Australian Government
Department of Health

phn
An Australian Government Initiative

Updated Activity Work Plan 2016-2018: Integrated Team Care Funding

The Activity Work Plan template has the following parts:

1. The updated Integrated Team Care Annual Plan 2016-2018 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 updated Budget for Integrated Team Care funding for 2016-2018.

Brisbane South PHN

When submitting this Activity Work Plan 2017-2018 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

The Activity Work Plan must be lodged via email to *Qld_PHN@health.gov.au* on or before 17 February 2017

Overview

This updated 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 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 2018-19 at a later date.

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

Aboriginal and Torres Strait Islander health is one of the six national priorities identified by the Federal Government. There are approximately 25,000 people within the Brisbane South PHN region who identify as being of Aboriginal and/or Torres Strait Islander origin. Whilst the majority of Queenslanders enjoy prosperity against most measures of wellbeing, such as education, employment and health, data continues to show a pronounced difference or 'gap' between Aboriginal and Torres Strait Islander, and non-Aboriginal and Torres Strait Islander Queenslanders.

The Brisbane South PHN strategic vision for the Integrated Team Care (ITC) program is to improve access to the most appropriate health services for Aboriginal and Torres Strait Islander peoples at the right time and in the right place. This is with a view to reduce preventable hospital admissions and emergency department presentations, improve understanding and appropriate use of the healthcare system, and support Aboriginal and Torres Strait Islander peoples to take part in a healthy lifestyle.

Brisbane South PHN worked in partnership with Brisbane North PHN (BNPHN), Gold Coast PHN (GCPHN) and Darling Downs West Moreton PHN (DDWMPHN) to commission the ITC program through a single service provider. The Improving Indigenous Access to Mainstream Primary Care (IIAMPC) component of the ITC funding will be delivered through a formal Services Agreement with the Institute of Urban Indigenous Health (IUIH) from 1 January 2017 to 30 June 2018. The Care Coordination and Supplementary Services (CCSS) component will be delivered through a formal Agency Agreement with BNPHN (and by subcontract, IUIH) from 1 July 2016 to 30 June 2018.

Activities included in this Activity Work Plan will address key areas for action identified through the Brisbane South PHN Whole of Region Needs Assessment and consultation undertaken with key stakeholders:

- Improved access to mainstream primary care services
- Improved access to coordinated and multidisciplinary care through place-based services and support
- Increased capacity of mainstream primary care services to deliver culturally appropriate and relevant services
- Improved coordination and collaboration across primary health care and relevant community services
- Improved community engagement, health literacy and systems navigation.

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 2016-18. These activities will be funded under the IAHP Schedule for Integrated Team Care.

Proposed Activities	
ITC transition phase	Brisbane South PHN worked closely with BNPHN, GCPHN, DDWMPHN and IUIH to plan the transition of the ITC program to a commissioned service provider. Brisbane South PHN appointed BNPHN as its agent (under a formal Agency Agreement) to assist in the management and distribution of ITC funding for care coordination and supplementary services, whereby BNPHN subcontracts IUIH. The Agency Agreement between Brisbane South PHN and BNPHN is for the period 1 July 2016 to 30 June 2018. Brisbane South PHN has commissioned IUIH (under a formal Services Agreement) for the delivery of the remaining ITC activities provided by Indigenous Health Project Officers (IHPOs) and Outreach Workers. The Services Agreement between Brisbane South PHN and IUIH is for the period 1 January 2017 to 30 June 2018. The ITC program has now been successfully commissioned in full.
Start date of ITC activity as fully commissioned	1 January 2017
Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?	Brisbane South PHN will continue to work closely with key sectorial partners including IUIH, Aboriginal and Torres Strait Islander Health Services (AMSs), Community Elders and members, non-government organisations, private service providers, Metro South Hospital and Health Service (MSHHS), and federal, state and local governments to ensure that planned actions are delivered.
Indigenous sector engagement	In line with ITC objectives, Brisbane South PHN and commissioned service providers are required to foster collaboration and support between mainstream, and Aboriginal and Torres Strait Islander health sectors. Brisbane South PHN will continue to work closely with groups within the Aboriginal and Torres Strait Islander sector, including IUIH, AMSs, Community Elders and members, non-government organisations, private service providers, MSHHS, and federal, state and local governments to ensure that planned actions meet emergent community needs.

