Our Aboriginal Health (Integrated Team Care) Activity Plan 2016-18

phn COUNTRY SA
An Australian Government Initiative

Strategic Vision

The Country SA Primary Health Network (CSAPHN) will ensure that eligible patients of both mainstream and Aboriginal Medical Services (AMS) have access to care coordination and appropriate health services to support best health outcomes for patients with chronic disease.

CSAPHN and the organisations we commission apply flexible approaches to ensure Aboriginal and Torres Strait Islander people are able to access high quality care, including through the mainstream health sector.

This flexibility will be utilised to tailor the role and activities of the Indigenous Health Project Officers, Outreach Workers and Care Coordinators to suit the needs of particular communities, taking into account the objectives of the ITC activity.

We will support contracted organisations to ensure that Aboriginal and Torres Strait Islander employees are provided with a culturally safe working environment and maintain our responsibility to oversee the ITC workforce across our region, including enablement of professional and peer support.

Our Activity Plan 2016-18

Updated in February 2017, this Activity Work Plan covers the period from 1 July 2016 to 30 June 2018. To assist with PHN planning, each new activity nominated in this work plan is for a period of 12 months.

The aims of Integrated Team Care (ITC) are to:

- Contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care.
- Contribute to closing the gap in life expectancy by improving 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.

The objectives of ITC are to:

- Achieve better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people, through better access to the required services and better care coordination and provision of supplementary services.
- Foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors.
- Improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people.
- Increase the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule (MBS) items, including Health Assessments.
- Support mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify.
- Increase awareness and understanding of measures relevant to mainstream primary care.

Transition phase

The ITC Activity is fully commissioned mainly to Aboriginal Community Controlled Health Organisations (ACCHOs) where possible in a direct market approach. Tools were developed to support the commissioning process. This included:

- A communications and engagement strategy for staff, service providers, general practitioners, clients and Aboriginal communities.
- Provision of information with regards to roles, responsibilities, objectives, key performance indicators and outcomes required of the program.

- Development of a Monitoring and Assessment Framework to ensure effective performance and continuous improvement occurs.
- The development of service delivery tools and resources including program policies, procedures, guidelines, service principles, incorporating evidence based practices and tools recommended by the South Australian Health and Medical Research Institute (SAHMRI) and undertaking the Flinders Model of Chronic Disease Management.

Involvement of other organisations/pooling of resources

Country SA PHN 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 Integrated Team Care through the use of the Aboriginal Outreach Worker to support current clinical studies including the Diabetes Study being delivered in communities.

Although Country SA PHN will commission services directly to identified service providers within country South Australia, Country SA PHN will work closely with the Aboriginal Health Council of South Australia to ensure affiliated Aboriginal Community Controlled Health Organisations are well supported.

Description of ITC activity

Indigenous Health Project Officers (IHPO) will be located within contracted organisations to deliver the following activities across three 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.
- 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.
- Delivering support to mainstream primary care providers in providing culturally appropriate services including:
  - Delivery of Royal Australian College of General Practitioners approved cultural competency training.
  - Assisting mainstream primary care providers to become registered with the Practice Incentive Payment: Indigenous Health Incentive.
  - Disseminating information to mainstream primary care providers around Aboriginal specific Medicare Benefits Schedule items.
  - Education events and workshops to assist mainstream primary care providers in delivering quality services to Aboriginal people.
  - 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.
- 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 Integrated Team Care activity and peer support meetings, facilitated by CSAPHN.
- Communicate and work with other Indigenous Health Project Officers 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.
- Undertake activities that improve the cultural competency of mainstream health providers, including, but not limited to, Cultural Awareness Training.

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:

- 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.
- Assisting patients to:
  - Adhere to treatment regimens - for example, encouraging medication compliance.
  - Develop chronic condition self-management skills.
  - 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 Supplementary Services, the Integrated Team Care 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.

Aboriginal Outreach Workers which are a support role to provide practical assistance to clients, mainly in the form of travel assistance in accessing health appointments and medications. Aboriginal Outreach Workers will support Care Coordinators and Indigenous Health Project Officers in engaging the Aboriginal community.

Dual roles of the Care Coordinators and Aboriginal Outreach Workers, named the Outreach Care Coordinators, will take on both care coordinator and engagement with the community and practical assistance to clients. In these instances, 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.