Hunter New England and Central Coast
Integrated Team Care
Activity Work Plan
July 1, 2021 – June 30, 2022

ITC - 1010 - IT1.01 Care coordination and supplementary services

Activity Metadata

Applicable Schedule *

Integrated Team Care

Activity Prefix *

ITC

Activity Number *

1010

Activity Title *

IT1.01 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 *

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.

Description of Activity *

The ITC model varies slightly across the HNECC region, with the primary reason for this variation being the difference in access, i.e. timeliness to see specialists, allied health clinicians etc, experienced by those living in rural and remote areas in comparison to metropolitan communities.

In the metropolitan areas of our region, the predominant model is a concentrated 12-week clinical care coordination program,

which is followed by up to 9 months less intense support, if required. If they require further Care Coordination at a later date, clients who are eligible will return to the program through GP referral.

In addition to the eligibility criteria as outlined in the Program Implementation Guidelines, the HNECC ITC model requires a 715 Health Assessment at point of referral. Priority is given to clients who have complex chronic care needs and require intense multidisciplinary coordinated care for their chronic disease than is currently able to be provided by general practice and/or AMS staff.

The Care Coordination activities of the program focus on both the clinical and non-clinical components of a patients care. Patients are supported by the Care Coordinator and Outreach worker to:
• Ensure there are arrangements in place for a patient to get to appointments;
• Assist the patient to participate in regular reviews by their primary care provider/s;
• Supporting a patient's adherence to treatment regimens (e.g. Medication compliance);
• Supporting and encouraging the patient and the family to develop chronic condition self-management skills; and
• Linking the patient and family with appropriate community-based services such as those providing support for daily living.

Indigenous Health Project Officers (Relevant to IT1):
• Working as team leaders in the PHN region, i.e. overall ITC program lead, including providing regional guidance and strategic direction for the team;
• Developing and implementing a coordinated team-based approach to Aboriginal and Torres Strait Islander health, especially between the AHAO, Outreach Worker and Care Coordinator positions;
• Supporting Care Coordinators and Outreach Workers;

Care Coordinators (Relevant to IT1):
• Arranging the required services outlined in the client's care plan, in close consultation with their home practice;
• Ensuring there are arrangements in place for the client to get to appointments;
• Involving the client's family or carer as appropriate;
• Transferring and updating the client's medical records;
• Assisting the client to participate in regular reviews by their primary care providers;

Outreach Workers (Relevant to IT1):
• Encouraging and helping Aboriginal and Torres Strait Islander people to attend appointments with GPs, including for Aboriginal and Torres Strait Islander Health Assessments and care planning;
• Assisting Aboriginal and Torres Strait Islander people to travel to and from appointments;
• Encouraging and assisting Aboriginal and Torres Strait Islander people to:
o attend appointments with referred specialist services and Care Coordinators, as necessary;
o attend appointments for relevant diagnostic tests and /or referrals to other primary health care providers (including allied health);
o collect prescribed medications from the pharmacist;
o return for follow up appointments with their GP and/or practice nurse; and
o fill out forms and understand instructions from reception staff.

Workforce Type	FTE	AMS	MPC*	PHN
Indigenous Health Project Officers	5.0			5.0
Care Coordinators	17.0	8.0	9.0	
Outreach Workers	10.0	5.0	5.0	

*Mainstream Primary Care organisation
ITC staff across the PHN, AMSs and MPCs were given the opportunity to co-develop a pilot testing validated PREMs and PROMs for patients of the care coordination program. The collection and assessment of measures reported by patients is ongoing and well supported by both care providers and patients.
• ITC staff from across the region are invited to an annual networking and learning event each year that is hosted by the PHN. There are opportunities to link and meet with other stakeholders, e.g. AHMRC, researchers and other PHN ITC workforce.
• ITC staff are given opportunities to attend state and national conferences and education events relevant to the delivery of activities and services under the Indigenous Australians Health program.

Needs Assessment Priorities *

Needs Assessment

HNECC PHN Needs Assessment 2019/20-2021/22

Priorities

Priority	Page reference
High rates of chronic disease	42
A lack of health service integration, coordination and information sharing	42
High rates of chronic disease hospitalisations	42
Barriers to screening in primary care	42
Cost barriers to healthcare	42
Poorer health outcomes for Aboriginal and Torres Strait Islander people	60
Higher rates of chronic disease amongst Aboriginal and Torres Strait Islander people	60
Reduced access to health services for Aboriginal and Torres Strait Islander people	60
A low proportion of Aboriginal and Torres Strait Islander people having a 715 health assessment	60
Improve Aboriginal and Torres Strait Islander people's access to high quality, culturally appropriate health care, including primary care and care coordination services.	n/a

Activity Demographics

Target Population Cohort

Aboriginal and Torres Strait Islander people with a diagnosed chronic condition.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

The combination of ITC activities being undertaken will further strengthen the local and regional partnerships and engagement between HNECC PHN, the Aboriginal Community Controlled Health Service (ACCHS) sector, general practice and mainstream primary care organisations.

