Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks:
Integrated Team Care Funding

Activity Work Plan 2016-2017:

- **Annual Plan 2016-2017**

Country SA PHN

Introduction

Overview

The aims of Integrated Team Care 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 improved 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 Integrated Team Care 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 for Aboriginal and Torres Strait Islander people and follow up items;
- 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.

Each PHN must make informed choices about how best to use its resources to achieve these objectives. PHNs will outline activities to meet the Integrated Team Care objectives in this document, the Activity Work Plan template.

This Activity Work Plan covers the period from 1 July 2016 to 30 June 2017. To assist with PHN planning, each activity nominated in this work plan should be proposed for a period of 12 months. The Department of Health will require the submission of a new or updated Activity Work Plan for 2017-18 at a later date.

The Activity Work Plan template has the following parts:

1. The Integrated Team Care Annual Plan 2016-2017 which will provide:
    a) The strategic vision of your PHN for achieving the ITC objectives.
    b) A description of planned activities funded by Integrated Team Care funding under the Indigenous Australians' Health Programme (IAHP) Schedule.
2. The indicative Budget for Integrated Team Care funding for 2016-2017.

Activity Planning

PHNs need to ensure the activities identified in this Annual Plan correspond with the:

- ITC aims and objectives;
- Item B.3 in the Integrated Team Care Activity in the IAHP Schedule;
- Local priorities identified in the Needs Assessment;
- ITC Implementation Guidelines; and
- Requirement to work with the Indigenous health sector when planning and delivering the ITC Activity.

Annual Plan 2016-2017

Annual plans for 2016-2017 must:

- base decisions about the ITC service delivery, workforce needs, workforce placement and whether a direct, targeted or open approach to the market is undertaken, upon a framework that includes needs assessment, market analyses, and clinical and consumer input including through Clinical Councils and Community Advisory Committees. Decisions must be transparent, defensible, well documented and made available to the Commonwealth upon request; and
- articulate a set of activities that each PHN will undertake to achieve the ITC objectives.

Activity Work Plan Reporting Period and Public Accessibility

The Activity Work Plan will cover the period 1 July 2016 to 30 June 2017. A review of the Activity Work Plan will be undertaken in 2017 and resubmitted as required under Item F.7 of the ITC Activity in the IAHP Schedule.

Once approved by the Department, the Annual Plan component must be made available by the PHN on their website as soon as practicable. Sensitive content identified by the PHN will be excluded, subject to the agreement of the Department. Sensitive content includes the budget and any other sections of the Annual Plan which each PHN *must list at Section 1(b)*.

1. (a) Strategic Vision for Integrated Team Care Funding

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

CSAPHN intends to utilise flexibility to tailor the role and activities of the IHPOs, 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.

Throughout the commissioning of services under the ITC Program, CSAPHN will ensure that the following Closing the Gap principals are adhered to including:

1. Priority principle: Programmes and services will contribute to Closing the Gap by meeting the targets agreed by the Council of Australian Governments (COAG) while being appropriate to local needs
2. Indigenous engagement principle: Engagement with Aboriginal and Torres Strait Islander men, women, children and communities will be central to the design and delivery of programmes and services.
3. Sustainability principle: Programmes and services must be considered within a context of a real and practical capacity for resourcing and while the aim is resourcing over an adequate period of time to meet the COAG targets each activity must include a target for self-sustainability in the local setting.
4. Access principle: Programmes and services should be physically and culturally accessible to Aboriginal and Torres Strait Islander people and recognise the diversity of our near urban, regional and remote needs. Service delivery will be provided according to an equitable spread of resources across our region.
5. Integration principle: There must be collaboration between and within our own organisation and required of government provided services and NGO providers to effectively coordinate programmes and services**.**
6. Accountability principle: Programmes and services should have regular and transparent performance monitoring, review and evaluation.

CSAPHN will commission service delivery arrangements that most effectively and efficiently meet the needs of patients. Consideration will be given to existing service arrangements including those delivered by the Aboriginal Community Controlled Health Sector.

Our decisions on the engagement of a provider will be transparent, defensible, well documented and made available to the Commonwealth. The CSAPHN will transition its existing CTG service model to meet the needs of the new ITC activity. The goal of the transition will be to shift existing activities to ACCHO's wherever achievable.

1. (b) Planned activities funded by the IAHP Schedule for Integrated Team Care Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-17. These activities will be funded under the IAHP Schedule for Integrated Team Care.

