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

Brisbane North 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

Through the activities described in this Activity Work Plan, the Brisbane North PHN aims to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and improve coordination of care to ensure patients receive the right care in the right place at the right time by working towards our strategic vision and goals as documented below.

The Board of Brisbane North PHN endorsed our Strategic Plan 2016-2019 in March 2016. Our vision of a community where good health is available for everyone is underpinned by the following three strategic goals.

By working with others we will:

1. Re-orient the health system toward care in our community
   Evidence shows that best population health outcomes are achieved in systems with strong investment in primary health care. Australians prefer to live healthy lives, in their own homes, as long as possible.

2. Achieve a health and community care system responsive to consumer need
   Building responsive systems requires consumers who are health literate, channels through which needs can be expressed, and providers and funders who are willing and able to shape care delivery according to those expressed needs.

3. Target resources to best meet health and community care needs for our region
   The PHN is committed to managing its resources to achieve maximum efficiency and effectiveness. Alone, the PHN’s resources are insufficient to meet the needs of our region, leading the PHN to adopt a collective impact approach, influencing others to work in a more coordinated fashion on common goals. As a commissioning agency, the PHN targets resources in accordance with community-led plans to ensure the most equitable delivery of services.

The PHN South East Queensland Integrated Team Care Annual Plan 2017-18 (Attachment 2) demonstrates how the PHN will achieve the Integrated Team Care objectives.
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.

<table>
<thead>
<tr>
<th>Public Accountability</th>
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<tr>
<td>What are the sensitive components of the PHN’s Annual Plan?</td>
<td>All financial aspects of the ITC program are considered sensitive and will not be uploaded to the Brisbane North PHN website.</td>
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<th>Proposed Activities</th>
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<td>ITC transition phase</td>
<td>Brisbane North PHN and its predecessor the Medicare Local has commissioned the same service provider to deliver Integrated Team Care (ITC) and the predecessor programs since 2001. This service provider has delivered all aspects of the ITC program from 1 July 2016 in the Brisbane North PHN region. Accordingly, the six-month transition phase did not affect Brisbane North PHN and there was no disruption to the program in the Brisbane North region.</td>
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<td>Start date of ITC activity as fully commissioned</td>
<td>1 July 2016.</td>
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<td>Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?</td>
<td>Four PHNs in South East Queensland (SEQ) (Brisbane North, Brisbane South, Gold Coast and Darling Downs &amp; West Moreton) have contracted the Institute for Urban Indigenous Health (IUIH) to deliver the Integrated Team Care program. This has been achieved by the other three PHNs channelling ITC funding through a single contract between Brisbane North PHN and IUIH. Individual Agency Agreements have been negotiated between Brisbane North PHN and the other three PHNs.</td>
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<td>Service delivery and commissioning arrangements</td>
<td>ITC services have been commissioned in line with Brisbane North PHN’s Commissioning Framework (see Attachment 1). The delivery of ITC services were procured through a direct engagement method to an existing local provider, IUIH. A local and regional plan has been formulated through collaboration and a co-design process. The IUIH continues to deliver the program in conjunction with its member Aboriginal and Torres Strait Islander community controlled health services and other primary health care services. Program staff are positioned in community controlled health services and other IUIH premises throughout the region.</td>
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<td>Decision framework</td>
<td>In the 2016 Brisbane North PHN Health Needs Assessment, Indigenous health was identified as one of the five priority themes. It was acknowledged that, “Aboriginal and Torres Strait Islanders experience significant health inequalities across a number of indicators which is resulting in poorer life expectancy than the population as a whole”. As part of the commissioning process, a range of stakeholders, which included members of the PHN Clinical Council and Community Advisory</td>
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Committee, participated in co-design workshops to assist in activity planning and provided input on identified needs and proposed solutions. Based on the ITC guidelines and market analysis, Brisbane North PHN concluded that there is one Indigenous health organisation in the region that could successfully deliver the ITC program at the required scale.

This organisation (IUIH) oversees five community controlled health services in the region, which are all involved in the ITC through the placement of a Care Coordinator in their practices. This organisation had successfully delivered the Care Coordination and Supplementary Services program since its inception in 2011.

Accordingly, Brisbane North PHN took a direct approach in commissioning IUIH for ITC activities.

Brisbane North PHN is progressing a planned Aboriginal and Torres Strait Islander Engagement project. This project aims to develop a regional framework which will broaden engagement with Aboriginal and Torres Strait Islander communities in order to enhance planning, commissioning and evaluation of health services within the Brisbane North and Moreton Bay regions.

Project partners will include IUIH and the Metro North Hospital and Health Service.

Brisbane North PHN’s commissioning decision is based on the historical success of program delivery by IUIH, consultation with the Department of Health and ensuring continuity of service delivery.

