Integrated Team Care

Activity Work Plan

2021/22 – 2024/25

phn
DARLING DOWNS
AND WEST MORETON
An Australian Government Initiative

Local Integrated
Primary Health Care

Table of Contents

E: info@ddwmphn.com.au www.ddwmphn.com.au

1. Integrated Team Care Activity Work Plan

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aboriginal and Torres Strait Islander Health

AIM OF ACTIVITY

The aim of this activity is to improve health outcomes and close the gap on life-expectancy for Aboriginal and Torres Strait Islander people by:

a) Providing access to care-coordination and multidisciplinary care for Aboriginal and Torres Strait Islander people with chronic conditions;

b) Improving the cultural competency of mainstream primary care services to deliver more culturally safe and responsive health care for Aboriginal and Torres Strait Islander people;

c) Ensure alignment of these activities to the National Agreement on Closing the Gap and its priority reforms.

DESCRIPTION OF ACTIVITY

Led by the Director – Aboriginal and Torres Strait Islander Health, the Darling Downs and West Moreton PHN ITC (Integrated Team Care) program will include the following activities:

A) Care Coordination and Supplementary Services

The PHN will deliver care-coordination and supplementary services that:

- Support Aboriginal Medical Services (AMS) and Aboriginal Community Controlled Health Organisations (ACCHOs) to deliver high quality services that meet the needs of people and their community;
- Support mainstream Primary Care providers and commissioned services to access ITC services;
- Support AMS and Aboriginal organisations to self-manage ITC programs and supplementary service funds;
- Commission service providers within an integrated contracting arrangement under the ITC program guidelines with a focus on continuity of care;
- Support ITC Care Coordinators and Outreach workers in their roles to ensure optimum outcomes for the community;
- Support the ITC and the Primary Care workforce to be more culturally competent.

Tasks of ITC Care Coordinators include:

- Identifying when a client's condition may require further assistance from a health professional;
- Develop and maintain a close relationship with their client's GP;
- Assisting clients to access a range of services such as appointments with specialists and allied health professionals, arrangements for home help and making connections with support groups;
- Expedite access to an urgent and essential allied health or specialist services, necessary transport to access a service, and for assisting access to GP-approved medical aids;
- Improve their client's capacity to engage with the broader health system;
- Assisting clients to adhere to treatment regimens, develop chronic condition self-management skills and connect with appropriate clinical care.

Care Coordinators are also expected to manage the expenditure of Supplementary Services Funds as appropriate (as per ITC Implementation Guidelines). To assist with this allocation, urgent priority is given to:

- Address risk factors, such as a waiting period for a service that is longer than is clinically appropriate;
- Reduce the likelihood of a hospital admission;
- Are likely to reduce a patient's length of hospital stay;
- Are not available through other funding sources; and/ or
- Ensure access to a clinical service that would not be accessible because of the cost of a transport service.

B) Culturally Competent Mainstream Services

To improve the cultural awareness and competency of mainstream primary care services, the PHN will:

- Provide workforce development for primary care providers, through the identification, distribution and delivery of targeted information, mentoring and cultural awareness/capability training;
- Investigate and promote contemporary workforce development practices to:
    - Identify and eliminate racism;
    - Embed and practice meaningful cultural safety;
    - Support Aboriginal and Torres Strait Islander cultures.

C) Alignment of activities to the National Agreement on Closing the Gap

The activities of Care Coordination and Supplementary Services and Improving Cultural Competency outlined in this activity align to the National Agreement on Closing the Gap Priority Reform Areas as follows:

- **Care Coordination and Supplementary Services**

  Aligns to Priority Reform; Building the community-controlled sector

  Our PHN will ensure the Aboriginal and Torres Strait Islander community-controlled sector are strong and sustainable and delivering high-quality services to meet the needs of Aboriginal and Torres Strait Islander people across our region.

- **Culturally Competent Mainstream Services**

  Aligns to Priority Reform; Improving mainstream institutions

  Our PHN will ensure our organisation and the services we commission are accountable for Closing the Gap and are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people. We will also aim to improve the cultural awareness and competency of mainstream primary care services to decrease the number of Aboriginal and Torres Strait Islander people who experience racism and who feel culturally unsafe in dealing with mainstream institutions.

NEEDS ASSESSMENT PRIORITY

Darling Downs and West Moreton Live Health Needs Assessment 2022/24.

NEEDS ASSESSMENT PRIORITY
Health for Aboriginal and Torres Strait Islander People

E: info@ddwmphn.com.au www.ddwmphn.com.au

phn
DARLING DOWNS
AND WEST MORETON

An Australian Government Initiative

E: info@ddwmphn.com.au

P: 07 4615 0900

W: www.ddwmphn.com.au

Darling Downs Office

Level 1, 162 Hume Street
(PO Box 81),
Toowoomba QLD 4350

West Moreton Office

Level 5, World Knowledge Centre,
37 Sinnathamby Boulevard,
Springfield Central QLD 4300

Local Integrated
Primary Health Care

ABN 51 605 975 602