Public Accountability	
What are the sensitive components of the PHN's Annual Plan? Please list	The following aspects of the transition plan are sensitive: • Decision framework (Direct market selection process of ACCHO's and identified service providers) • Workforce transition (PHN ceasing employment as of 31st December 2016) These aspects are subject to the delivery of the communications and engagement strategy.

Proposed Activities	

Six-month transition phase	In consideration of the various requirements and local peculiarities to Country South Australia, Country SA PHN will be commissioning services to the Aboriginal Community Controlled Health Organisations and identified service providers to deliver the Integrated Team Care services. This will include:
	• Commissioning based on a direct market approach.
	• Development of the tools necessary to support the commissioning process including but not limited to:
	  ○ 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. • Country SA PHN current staff and service providers have all been retained for the transition period e.g. MMGPN, RDGPN & Pangula Mannamurna • Workforce transitioning of existing staff will not occur, rather ACCHOs will advertise the new positions for which staff will be encouraged to apply.
Anticipated start date of ITC activity	1st July 2016 – Service continuity ensured through transition period by current providers July 2016- Continue preliminary discussions with service providers August 2016 – Deliver commissioning process supporting documentation September 2016- Commence commissioning process, final discussions with Service Providers October 2016 – Complete commissioning Process, contracts to be signed and returned November 2016- External ITC Workforce Application Process by ACCHO's and identified Service Providers recommended commencement December 2016- Transition activities completed, handover of clients etc. 1st January 2017- Transition completed, contracted Service Delivery commences
Will the PHN be working with other organisations and/or pooling resources for ITC?	Country SA PHN will be 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. 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 ACCHOs are well supported.

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<td>Service delivery and commissioning arrangements</td>
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Country SA PHN will not be considering an open approach to market as the most effective and efficient process and will ensure that the service delivery principles are able to be achieved through direct market research and analysis with contracted service providers.

Country SA PHN have supported the concept of self-management and self-determination by transitioning ITC activity to ACCHOs where available. The following is the proposed service delivery model for ITC:
<table>
<tr><th>ACCHO'S/Identified Service Provider</th><th>Service Locations</th><th>FTEs</th></tr>
<tr><td>Ceduna Koonibba Aboriginal Health Service Corporation</td><td>Far West; Eyre Peninsula; Ceduna; Yalata; Oak Valley; Scotdesco; Streaky Bay</td><td>1.0FTE – CC
1.0FTE – AOW
1.0FTE - IHPO</td></tr>
<tr><td>Port Lincoln Aboriginal Health Service</td><td>Port Lincoln; Cummins; Tumby Bay; Port Kenny;
Port Neil</td><td>1.0FTE–CC/AOW</td></tr>
<tr><td>Pika Wiya Aboriginal Health Service Corporation</td><td>Port Augusta; Nepabunna; Copley; Marree; Peterborough; Hawker; Quorn; Jamestown; Laura; Gladstone; Port Pirie; Crystal Brook, Marree</td><td>1.0FTE – CC
1.0FTE –AOW
1.0FTE - IHPO</td></tr>
<tr><td>Nunyara Health Service Inc.</td><td>Whyalla; Wudinna; Cowell; Lock; Cleve; Woomera; Andamooka</td><td>1.0FTE–CC/AOW</td></tr>
<tr><td>Umoona Tjutagku Health Service Aboriginal Corporation</td><td>Coober Pedy; Oodnadatta; Marla Bore</td><td>1.0FTE–CC/AOW</td></tr>
<tr><td>Nganampa Health Council</td><td>Pipalyatjara; Nyapari; Amata; Fregon; Umuwa; Pukatja; Mimili; Iwantja</td><td>1.0FTE-CC/AOW</td></tr>
<tr><td>Pangula Mannamurna Aboriginal Corporation</td><td>Mount Gambier; Kingston; Border Town; Naracoorte; Millicent; Keith</td><td>1.0FTE–CC/AOW</td></tr>
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	Murray Mallee General Practice	Murray Bridge; Raukkan; Mannum; Lameroo; Pinnaroo	1.0FTE–CC/AOW 1.0FTE - IHPO
	Riverland Division General Practice	Berri; Renmark; Loxton; Waikerie; Barmera	1.0FTE–CC/AOW
	Northern Health Network	Clare; Barossa; Gawler; Nuriootpa; Eudunda; Freeling; Kapunda; Riverton; Point Pearce; Moonta; Wallaroo; Ardrossan; Maitland; Warooka	1.0FTE – CC 1.0FTE – AOW 1.0FTE - IHPO

In this service delivery model there are four 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 East, Riverland and Murraylands, Adelaide Hills
- IHPO Yorke: Clare Valley, Barossa and Yorke Peninsula

The IHPO's will provide support to Care Coordinator and Outreach Worker teams located within identified service providers specific to their allocated Regional area. In some instances Care Coordinator and Outreach Worker roles have been combined to ensure resource allocation could occur effectively across the region.