IUIH has been successful in delivering the Care Coordination and Supplementary Services program since it began. There exists a strong relationship between the PHN and IUIH and positive past experience has contributed to this commissioning decision.

There has been close consultation between the Department of Health and the PHN on ITC matters. Department of Health contacts are aware of the established IUIH partnership and the success of past programs.

Continuity of services played a role in the procurement decision. IUIH had been delivering the Care Coordination and Supplementary Services and this enabled a seamless transition to the ITC.

The IUIH has been contracted to deliver all aspects of the ITC in the Brisbane North PHN region. Through the single contract between Brisbane North PHN and the IUIH, the IUIH deliver only the Care Coordination and Supplementary Services component of the ITC program in the Brisbane South, Gold Coast and Darling Downs & West Moreton PHN regions.

Brisbane North PHN play an important role in bringing the four PHNs and the IUIH together to make the ITC a success. As Brisbane North PHN is the lead PHN in this model, the PHN facilitates regular meetings with PHNs and IUIH to stay informed and connected to the program. Brisbane North PHN also facilitates an ITC forum to highlight ITC activities and bring stakeholders together to network and build relationships.

For a full description of the *South East Queensland Integrated Team Care Annual Plan 2017-18*, see Attachment 2.

In the Brisbane North PHN region the commissioned IUIH ITC team consists of:
• two Indigenous Health Project Officers
• two Outreach Workers and
• six Care Coordinators, 5 of whom are positioned in AMSs.

On a South East Queensland scale (which includes Brisbane North, Brisbane South, Gold Coast and Darling Downs & West Moreton PHN regions), Care Coordinators are positioned in all of the IUIH affiliated AMSs*. There are a total of 24 FTE spread out among the 18 AMSs in South East Queensland. Included in the 24 FTEs, are 4 mainstream Care Coordinators and 1 Care Coordinator manager.

Locations of SEQ AMSs include:

Moreton Aboriginal and Torres Strait Islander Community Health Service
• Caboolture Clinic
• Morayfield Clinic
• Strathpine Clinic
• Deception Bay Clinic.

Aboriginal and Torres Strait Islander Community Health Service Brisbane
• Brisbane Clinic
• Acacia Ridge Clinic
• Browns Plains Clinic
• Logan Clinic
• Woodridge Mums & Bubs
• Northgate Clinic.

Kambu
• Ipswich Clinic
• Laidley Clinic
• Goodna Clinic.

Kalwun Health Service
• Miami Clinic
• Oxenford Clinic
• Bilinga Clinic.

Yulu-Burri-Ba
• Dunwich Clinic
• Capalaba Clinic.

*AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services
South East Queensland
Integrated Team Care (ITC) Annual
Plan 2017-18

The aims of the ITC Activity are to:

1. 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

2. 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.

This action plan provides an outline of activities to be conducted under the ITC program to be delivered by IUIH on behalf of the SEQ PHNs, namely:

1. Brisbane North PHN
2. Brisbane South PHN
3. Gold Coast PHN
4. Darling Downs West Moreton PHN, for the geographical area overlapping with the IUIH footprint.

This Plan reflects the 6 key Objectives of the new Integrated Team Care (ITC) program, and operates under the principles identified in the National Indigenous Reform Agreement and recognised in the Commonwealth Department of Health ITC Activity Implementation Guidelines 2016-17 – 2017-18, namely:

Priority principle: Programmes and services should contribute to Closing the Gap by meeting the targets agreed by the Council of Australian Governments (COAG) while being appropriate to local needs.

Indigenous engagement principle: Engagement with Aboriginal and Torres Strait Islander men, women, children and communities should be central to the design and delivery of programmes and services.

Sustainability principle: Programmes and services should be directed and resourced over an adequate period of time to meet the COAG targets.

Access principle: Programmes and services should be physically and culturally accessible to Aboriginal and Torres Strait Islander people and recognise the diversity of Indigenous populations.

Integration principle: There should be collaboration between and within governments at all levels and their agencies to effectively coordinate programmes and services.

