Australian Government
Department of Health

phn
An Australian Government Initiative

Updated Activity Work Plan 2018-2021: Integrated Team Care Funding

The Activity Work Plan template has the following parts:

1. The updated Integrated Team Care Annual Plan 2018-2019 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 2018-2021 (attach an excel spreadsheet using template provided).

Gold Coast PHN

When submitting this Activity Work Plan 2018-2019 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

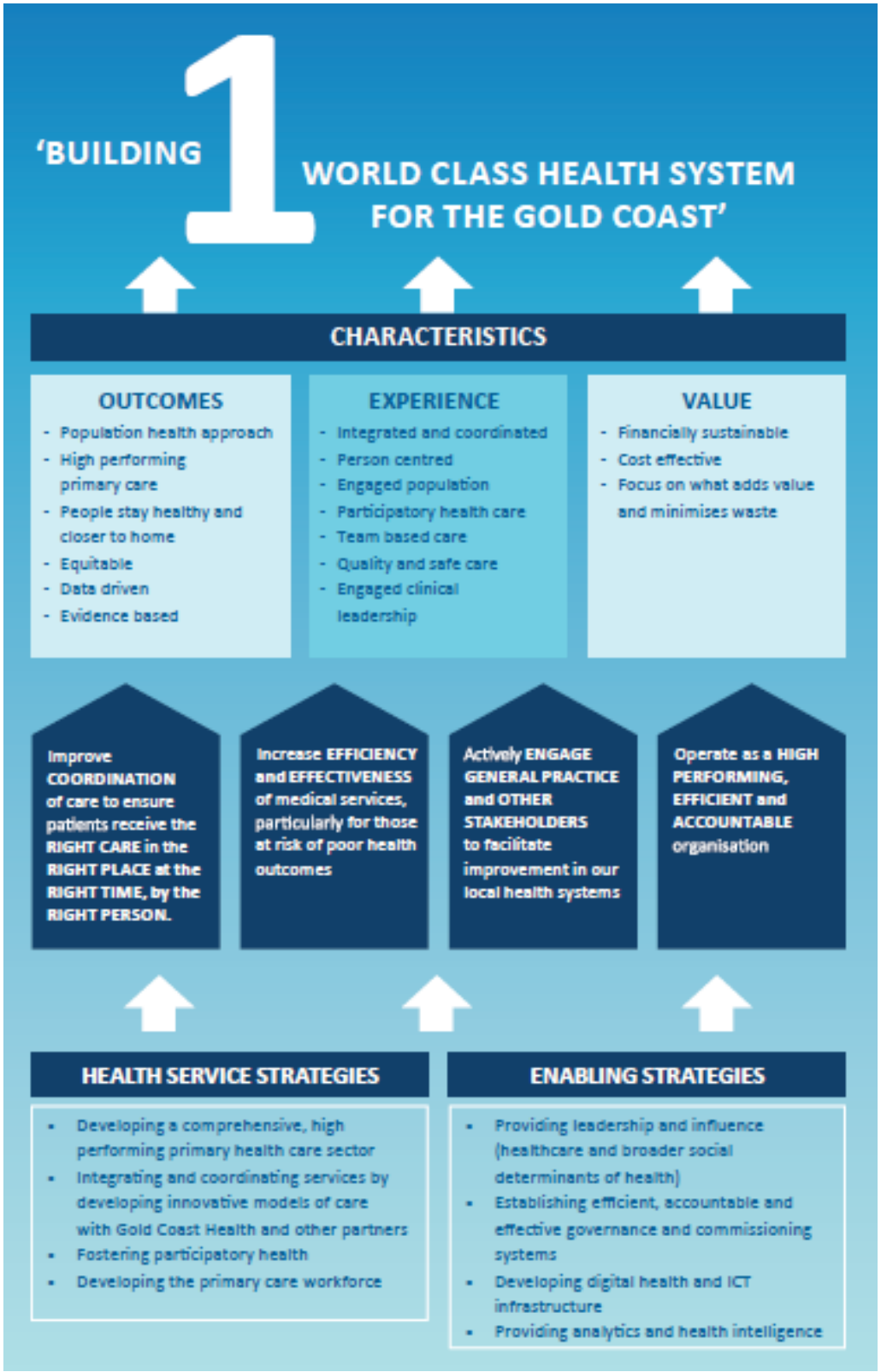
The Activity Work Plan must be lodged via email to *Qld_PHN@health.gov.au* on or before 30 April 2018