Description of ITC Activity	The aims of the ITC program 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 are to:
	1. 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
	2. foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors
	3. improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people
	4. 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
	5. support mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify, and
	6. increase awareness and understanding of measures relevant to mainstream primary care.
	ITC is provided by teams of IHPOs, Care Coordinators and Outreach Workers who work in the Brisbane South PHN region across both mainstream, and Aboriginal and Torres Strait Islander health sectors.
	The ITC workforce employed by IUIH as noted under ITC Workforce will help to ensure the following key tasks are undertaken by IUIH.
	The Brisbane South PHN-IUIH Service Level Agreement states that to deliver the ITC program, IUIH must:
	• ensure IHPOs and Outreach Workers work collaboratively with service providers in order to link patients with the applicable services
	• establish links with other Indigenous Chronic Disease Package and Indigenous Australian's Health Program initiatives including the Community Controlled Health Service sector and mainstream health service sector
	• ensure the IHPOs and Outreach Workers:
	  ○ arrange services as required and assist patients to attend appointments
	  ○ check medical records are complete and current
	  ○ check that regular reviews are undertaken by the patient's primary care providers
	  ○ attend the yearly South East Queensland ITC Forums
	  ○ present at the yearly South East Queensland ITC Forums on request
	  ○ attend and present at quarterly PHN stakeholder meetings

	○ attend and present at monthly meetings with Brisbane South PHN ○ update and maintain a webpage within the IUIH website dedicated to ITC which contains the ITC referral form, which will be GP software compatible • develop ITC communication tools and resources in consultation with Brisbane South PHN and should acknowledge the support of Brisbane South PHN, as well as Funding from the Department of Health, in all communication materials when promoting the ITC program. The roles and responsibilities of IHPOs, Care Coordinators and Outreach Workers are documented in Integrated Team Care Activity Implementation Guidelines 2016-2017 to 2017-18 (the Guidelines). In order to fulfil their roles, the work of the ITC team may include: IHPOs • promoting the objectives and outcomes of the ITC program to community organisations, for example through websites, conference presentations, at meetings and in reference groups for other projects; • 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; • promoting mainstream primary care providers to Aboriginal and Torres Strait Islander people as a valid, trustworthy and accessible first point of health care; • assisting mainstream primary care providers to manage specific Aboriginal and Torres Strait Islander health needs and issues; • 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; • disseminating information about the availability of programmes (Commonwealth, state and local) that provide services for Aboriginal and Torres Strait Islander people (e.g. Medical Outreach – Indigenous Chronic Disease Programme (MOICDP), Visiting Optometrists Scheme (VOS), and the Rural Health Outreach Fund (RHOF); • developing and disseminating resources for Aboriginal and Torres Strait Islander people about accessing services and managing chronic disease; • developing and mapping referral pathways that incorporate available services at the local, regional and jurisdictional level; and • assisting with programme and service coordination.

	Care Coordinators • 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 there are arrangements in place for the patient to get to appointments; • involving the patient's family or carer as appropriate; • transferring and updating the patient's medical records; • 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 program 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. For care coordination to be effective, Care Coordinators need to work collaboratively with the services in their local areas, including services provided by state/territory governments, local governments and non-government organisations, in order to link patients with the services they need. Where appropriate, Care Coordinators are required to establish links with other relevant activities (for example, MOICDP, which provides for outreach services delivered by multidisciplinary teams). They are also expected to work in collaboration with IHPOs and Outreach Workers.

	Outreach Workers • 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; • 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: - attend appointments with referred specialist services and care coordination, as necessary; - attend appointments for relevant diagnostic tests and /or referrals to other primary health care providers (including allied health); - collect prescribed medications from the pharmacist; - return for follow up appointments with their GP and/or practice nurse; and - fill out forms and understand instructions from reception staff. • encouraging Aboriginal and Torres Strait Islander people to: - identify their Aboriginal and/ or Torres Strait Islander status; and - register for a Medicare card. • providing support for outreach/visiting health professionals where required; • distributing information to Aboriginal and Torres Strait Islander people about how to access available services (e.g. care coordination, PBS co-payment). The Brisbane South PHN-IUIH Services Agreement (non-clinical services) also states that IUIH must deliver cultural awareness training that meets the Practice Incentives Program Indigenous Health Incentive accreditation requirements for general practice and their staff. Training must be delivered to at least 40 individuals, through at least 2 group training sessions (spaced approximately 6 months apart), in the Brisbane South region each year. The IUIH Project Plan outlines the following activities to be undertaken in order to meet this requirement and, more broadly, assist mainstream primary care services to become more culturally competent: • identify and promote opportunities for engagement, networking and exchange between mainstream primary care and Aboriginal and Torres Strait Islander community controlled health sector staff in the context of educational events, in-service training, community activities and other events • encourage specific workforce skills and knowledge exchange, for example, through visits by mainstream primary care practice managers and key clinical staff to Aboriginal and Torres Strait Islander community controlled health sector clinics, and vice versa

