Country SA - Integrated Team Care
2019/20 - 2023/24
Activity Summary View

ITC - 1000 - ITC 1- Care Coordination and Supplementary Services v3

Activity Metadata

Applicable Schedule *

Integrated Team Care

Activity Prefix *

ITC

Activity Number *

1000

Activity Title *

ITC 1- Care Coordination and Supplementary Services v3

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 care coordination, multidisciplinary care, and support for self-management.

John and Jenny have Diabetes and severe Kidney disease that requires dialysis, and they were unable to travel for their dialysis three times a week as they worked. The pressure they received from attending appointments during work time was significant. There are significant health costs as a result of the treatments including ongoing appointments, medications, and medical aids. John and Jenny would frequently miss appointments with specialists mainly due to costs both for the appointments and for travelling and staying in Adelaide to receive their specialist care. Initially, the ITC team were engaged to work with John and Jenny

in facilitating access with the required specialist teams and services using Supplementary Services funding for travel, accommodation and gap payments, the ITC Team were able to work with both the multi-disciplinary team involved and John and Jenny around the options that they could choose that best suited them and their situation, they were able to facilitate access for John and Jenny to at home peritoneal dialysis. By working with John and Jenny in making informed and involved decisions in their care, John and Jenny are able to continue working and have significantly reduced their stress and worry surrounding their health care and employment.

Description of Activity *

Workforce Type	FTE	AMS	MPC	PHN
Indigenous Health Project Officers	4.0	1.5	2.5	-
Care Coordinators	3.0	1.0	2.0	-
Outreach Workers	3.0	1.0	2.0	-
Dual Role: Care Coordinator/Outreach Worker	7.0	5.0	2.0	-

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. The service regions pertaining to these Indigenous Health Project Officer roles has changed in the 2021-24 period to align with greater support needs of the General Practices in the South and East region. The FTE has been increased to 1.5FTE in this region (an addition of 0.5FTE). The Western Region has merged with the Northern region and in recognition of the high population, a 0.5FTE remains in this area.

These areas include:

- IHPO North and Western: Flinders, Port Augusta and Far North, 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 individua
- 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:

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- 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 Aboriginal Community Controlled Health Services

The service delivery model required a realignment in terms of the Indigenous Health Project Officer Role allocations, to reduce identified gaps within the South & East region. The size of these regions, proportion of the Aboriginal population for whom English is a second language and access to mainstream general practice services have all been taken into account for the ITC Activity moving into a new funding cycle.

ITC Region	% of FTEs	% of GP	% Of Aboriginal Population	% Km2
South & East	24%	49%	30%	4%
Central	18%	32%	17%	3%
North & Western	59%	20%	53%	93%

Note: If underspends are available, CSAPHN will offer additional support in service capacity and workforce development for the service providers.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment For Country SA

Priorities

Priority	Page reference
Aboriginal Health (GEN-1)	45

Activity Demographics

Target Population Cohort

Aboriginal and Torres Strait Islander people with a diagnosed chronic condition

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Lower North	40502
Yorke Peninsula	40504
Gawler - Two Wells	40201
Mid North	40503
Murray and Mallee	40703
Barossa	40501
Limestone Coast	40702
Fleurieu - Kangaroo Island	40701
Outback - North and East	40602
Eyre Peninsula and South West	40601
Adelaide Hills	40102

Activity Consultation and Collaboration

Consultation

CSAPHN works in consultation with AHCSA, ACCHOS, the Aboriginal Health Directors of the 6 Regional LHNs, RDWA, Wellbeing SA, SA Health, communities, and Elders as well as across various condition specific committees and networks.

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.

Activity Milestone Details/Duration

Activity Start Date

30/06/2018

Activity End Date

29/06/2024

Service Delivery Start Date

01/07/2018

Service Delivery End Date

30/06/2024

Other Relevant Milestones

Activity is valid for full duration of 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: Yes
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

Yes

Decommissioning details?

There is no planned decommissioning of the ITC Activity this financial year.

However due to the open tender of the four regions and realignment of the service model, decommissioning of a service provider is a possibility however this is dependent on the tender outcome on 30th April 2021.

If required in this instance clear communications and feedback will be provided to the appropriate service provider. about the outcomes of monitoring and/or commissioning processes and in order to ensure effective transition of the program, the new service provider if required 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.