Overview

This updated Activity Work Plan covers the period from 1 July 2018 to 30 June 2019. To assist with PHN planning, each new activity nominated in this work plan should be proposed for a period of 12 months.

(a) Strategic Vision for Integrated Team Care Funding

On 1 July 2015, the Primary Care Gold Coast commenced as the Gold Coast PHN, establishing its vision and goals aligned with Commonwealth government expectations. Our Vision is 'Building one world class health system for the Gold Coast". GCPHN's Strategic plan sets out what the characteristics of one world class health system for the Gold Coast are as depicted in the below diagram. The Strategic Goals and Strategies to achieve our Vision are underpinned by a commitment to the Triple Aims of improving Outcomes, Experience and Value.


'BUILDING 1 WORLD CLASS HEALTH SYSTEM FOR THE GOLD COAST'
CHARACTERISTICS
OUTCOMES
- Population health approach
- High performing primary care
- People stay healthy and closer to home
- Equitable
- Data driven
- Evidence based
EXPERIENCE
- Integrated and coordinated
- Person centred
- Engaged population
- Participatory health care
- Team based care
- Quality and safe care
- Engaged clinical leadership
VALUE
- Financially sustainable
- Cost effective
- Focus on what adds value and minimises waste
Improve COORDINATION of care to ensure patients receive the RIGHT CARE in the RIGHT PLACE at the RIGHT TIME, by the RIGHT PERSON.
Increase EFFICIENCY and EFFECTIVENESS of medical services, particularly for those at risk of poor health outcomes
Actively ENGAGE GENERAL PRACTICE and OTHER STAKEHOLDERS to facilitate improvement in our local health systems
Operate as a HIGH PERFORMING, EFFICIENT and ACCOUNTABLE organisation
HEALTH SERVICE STRATEGIES
- Developing a comprehensive, high performing primary health care sector
- Integrating and coordinating services by developing innovative models of care with Gold Coast Health and other partners
- Fostering participatory health
- Developing the primary care workforce
ENABLING STRATEGIES
- Providing leadership and influence (healthcare and broader social determinants of health)
- Establishing efficient, accountable and effective governance and commissioning systems
- Developing digital health and ICT infrastructure
- Providing analytics and health intelligence

Aboriginal and Torres Strait Islander Health is one of the 6 national priority areas for PHNs. Over the next 3 years, GCPHN has set the strategic KPI for Aboriginal and Torres Strait Islander health as:

“Improvements to clinical indicators for Chronic Disease management (Diabetes, CKD, COPD, CHD).”

This will be achieved through the objectives and activities of the ITC program as documented in this Activity Work Plan.

Indigenous health checks are essential to effectively identify those at risk of chronic disease and those at an early stage and improve self-management. Over the past 12 months (to March 2018) approximately 3,338 Item 715 ATSI Health Checks have been completed by mainstream practices and Kalwun Health Service (2,711 by Kalwun and 627 by mainstream). The ongoing work of the ITC program will continue to see these numbers increase.

GCPHN will continue to collaborate with Kalwun Health to collect de-identified data on all patients both Aboriginal & Torres Strait Islander and non-Indigenous. This data will be aggregated with mainstream general practice data to commence comparing clinical outcomes of indigenous v’s non- indigenous patients.

The data analysis will highlight the patients at highest risk of poor outcomes, and focus resources to ensure their care is better coordinated. This standardised approach across both Aboriginal & Torres Strait Islander and non-Indigenous service providers will ensure mainstream services are culturally competent with the aim of increasing access for Aboriginal & Torres Strait Islander patients to these services.