	• review, refine and continue to deliver a tailored package of accredited cultural awareness training developed by the IUIH team and to offer delivery of the training for mainstream primary care providers, either on site at individual practices or for groups of practice staff in an off-site location • continue to refine and improve training in the application of MBS items which form an important part of the cycle of care for Aboriginal and Torres Strait Islander clients, as a component of the cultural training package delivered to mainstream general practice staff • build on the relationships established during delivery of the formal cultural training package to provide the opportunity for ongoing contact and reflective learning with the ITC team beyond the short period of the "introductory" training • actively promote community and cultural events to mainstream practices, providing linkages to facilitate attendance and participation of practice staff • provide more intensive support and mentorship for mainstream primary care providers: (1) in areas where access to services provided by Aboriginal and Torres Strait Islander community controlled health services is limited; and (2) mainstream general practices demonstrating a strong commitment to enhancing their accessibility and responsiveness to the needs of their local Aboriginal and Torres Strait Islander populations • support provision of timely advice, support and assistance for mainstream primary care providers to enhance understanding of the needs of Aboriginal and Torres Strait Islander clients and to improve engagement and accessibility of services overall • continue to develop, refine and deliver specific strategies for working with pharmacies to address gaps in knowledge and capacity in delivering services for Aboriginal and Torres Strait Islander people; continue to draw on the networks and expertise of the IUIH Regional Pharmacist to assist with engagement and peer education, as well as developing / refining CTG co-payment scheme educational resources and tools. *Outputs* Brisbane South PHN must oversee the monitoring and performance of the ITC program using the reporting template provided by DOH in the Indigenous Australians' Health Programme Funding Schedule and, as the commissioned service provider, IUIH must ensure that data is submitted in accordance with these reporting requirements. As part of the mandatory reporting template, IUIH will also be required to comment on: • activities undertaken in the Brisbane South PHN region to meet the needs of Aboriginal and Torres Strait Islander peoples receiving care coordination under the ITC program • how referral, intake and discharge processes are supporting Aboriginal and Torres Strait Islander peoples receiving care coordination under the ITC program

	• work that has been done to address barriers to accessing mainstream services for Aboriginal and Torres Strait Islander peoples, including helping services to become more culturally appropriate
	• activities and approaches that have been implemented to improve culturally safe workplaces and services, for example, cultural awareness training.
	
	As part of the formal Services Agreement, IUIH must also undertake the following activities:
	
	• Actively participate in meetings and forums with stakeholders, general practices and Brisbane South PHN
	  ○ Attend all monthly meetings with Brisbane South PHN, and the annual SEQ ITC forum
	• Actively promote a feedback approach to clients
	  ○ Return of at least of 6 Patient Opinion reports and other feedback reports as mutually agreed to
	• Delivery of cultural awareness training programs that meets Practice Incentive Program Indigenous Health Incentives accreditation requirements for general practice and their staff
	  ○ Delivery of at least 2 programs in the Brisbane South PHN region spaced approximately 6 months apart each year
	  ○ Delivery of training to at least 40 individuals in the Brisbane South PHN region each year
	• Actively engage general practice, allied health, pharmacy and other health professionals when delivering services
	  ○ Engagement with 25 general practices in the Brisbane South PHN region each quarter
	  ○ Engagement with 25 allied health, pharmacy and other health professionals in the Brisbane South PHN region each quarter
	
	Short-term outcomes
	
	• High levels of stakeholder satisfaction
	• Improved health professional knowledge and confidence
	• Positive consumer experience and satisfaction
	• Increased access to culturally-appropriate healthcare treatment across mainstream, and Aboriginal and Torres Strait Islander health sectors
	• Improved health literacy
	• Demonstrated value for money of service
	• Reduced potentially preventable hospital admissions, emergency department presentations and length of stay
	• Improved collaboration regarding integration with secondary and tertiary sector
	
	Long-term outcomes
	
	• Service profile meets the needs of the population
	• Improved access
	• Improved patient health and wellbeing
	• Improved system level value for money

<table>
<tr><td>ITC Workforce</td><td>For the period 1 July 2016 – 31 December 2016:
<table><tr><th>Position</th><th>No. of employees</th><th>FTE</th><th>Organisation</th></tr><tr><td>IHPO</td><td>2</td><td>2</td><td>Brisbane South PHN</td></tr><tr><td>Care Coordinator</td><td>8</td><td>8</td><td>IUIH</td></tr><tr><td>Outreach Worker</td><td>3</td><td>3</td><td>Brisbane South PHN</td></tr></table>As the ITC program has been successfully commissioned in full all IHPOs, Care Coordinators and Outreach Workers are now employed by IUIH.

In the immediate term, it is expected that the make-up of the ITC workforce will continue without significant change. In reviewing agreed work plans and budgets, Brisbane South PHN will liaise with IUIH to ensure appropriate resources are deployed to meet the program objectives.</td></tr>
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