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 and maintain service continuity for the patients.

Co-design or co-commissioning comments

Direct negotiation with current commissioned providers.
In order to achieve the aims of the ITC Activity, as set out in the Guidelines, CSAPHN service delivery and commissioning arrangements involve both a direct service and an open market approach. CSAPHN has provided fifty percent (50%) of total allocated funding directly to Aboriginal Community Controlled Health Organisations.

Country SA PHN (CSAPHN) undertook an open tender approach within four specific regions below to commission services and to re-approach ACCHO's and to test the market.

- Port Augusta and Outback
- Whyalla and Upper Eyre
- Barossa, Gawler Yorke Peninsula and Mid North
- Riverland

The RFT process aimed to secure a fair and equitable commissioning of services in the Integrated Team Care activity (ITC) due to changing market conditions, an increasing focus on self-determination, and changes to the overall CSAPHN ITC service model. The RFT was designed to incorporate the recommendations regarding commissioning of Aboriginal specific health programs and services, in line with the Closing the Gap framework and the PHNs and ACCHO Guiding Principles. CSAPHN has a commitment to acknowledging the leadership of ACCHOs and other Aboriginal and Torres Strait Islander organisations in their regions and towards developing commissioning processes that build capacity and support Aboriginal and Torres Strait Islander organisations

1. The following four service providers to continue delivering ITC Activity, noting current service model to remain.
   - Nganampa Health Council
   - Yadu Health Aboriginal Corporation
   - Pangula Mannamurna Aboriginal Health Corporation
   - Umoona Tjutagku Health Service Corporation

2. The following two service providers will undergo service model realignments.
   - Moorundi Aboriginal Community Controlled Health Service, additional 0.5FTE IHPO
   - Port Lincoln Aboriginal Health Service, removal of 1.0 IHPO

3. The following four regions will be open tendered, which provides the ACCHO's, AHS, and other culturally appropriate organisations the opportunity to apply if interested.
   - Whyalla and Upper Eyre region/s
   - Port Augusta and Outback region/s
   - Barossa, Gawler, Yorke Peninsula and Mid North region/s
   - Riverland region/s

Note: Please refer to proposed service model realignment.

ITC - 2000 - ITC 2 – Culturally competent mainstream services v3

Activity Metadata

Applicable Schedule *

Integrated Team Care

Activity Prefix *

ITC

Activity Number *

2000

Activity Title *

ITC 2 – Culturally competent mainstream services v3

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 *

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.

John and Jenny have severe COPD and Asthma. They have significant health costs because of their treatments, including ongoing appointments, medications, and medical aids. John and Jenny would frequently miss appointments with specialists having previously experienced a lack of cultural safety in their care. Their experience resulted in feelings of extreme hurt and anxiety. They have not seen a health professional in quite some time as a result.

The ITC Team were able to re-engage with John and Jenny after significant work and using self-management techniques was able to convince them to attend health appointments to which resulted in updated care planning information and referral to a Respiratory Physician required. Supplementary Services funding then was able to access a Respiratory Physician 130km from the location, the travel was facilitated by the Aboriginal Outreach Worker and with the support provided, despite being nervous at obtaining the service, John and Jenny had attended the actual appointment on their own. They noted that the doctor was very informative, understanding and were pleased with the treatment plan.

The ITC Team did a follow up call to see how they were managing. They noted that they were feeling so much better with significantly easier breathing since undertaking the treatment plan. This is a drastic change in attitude towards health services and resulted in better care.

Description of Activity *

Workforce Type	FTE	AMS	MPC	PHN
Indigenous Health Project Officers	4.0	1.5	2.5	-
Care Coordinators	3.0	1.0	2.0	-
Outreach Workers	3.0	1.0	2.0	-
Dual Role: Care Coordinator/Outreach Worker	7.0	5.0	2.0	-

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:

- 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:

- Facilitating a collaborative planning workshop to guide activities for the duration of the 2021-24 period.
- Facilitating bi-monthly Indigenous Health Project Officer meetings.
- Facilitating ITC Staff Forums (Workforce Development Network)

*AMS refers to Aboriginal Community Controlled Health Services in the CSAPHN services context.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment For Country SA

Priorities

Priority	Page reference
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