In order to achieve this a strong working partnership will be maintained between Institute of Urban Indigenous Health (IUIH), GCPHN, Kalwun Development Corporation (Kalwun Health, the only local Aboriginal Medical Service), Gold Coast Hospital and Health Service (GCH) and other providers of A&TSI services including mainstream providers within the Gold Coast region.

1. (b) Planned activities funded by the Indigenous Australians' Health Program Schedule for Integrated Team Care Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2018-19. 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	NIL

Proposed Activities	
ITC transition phase	GCPHN ITC program was fully commissioned as of 1 October 2016.
Start date of ITC activity as fully commissioned	1 October 2016 Kalwun Development Corporation (Kalwun) (the only Gold Coast Aboriginal Medical Service (AMS) was commissioned to deliver the Aboriginal Health Worker (AHW) and Project Officer (PO) components of the program. The Care Coordination and Supplementary Services (CCSS) delivery continues to be commissioned to the Institute of Urban Indigenous Health (IUIH) through Brisbane North PHN from July 2016.
Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?	GCPHN works in collaboration with the following stakeholders to complete and inform the needs assessment and determine locally appropriate and integrated service solutions: • the Karulbo Partnership (a local regular meeting with representation from organisations working in relation to A&TSI health and wellbeing with around 30 attendees at meetings) • the A&TSI community • Kalwun (AMS), • Institute of Urban Indigenous Health (IUIH) • Gold Coast Health – Aboriginal & Torres Strait Islander Services • other health and social service providers. South East Queensland PHNs collaborated to jointly commission the CCSS service delivery component to IUIH (through a single contract managed by Brisbane North PHN) with a renewed contract in place from 1 July 2018, this enables pooling of supplementary service funds. Quarterly meeting is held between all South East Queensland PHN and IUIH to review process across ITC.
Service delivery and commissioning arrangements	GCPHN will continue to directly commission the mainstream component of program to Kalwun (AMS) from 1 July 2018 to 30 June 2019. The CCSS service delivery component will continue to be commissioned to IUIH (through a single contract managed by Brisbane North PHN) from 1 July 2018 to June 30 2019.

Decommissioning	N/A
Decision framework	Needs assessment and market analyses is an ongoing process conducted through the annual GCPHN Needs assessment. This involves partnership and consultation with Indigenous organisations and the Karulbo Partnership, Clinical Councils and Community Advisory Committees who provided advice to the Board which informed the development of the Activity Work Plan and commissioning approach. GCPHN has made the decision to continue to contract IUIH to deliver the Care Coordination and Supplementary Services (CCSS) component through Brisbane North PHN as this has been a Directive from DoH since 2016. GCPHN has made the decision to continue to contract Kalwun for the Aboriginal Health Worker (AHW) and Project Officer (PO) components of the program. The decision was based on past performance and feedback from an independent consultant that Kalwun was demonstrating outcomes and capability of a highly effective integrated care organisation.
Indigenous sector engagement	Engagement is regularly held with Indigenous organisations and reviewed during its development by the Karulbo Partnership, Clinical Councils and Community Advisory Committees who provided advice to the Board on the Activity Plan. GCPHN is a member of a regional Indigenous health planning stakeholder group to ensure a collaborative approach. Other members include Kalwun, Gold Coast Health and IUIH. This group will be engaged throughout planning process to ensure advice and input from all key stakeholders.
Decision framework documentation	GCPHN's commissioning framework aligns with the DoH requirements under Item B.3 of the ITC Schedule. In relation to the CTG increasing indigenous access to mainstream services program through the Aboriginal Health Worker (AHW) and Project Officer (PO) our decision-making process followed the framework as follows: A needs assessment was conducted that indicated the most appropriate provider for the program was an Indigenous health organisation, with proven expertise in providing highly effective and culturally appropriate holistic health services to the local population. Additionally, it was assessed that considerable efficiencies could be attained, and duplication and waste reduced, through the delivery of the mainstream access program with other AMS programs targeting the population that does attend the Indigenous AMS. Some of these include efficiency in consistent strategy, coordination of services, including reducing the likelihood of duplicated services, and consistency and economies in the development and delivery of relevant training, staff mentoring and professional development. Also considered critical as part of the needs assessment was that any potential service provider was well respected and supported by the local Indigenous population. The alignment between the objectives of this program and the contractual obligations and deliverables required of an

