity 1</th></tr>
<tr><td>ACTIVITY TITLE</td><td>ITC1 – Care coordination and supplementary services</td></tr>
<tr><td>Program Key Priority Area</td><td>Indigenous Health</td></tr>
<tr><td>Needs Assessment Priority</td><td>Improve Aboriginal and Torres Strait Islander people's access to high quality, culturally appropriate health care, including care coordination services.</td></tr>
<tr><td>Aim of Activity</td><td>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.</td></tr>
<tr><td>Description of Activity</td><td>
<table>
<tr><th>Workforce Type</th><th>FTE</th><th>AMS</th><th>MPC</th><th>PHN</th></tr>
<tr><td>Indigenous Health Project Officers</td><td>4.0</td><td>2.0</td><td>2.0</td><td></td></tr>
<tr><td>Care Coordinators</td><td>3.0</td><td>1.0</td><td>2.0</td><td></td></tr>
<tr><td>Outreach Workers</td><td>3.0</td><td>1.0</td><td>2.0</td><td></td></tr>
<tr><td>Dual Role: Care Coordinator/Outreach Worker</td><td>7.0</td><td>5.0</td><td>2.0</td><td></td></tr>
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CSAPHN will continue to work collaboratively with the service providers to ensure ITC Activity is delivered as per Implementation Guidelines. Delivery of face to face Integrated Team Care Staff Forums on a bi-annual basis to:
• Support collaboration with the service providers and CSAPHN
• Support workforce development activities
• Support staff knowledge exchange and support across the service area
• Encourage cross-area service collaboration.

In the service delivery model, there are 4.0 FTE Indigenous Health Project Officer roles designated to regional areas and operating out of contracted organisations.

These areas include:
• IHPO North: Flinders, Port Augusta and Far North.
• IHPO Eyre and Western: Ceduna, Yalata, Oak Valley and Port Lincoln
• IHPO East/South: Riverland and Murraylands, Adelaide Hills, Fleurieu & South East.
• IHPO Yorke: Clare Valley, Barossa and Yorke Peninsula

Four IHPOs will be located within contracted organisations to deliver the following activities across four regions of Country South Australia:
• Identify and engage appropriately qualified health professionals to provide services that achieve the best possible health outcomes for patients with a chronic or complex condition; and have the most appropriate and appropriately qualified professionals to best meet the needs of each individual
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	• Establish and maintain partnerships with relevant organisations at the local level, including General Practice, Aboriginal and Torres Strait Islander health organisations, Local Hospital Networks and other local organisations, and put the necessary protocols and procedures in place to ensure services are delivered in a culturally appropriate manner.
	  ○ Partner with RDWA to maximise the use of locally available specialist and allied health services under the Medical Outreach Program.
	  ○ Partner with RHD SA to ensure patients identified on the ARF and RHD register are able to participate in the Care Coordination and Supplementary Services Funding Services.
	  ○ Partner with the Aboriginal Chronic Disease Consortium to ensure the use of services and resources available are disseminated to primary health care services.
	• Provision of community education around Chronic Diseases and their management including but not limited to:
	  ○ Delivery of health specific events
	  ○ Delivery of information workshops based on information from evidence-based research
	• Providing a workforce development plan for care coordinators and outreach workers within their region, identifying individual training needs; identifying and providing resources to incorporate evidence-based practices in care coordination and ensuring continual improvement practices are embedded in workplace culture.
	  ○ Facilitate and coordinate monthly peer support meetings for all regional Care Coordinators and Aboriginal Outreach Workers. Meetings to include case discussions.
	  ○ Indigenous Health Project Officers are expected to participate in bi-monthly ITC activity and peer support meetings, facilitated by CSAPHN.
	
	Communicate and work with other IHPOs across the regions to work on collaborative projects and ensure overlap of administration and resources does not occur.
	• Development and provision of local resources for care coordinators and Aboriginal outreach workers to assist in care coordination for clients including but not limited to:
	  ○ Provision of service mapping, referral pathways and other information which incorporates the broader social service network and health networks to assist care coordinators to deliver on holistic service provision.
	  ○ Provision of resources to Care Coordinators to facilitate supplementary services funding management.
	• Ensure effective engagement of clients from other programs that are eligible for services;
	
	There will be three Care Coordinators whose role will be:
	• to deliver direct client care coordination services in accordance with a care plan developed by a referring GP for eligible patients including:
	• providing appropriate clinical care, consistent with the skills and qualifications of the Care Coordinator;

