Country SA - Integrated Team Care
2025/26 - 2028/29
Activity Summary View

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

Activity Metadata

Applicable Schedule *

Integrated Team Care

Activity Prefix *

ITC

Activity Number *

1000

Activity Title *

ITC 1 - 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 *

This program is the subject of a review process initiated by the Department of Health and Aged Care that was undertaken by Ninti One Limited. This program is provided by Country SA PHN with the knowledge that there are changes in progress and the ongoing role of PHNs is unclear.

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.

Working within communities where seeking assistance for chronic health conditions is challenging. Chronic conditions add pressure to the population, including costs related to treatments and ongoing appointments, medications and medical aids. This activity is to reduce pressure on patients and aid in facilitating access with the required specialist teams and services using Supplementary Services funding for travel, accommodation and gap payments. The ITC Team will work with both the multi-disciplinary team and patients around options that best suit their situation, and support integration and coordination of services.

Description of Activity *

The Indigenous Health Project Officers (IHPO) allocated within regions will:

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

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 to:
- put the necessary protocols and procedures in place to ensure services are delivered in a culturally appropriate manner
- support mainstream services with creating a welcoming environment for Aboriginal and Torres Strait Islander people.

Provide 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

Provide 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

The Care Coordinators 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:
- provide appropriate clinical care, consistent with the skills and qualifications of the Care Coordinator;
- arrange the required services outlined in the patient's care plan, in close consultation with their home practice;
- ensure the client is connected to the wider social network to ensure that a whole of life and whole of health aspect is undertaken.
- ensure there are arrangements in place for the patient to get to appointments;
involve the patient's family or carer as appropriate;
- assist the patient to participate in regular reviews by their primary care providers; and
- assist patients to adhere to treatment regimens, 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.

The Aboriginal Outreach Workers are support roles 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.

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.

Needs Assessment Priorities *

Needs Assessment

Country SA PHN_Needs Assessment 2025-2028_Nov 2025

Priorities

Priority	Page reference
Culturally appropriate health services	213
Appropriate support to ACCHOs to improve individual and community health outcomes	213
Integrated and coordinated multidisciplinary care for Aboriginal people with chronic disease	214

Activity Demographics

Target Population Cohort

Aboriginal and Torres Strait Islander people with a diagnosed chronic condition

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

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

Collaboration

CSAPHN works 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.

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.

Activity Milestone Details/Duration

Activity Start Date

29/06/2018

Activity End Date

30/06/2027

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

Decommissioning

No

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 involved 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.