Accountability principle: Programmes and services should have regular and transparent performance monitoring, review and evaluation.
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<td><strong>Objective 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</strong></td>
<td>Provide overall ITC program coordination regionally, building on a proven and effective method of delivering care coordination and supplementary services for Aboriginal and Torres Strait Islander people; support quarterly meetings of the full ITC regional team to foster collaboration, integration and a culture of reflection and continuous quality improvement in care for Aboriginal and Torres Strait Islander people with complex chronic conditions.</td>
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<td>Optimise the integration of funding streams and services for Aboriginal and Torres Strait Islander people with chronic conditions through ITC program managers working alongside (1) the SEQ Outreach Services Regional Coordinator; (2) Senior program staff in IUIH including Clinical Director, managers of Allied Health, Social Health, Eye Health and Oral Health services; and (3) Senior PHN practice and program staff across the region.</td>
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<td>Maintain a skilled, cultural competent and responsive team of Care Coordinators across the region through (1) targeted recruitment processes building on cumulative knowledge of the skills, qualities and characteristics likely to provide best fit for the roles, including active strategies to recruit Aboriginal and Torres Strait Islander professionals to CC roles; (2) comprehensive induction and training, including cultural competency training and ongoing cultural mentorship; (3) facilitated supervision and reflective practice, and (4) provision of regional back-fill for Care Coordinators to effectively support periods of staff leave.</td>
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<td>Foster close working relationships between Care Coordinators and individual clinics through local GPs and practice managers, and in the case of mainstream general practices, through IHPOs and alongside Outreach Workers, to promote effective local systems for chronic disease management – including uptake of chronic disease care planning and multidisciplinary team care arrangements, care plan review and case conferencing.</td>
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<td>Maintain a strength-based approach by Care Coordinators, focusing on the needs of the client in the context of their home and family, building on identified strengths to support clients to gain knowledge and skill in managing their chronic conditions into the future.</td>
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<td>Deliver a regionally coordinated approach to the purchasing and supply of medical aids available through the supplementary services scheme, generating significant savings per client accessing the scheme, and ensuring that maximum reach and benefit can be obtained from the available supplementary services pool.</td>
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<td>Bring together all regional Care Coordinators monthly to share learnings and to foster systems and processes for continuous quality improvement in complex chronic disease care.</td>
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<td>Adapt the existing IUIH CCSS regional hotline to assume the role of a regional ITC program Hotline, providing a single point of contact for information, advice and connection with relevant services for providers and for clients and community.</td>
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| **Objective 2: Foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors** | Maintain regular meetings of the PHN practice support staff and IUIH ITC program managers and senior workers, ensuring close communication and collaboration at program delivery level.  
Maintain regular meetings of Senior IUIH and PHN staff (CEOs, Senior Managers) – at least 6 monthly.  
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. |
| **Objective 3: Improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people** | 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 on the north side of Brisbane 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. |
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<td>Objective 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</td>
<td>Continue to capitalise on the success of the Deadly Choices campaign, including marketing, merchandise, and community engagement strategies to build health literacy and to encourage knowledge about – and uptake of – comprehensive preventive health assessments. Provide opportunities for mainstream general practice staff to learn practice tips and skills in the implementation of MBS items such as the preventive health assessment (item 715), including through one-to-one training by Aboriginal and Torres Strait Islander nurses employed by IUIH, where a practice demonstrates commitment to building these skills in their workforce. Support individual mainstream general practices, particularly those with significant numbers of Aboriginal and Torres Strait Islander clients, to monitor the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule (MBS) items through their practices, and to provide feedback to managers and staff on progress against these item numbers over time. Work closely with BNPHN program staff to collect and collate data on overall uptake of Aboriginal and Torres Strait Islander specific MBS items across the north side of Brisbane. Utilise promotional and educational opportunities arising at community events, with local community agencies and with individual clients supported by the ITC team to encourage uptake of MBS items such as the preventive health assessment (item 715) by Aboriginal and Torres Strait Islander clients. Utilise the role of the Indigenous Outreach Workers to actively support Aboriginal and Torres Strait Islander clients to attend for preventive health assessments, and to support active recall and assistance with transport where needed to access ongoing follow up services.</td>
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<td>Objective 5: Support mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify</td>
<td>Provide education, in-service training and mentorship for mainstream primary care providers – in particular practice managers and reception staff, to promote awareness of the importance of identifying and recording Aboriginal and Torres Strait Islander status for all clients, and to build skills in encouraging Aboriginal and Torres Strait Islander clients to self-identify. Continue to deliver training for mainstream primary care providers on strategies to increase identification of Aboriginal and Torres Strait Islander people, as a core component of the accredited Cultural Training package. Actively identify opportunities through (1) resources including flyers and posters in clinics; (2) local community groups; and (3) community events, to raise awareness and confidence amongst Aboriginal and Torres Strait Islander people to self-identify.</td>
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<td>Objective 6: Increase awareness and understanding of measures relevant to mainstream primary care</td>
<td>Disseminate information about the availability of key programmes that provide targeted services for Aboriginal and Torres Strait Islander people including MOICDP / Outreach Services, IUIH Home Support (Community Aged Care Services), ITC Outreach Worker support, Care Coordination and Supplementary Services components of the ITC package, IUIH Connect, and other relevant programs and services. Provide opportunities, as outlined throughout this plan, for training in the availability and implementation of key CTG measures including CTG Co-payment scheme, PIP IHI program, and MBS measures specific to and/or important for the provision of comprehensive care for Aboriginal and Torres Strait Islander people.</td>
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