Our Aboriginal Health (Integrated Team Care) Activity Plan 2016-17

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 2016-17

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; and
- 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; and
- Increase awareness and understanding of measures relevant to mainstream primary care.

Country SA PHN (CSAPHN) approach and vision towards a joint Mental Health and Alcohol and Other Drugs (MHAOD) System Reform

In response to the Commonwealth MHAOD reforms, the CSAPHN is inviting MHAOD service providers, consumers and other interested parties to actively contribute towards a co-design of a new and more effective primary MHAOD treatment service system within a stepped care approach.

This invitation is extended to providers across the continuum, including frontline service delivery; training, education and promotion; prevention; and early intervention.

Planned activities for Aboriginal Health (Integrated Team Care)

Six-month transition phase

In consideration of the various requirement and local peculiarities to country South Australia, CSAPHN will be commissioning services to the Aboriginal Community Controlled Health Organisations (ACCHOs) and identified service providers to deliver the ITC services.

Involvement of other organisations/pooling of resources

CSAPHN will be working with South Australian Health and Medical Research Institute to support the integration of research outcomes into service practices within Care Coordination and Supplementary Services activities.

Although CSAPHN will commission services directly to identified service providers within country South Australia, CSAPHN will work closely with the Aboriginal Health Council of South Australia to ensure affiliated ACCHOs are supported.

CSAPHN has supported the concept of self-management and self-determination by transitioning ITC activity to ACCHOs where available.

Description of ITC activity

Indigenous Health Project Officers will be located within contracted organisation to deliver the following activities across three regions of country South Australia:

- 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;
- Delivering support to mainstream primary care providers in providing culturally appropriate services;
- Provision of community education around chronic diseases and their management;
- Development and provision of local resources for Care Coordinators and Aboriginal Outreach Workers to assist in care coordination for clients; and
- Communicate and work with other Indigenous Health Project Officers across the region to work on collaborative projects and ensure overlap of administration and resources does not occur.

The Care Coordinators role will be to deliver direct client care coordinating services in accordance with a care plan developed by a referring GP 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;
- Ensuring the client is connected to the wider social network to ensure a whole life and whole health aspect is undertaken;
- Ensuring there are arrangements in place for the patients to get appointments;
- Involving a patient's family or carer, as appropriate; and
- Assisting the patient to participate in regular reviews by their primary care providers in order to adhere to treatment regimes, self-manage chronic conditions and connect with appropriate community-based services.

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, as well as specified medical aids they need to manage their condition effectively.

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

Dual roles of Care Coordinators and Aboriginal Outreach Workers, named Outreach Care Coordinators, will be qualified Aboriginal Health Workers or Aboriginal Enrolled Nurses or Aboriginal Registered Nurses. This dual role will cover care coordination, engagement with the community and practical assistance to clients.