Decision Framework	The following aspects were considered in the decision framework: • Program Requirements • Aboriginal Population Data • Needs Analysis • Market Analysis • Commissioning Strategy • Engagement with providers

	Specific information was assessed surrounding:
	
	• An intention to promote the policy direction of Aboriginal self-management and determination both through the organisations and ITC service delivery.
	• Which service providers had capacity to deliver the ITC Services:
	  ○ Proven history of Aboriginal Client engagement
	  ○ Current teams that deliver chronic disease services
	  ○ Current model of delivery of chronic disease services
	  ○ Existing resources that could be enhanced
	In addition, the following factors have been taken into account
	• Business capacity of the organisation to be able to deliver services under the program
	• The service locations
	• The role of AHCSA and how they can affect policy and direction within the ACCHOs and support other funded organisations where the program is delivered
	• The General Practice Support team have also been recording and documenting the capacity of General Practice to deliver Aboriginal Health services

Decision framework documentation	The decision framework has been documented and is supported by: • The Closing the Gap Audit • General Practice Team General Practice Aboriginal client capabilities • Needs analysis • Market analysis • Service provider engagements
Description of ITC Activity	A visual representation of the Service Delivery Model that is being delivered is attached. Four IHPOs will be located within contracted organisations 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 including:
	  ○ Delivery of RACGP approved cultural competency training
	  ○ Assisting mainstream primary care providers to become registered with the PIP: Indigenous Health Incentive.
	  ○ Disseminating information to mainstream primary care providers around Aboriginal specific MBS 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
	• 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.
	• Communicate and work with other IHPOs across the regions to work on collaborative projects and ensure overlap of administration and resources does not occur.
	
	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.

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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.

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.

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.
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. 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.
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<tr><td>ITC Workforce</td><td>
The following tables identify the six month rollover period including current contracted service providers; and the transition model anticipated from 1st January 2017.
<table>
<tr><th colspan="2">1 July 2016 – 31 December 2016</th><th colspan="2">1 January 2017 - 30 June 2017</th></tr>
<tr><td>Eyre & Western
Country SA PHN</td><td>1.0 FTE CC
1.0 FTE AOW</td><td>Ceduna Koonibba Aboriginal Health Service Corporation (AMS)</td><td>1.0FTE – CC
1.0FTE – AOW</td></tr>
<tr><td>North</td><td>1.0 FTE IHPO</td><td>Port Lincoln Aboriginal Health Service</td><td>1.0FTE–CC/AOW
1.0FTTE - IHPO</td></tr>
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Country SA PHN	1.0 FTE CC	*(AMS)*	
Yorke Peninsula including Gawler and Barossa Country SA PHN	0.6 FTE IHPO 1.0 FTE CC 2.0 FTE AOW	*Pika Wiya Aboriginal Health Service Corporation (AMS)*	1.0FTE – CC 1.0FTE –AOW 1.0FTE - IHPO
Northern Health Network NHN	0.3 FTE AOW	*Nunyara Health Service Inc. (AMS)*	1.0FTE–CC/AOW
Riverland RDGP	0.5 FTE IHPO 0.8 FTE AOW 1.2 FTE CCSS	*Umoona Tjutagku Health Service Aboriginal Corporation (AMS)*	1.0FTE–CC/AOW
Murray/Mallee MMGPN	0.5 FTE IHPO 0.8 FTE AOW 1.3 FTE CCSS	*Nganampa Health Council (AMS)*	1.0FTE-CC/AOW
South East Pangula Mannamurna	1.0 FTE CC 1.0 FTE IHPO	*Pangula Mannamurna Aboriginal Corporation (AMS)*	1.0FTE–CC/AOW
		Murray Mallee General Practice (Mainstream)	1.0FTE–CC/AOW 1.0FTE - IHPO
		Riverland Division General Practice (Mainstream)	1.0FTE–CC/AOW
		Northern Health Network (Mainstream)	1.0FTE – CC 1.0FTE – AOW 1.0FTE - IHPO