	• arranging the required services outlined in the patient's care plan, in close consultation with their home practice;
	• ensuring the client is connected to the wider social network to ensure that a whole of life and whole of health aspect is undertaken.
	• ensuring there are arrangements in place for the patient to get to appointments;
	• involving the patient's family or carer as appropriate;
	• assisting the patient to participate in regular reviews by their primary care providers; and
	• assisting patients to:
	  ○ adhere to treatment regimens - for example, encouraging medication compliance;
	  ○ develop chronic condition self-management skills; and
	  ○ connect with appropriate community-based services such as those that provide support for daily living.
	• Implement, where appropriate, a consistent approach to self-management programs utilising The Flinders Program for clients with a diagnosed chronic and/or complex condition(s) or at risk of developing one. Delivery of The Flinders Program to suitably assessed clients to develop collaborative care plans using a patient-centred approach;
	• Through the Supplementary Services Funding Pool, the ITC Activity also enables Care Coordinators to assist eligible patients to access specialist, allied health and other support services in line with their care plan and specified medical aids they need to manage their condition effectively.
	• Care Coordinators and Aboriginal Outreach Workers are expected to participate in monthly peer support meetings, facilitated by regional Indigenous Health Project Officers. Meetings to include case discussions.
	
	There will be three Aboriginal Outreach Workers which is a support role to provide practical assistance to clients, mainly in the form of travel assistance in accessing health appointments and medications and support Care Coordinators and Indigenous Health Project Officers in engaging the Aboriginal community.
	
	There will be seven dual roles for Care Coordinators and Aboriginal Outreach Workers. In the case of the dual roles for Care Coordinators and Aboriginal Outreach workers, named the Outreach Care Coordinators, the role will take on both Care Coordinator and engagement with the community and practical assistance to clients. There are two options available for these dual roles
	• The Care Coordinators will be qualified Aboriginal Health Workers or Aboriginal Enrolled Nurses or Aboriginal Registered Nurses to ensure that the dual role can be undertaken.
	• The role can be separated into two positions, one of Care Coordinator and one of Aboriginal Outreach worker as long as the total FTE value of the position is 1.0 FTE.
	
	*AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services
	
	The service delivery model remains unchanged from the 2018-19 financial year.
	
	Note: If underspends are available, CSAPHN will offer additional support in service capacity for the service providers.

Target population cohort	Aboriginal and Torres Strait Islander people with a diagnosed chronic condition
Indigenous specific	Yes
Coverage	Whole PHN Region
Consultation	CSAPHN works in consultation with ACCHOS, communities, elders and the SA Aboriginal Chronic Disease Consortium. The consortium has a very structured and detailed Community engagement and consultation process in which the Action Plan priorities have been driven by community.
Collaboration	CSAPHN work directly with each organisation and offer a range of other support and services to ensure a collaborative relationship. This relationship was and is continuing to be developed on an ongoing basis as ACCHOs are recognized as General Practice providers. CSAPHN are able to provide the same level of servicing provided to mainstream general practices in country South Australia. The relationship with each organisation is variable and fluctuates as contractual arrangements change, however ongoing communication exists with all ACCHOS to ensure current and future working engagements are positive and productive. The commitment between CSAPHN and ACCHOS is formalized through various mechanisms which includes Service Agreements, Collaborative Agreements or MOUs. CSAPHN is developing a Collaborative Agreement with The Aboriginal Health Council of SA (AHCSA) to establish a close working relationship that will foster ongoing partnerships with the peak body of the ACCHO's in South Australia. CSAPHN are working with the South Australian Health and Medical Research Institute to support the integration of research outcomes into service practices within Care Coordination and Supplementary Services activities. This includes integrating service provision in ITC through the use of the AOW to support current clinical studies including the Diabetes Study being delivered in communities. • Quarterly meetings: Department of Health (Primary & Aboriginal Health) cross portfolios: Aboriginal Health / Regional Strategies. • Quarterly meetings: SAHMRI, Wardliparingga • Quarterly meeting: Aboriginal Chronic Disease Consortium • Attended AHCSA Member Service CEO Forum as requested • State-wide Partnership Meeting • Ongoing engagement with all ACCHO's across Country SA PHN
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: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ 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. ☐ Open tender ☐ Expression of Interest (EOI)

	☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	There is no planned decommissioning this financial year. As future commissioning methods and service delivery model changes will be based on monitoring of activities in the activity, decommissioning of a service provider is a potential activity that may occur in the future. In this instance, clear communications will be provided with the service provider about the outcomes of monitoring and/or evaluation processes and an opportunity for the service provider to redress any potential issues that may be arising. If the issues persist into the next funding round an open tender will be completed in order to ensure the most appropriate service provider is identified in the market in the following circumstances: • without attempt to redress • where the attempt to redress has not resolved the issue • appropriate communications with the CSAPHN. As this funding is directly related to staffing and employment any future service provider will be asked to consider the use of the existing staff in the activity to reduce impacts of unemployment of existing staff. Where a specific change has occurred with the service providers, in order to ensure effective transition of the program, the new service provider will receive a complete hand over of the: • CTG specific information • CSAPHN ITC Activity • their service agreement requirements and • particular activities and KPIs that are a focus.

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<tr><th colspan="2">Proposed Activity 2</th></tr>
<tr><td>ACTIVITY TITLE</td><td>ITC2 – Culturally competent mainstream services</td></tr>
<tr><td>Program Key Priority Area</td><td>Indigenous Health</td></tr>
<tr><td>Needs Assessment Priority</td><td>Improve Aboriginal and Torres Strait Islander people’s access to high quality, culturally appropriate health care, including care coordination services.</td></tr>
<tr><td>Aim of Activity</td><td>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</td></tr>
<tr><td>Description of Activity</td><td>
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<tr><td>Consultants</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Other:</td><td></td><td></td><td></td><td></td></tr>
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Four IHPOs will be located within contracted organisations to deliver the following activities across four regions of Country South Australia:

Delivering support to mainstream primary care providers in providing culturally appropriate services including:

Identifying and addressing barriers faced by Aboriginal and Torres Strait Islander people when accessing mainstream primary care services, including but not limited to primary care, pharmacy, allied health and specialists
Disseminating information to mainstream primary care providers around Aboriginal specific MBS items, including 715 Preventative Health Assessments and follow-up items.
Connecting primary health care services to Aboriginal and Torres Strait Islander specific services, including but not limited to Aboriginal Community Controlled Health Services, Aboriginal Medical Services, ITC Care Coordination and Supplementary Services, Medical Outreach- Indigenous Chronic Disease
Capacity support to primary health care services in the delivery of Welcoming Environments
Provision of information and education surrounding self-identification of Aboriginal and Torres Strait Islander people
Delivery of RACGP accredited cultural competency training
Assisting mainstream primary care providers to become registered with the PIP: Indigenous Health Incentive.
Direct engagement, education events and workshops to assist mainstream primary care providers in delivering quality comprehensive services to Aboriginal people.
Direct engagement and support in the development of strategies for the delivery of quality improvement programs involving care for Aboriginal and Torres Strait Islander people.
Identifying cultural competency requirements under the RACGP Standards for general practices (5th edition) to support quality improvement changes.

Delivering specialised projects aimed at improving Aboriginal and Torres Strait Islander access to culturally appropriate mainstream services which include:

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	715 Health Assessment Community Incentive (Shirts and Caps) to support attendance to health services. - Engagement with Community on Days of Significance and other specialised community events to support attendance to health services. Actions from the CSAPHN, in a co-design and collaborative process with the Indigenous Health Project Officers include: - A consistent cultural competency framework for Indigenous Health Project Officers to plan and deliver consistent support to mainstream primary health care across the CSAPHN service area. - In delivering support to General Practice in accessing Practice Incentive Programs, investigation of the creation of a register for 'CTG Enabled' General Practices and inclusion of the information on the CSAPHN Health Service Directory. - Investigation of a Culturally Safe Endorsement Program for Primary Health Care services which uses the Guide to better care for Aboriginal and Torres Strait Islander consumers developed by the Australian Commission on Safety and Quality in Health Care as a basis. - Ensuring a collaborative approach across the teams through sharing resources and knowledge across the program - Using technology to connect with the teams and share resources: - Creation of an Integrated Team Care Indigenous Health Project Officer Portal using Health Connections: Community. - Undertake Health Connection: Video with the Indigenous Health Project Officers to support delivery of information - Participation in Health Pathways South Australia. - Facilitating of face to face Indigenous Health Project Officer meetings. Each IHPO host these meetings in their particular service area. *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	Whole PHN region
Consultation	CSAPHN works in consultation with ACCHOS, communities, elders and the SA Aboriginal Chronic Disease Consortium. The consortium has a very structured and detailed Community engagement and consultation process in which the Action Plan priorities have been driven by community.
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