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Kempsey - Nambucca	10802
Inverell - Tenterfield	11002
Port Macquarie	10804
Lake Macquarie - East	11101
Port Stephens	10603
Maitland	10602
Newcastle	11103
Lake Macquarie - West	11102
Lower Hunter	10601
Moree - Narrabri	11003
Wyong	10202
Upper Hunter	10604
Taree - Gloucester	10805
Tamworth - Gunnedah	11004
Great Lakes	10801
Gosford	10201
Armidale	11001

Activity Consultation and Collaboration

Consultation

Extensive consultation has and continues to occur across the programs and projects that foster collaboration and partnership. Collaboration is project specific and includes, but is not limited to:
• HNECC PHN Clinical Councils and Community Advisory Committees
• Primary care practitioners through established forums and meetings (i.e. GP Collaboration Panel and engaged Clinical Advisor roles)
• Project/ Program Steering Group meetings that include key stakeholder representation
• Stakeholder and Community forums
• Stakeholder surveys
Established formal and informal feedback mechanisms.

Collaboration

HNECC's core business involves the provision of services to and with the Aboriginal community through the commissioning of culturally appropriate quality services. It is therefore critical that HNECC effectively engages the Aboriginal community in order to achieve its vision and purpose. This includes but is not limited to: AMS / ACCHO sector, Peak Bodies, local Aboriginal and Torres Strait Islander community, NGOs, Lands Councils, community centres and Elders.

Activity Milestone Details/Duration

Activity Start Date

30/06/2021

Activity End Date

29/06/2024

Service Delivery Start Date

01/07/2021

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: No
Expression Of Interest (EOI): Yes
Other Approach (please provide details): Yes

Is this activity being co-designed?

No

Is this activity the result of a previous co-design process?

No

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

Decommissioning details?

Not Applicable

Co-design or co-commissioning comments

Not Applicable

ITC - 2010 - IT2.01 Culturally competent mainstream services

Activity Metadata

Applicable Schedule *

Integrated Team Care

Activity Prefix *

ITC

Activity Number *

2010

Activity Title *

IT2.01 Culturally competent mainstream services

Existing, Modified or New Activity *

Existing

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

Description of Activity *

Indigenous Health Project Officers activities (Relevant to IT2):
• Promoting the objectives and outcomes of the ITC Program to the broader community;
• Identifying and addressing barriers faced by Aboriginal and Torres Strait Islander people when accessing mainstream primary care services;
• Promoting mainstream primary care providers to Aboriginal and Torres Strait Islander people as a valid, trustworthy and accessible first point of health care;
• Providing support to mainstream primary care providers to encourage Aboriginal and Torres Strait Islander people to identify their Indigenous status when accessing mainstream primary care services;
• Delivering or coordinating cultural awareness training and quality improvement activities;
• Coordinating relevant education events;

Aboringal and Torres Strait Outreach Workers (Relevant to IT2):
• Distributing information/resources to Aboriginal and Torres Strait Islander communities about services that are available to/for them, and encouraging them to use primary health care services in their region, e.g. 715 Health Assessment
• Encouraging community to identify their Aboriginal status and register for a Medicare card
• Distributing information to Aboriginal and Torres Strait Islander people about how to access available services

Workforce Type	FTE	AMS	MPC	PHN
Indigenous Health Project Officers	5.0			5.0
Outreach Workers	10.0	5.0		5.0

*Please note these are the same staff as indicated in IT1.0

• Within this activity will be a localised initiative giving organisations involved in supporting clients of the ITC program an opportunity to hear and learn from Aboriginal Elders about local culture and customs, with the aim to broaden and enable the primary care health system in our region to be responsive and understanding of Abroginal health needs.
• AMS and MPC ITC staff will continue to co-present with PHN staff at Aboriginal Health education events delivered in the PHN region. Event attendees included GPs, Practice Nurses, Practice Managers, Clinical Service Managers and Allied health clinicians.

Needs Assessment Priorities *

Needs Assessment

HNECC PHN Needs Assessment 2019/20-2021/22

Priorities

Priority	Page reference
Low levels of health literacy	42
High rates of chronic disease	42
A lack of health service integration, coordination and information sharing	42
Lack of prevention and early intervention services	42
Cost barriers to healthcare	42
Poorer health outcomes for Aboriginal and Torres Strait Islander people	60
Higher rates of chronic disease amongst Aboriginal and Torres Strait Islander people	60
A low proportion of Aboriginal and Torres Strait Islander people having a 715 health assessment	60
Lack of culturally safe workplaces for the Aboriginal and Torres Strait Islander workforce	60
Improve Aboriginal and Torres Strait Islander people's access to high quality, culturally appropriate health care, including primary care and care coordination services.	n/a

Activity Demographics

Target Population Cohort

Aboriginal and Torres Strait Islander people with a diagnosed chronic condition

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Extensive consultation has and continues to occur across the programs and projects that foster collaboration and partnership. This includes: AMS/ACCHO sector, Peak Bodies, Local Aboriginal and Torres Strait Islander community, NGOs, Lands Councils, community centres and Elders.

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Activity Consultation and Collaboration

Consultation

Extensive consultation has and continues to occur across the programs and projects that foster collaboration and partnership. Collaboration is project specific and includes, but is not limited to:

• HNECC PHN Board
• HNECC PHN Clinical Councils and Community Advisory Committees
• LHD Consumer Advisory Committees
• Primary care practitioners through established forums and meetings (i.e. GP Collaboration Panel and engaged Clinical Advisor roles)
• Project/ Program Steering Group meetings that include key stakeholder representation
• Stakeholder and Community forums
• Stakeholder surveys
Established formal and informal feedback mechanisms.

Collaboration

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Is this activity the result of a previous co-design process?

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No

Decommissioning

No

Decommissioning details?

Not Applicable

Co-design or co-commissioning comments

Not Applicable