	AMS, were also considered an important consideration to achieve efficiencies in the delivery of these services. As a result a decision was made that if possible these programs be undertaken under a single governance structure within a service provider, in this case an AMS. An assessment of the market determined that there was only one organisation on the Gold Coast that met this criteria, that being Kalwun Health Services as the sole AMS on the Gold Coast. The proposal to commission this component of the ITC program was considered and supported by the Karulbo Indigenous Network that includes representatives from local Elders, health and community service delivery organisations and the GCHHS. The Karulbo Indigenous Network agreed to provide ongoing community engagement, monitoring and input into the program to ensure that it meets the needs of the local population.
Description of ITC Activity	The aim of the ITC program is to improve health equity for Aboriginal and Torres Strait Islander people through culturally appropriate mainstream primary care, provide assistance to Aboriginal and Torres Strait Islander people to obtain primary health care as required, and provide care coordination services to eligible people with chronic disease who require coordinated, multidisciplinary care. Details of delivery of components of model: GCPHN- Commissioner of Services • Increasing awareness of and maximising links between services for Aboriginal and Torres Strait Islander people, including those provided by Commonwealth and state/territory governments, AMSs, and other organisations • Facilitate working relationships and communication exchange between mainstream organisations, AMSs and their peak bodies • Increasing awareness and understanding of the COAG targets to close the gap in Indigenous disadvantage • Collaborating with local Indigenous health services and mainstream health services in a partnership approach for the delivery of primary care services • Performance management and evaluation of services. • De-identified data collection, analysis and report generation on the clinical indicators (Diabetes, CKD, COPD, and CHD) IUIH – Care Co-ordination and Supplementary Services IUIH has been commissioned through Brisbane North PHN to provide Care Co-ordination and Supplementary Services on behalf of Gold Coast PHN IUIH implement this service through the provision of a strategic team leader role within the GCPHN region, including regional guidance and strategic direction for the SEQ team and sub contract with Kalwun (Gold Coast AMS) to employ the local care co-ordinators (3.6 FTE) who work directly with the clients on the program. The model of care includes • Access to the service via referral from AMS practitioner or Mainstream GP via IUIH

	• A care-coordinator is allocated to the patient and makes direct contract to arrange and appointment, which may be a location of their choice or at one of the AMS centres.
	• The care co-ordinator will complete a holistic assessment including liaising with any other health professional involved in their care to determine their goals and needs.
	• A care plan is developed with the patients which includes building the patients understanding of their chronic disease and how to manage it The care co-ordinator sets up regular appointments with the client to monitoring the persons progress against their goals
	• Gold Coast Health run a number of chronic disease outpatient programs that specifically designed for indigenous that patients are referred too which include education and self-management training These include heart failure, diabetes, chronic obstructive pulmonary and kidney disease self-management programs
	• Local indigenous care co-ordinator has been trained by Flinders University in their self- management program and approach and at the time was the largest indigenous cohort training in the country.
	
	Overarching strategies include;
	• Increasing awareness of and maximising links between services for Aboriginal and Torres Strait Islander people, including those provided by Commonwealth and state/territory governments, AMSs, and other organisations
	• Developing and implementing strategies to improve access to mainstream primary care for Aboriginal and Torres Strait Islander people, including through outreach programmes such as the Medical Outreach – Indigenous Chronic Disease Programme (MOICDP), the Rural Health Outreach Fund (RHOF), and the Visiting Optometrists Scheme (VOS)
	• Increasing awareness and understanding of the COAG targets to close the gap in Indigenous disadvantage
	• Collaborating with local Indigenous health services and mainstream health services in a partnership approach for the delivery of primary care services
	• Implementation of the CCSS component of the ITC program
	
	Kalwun - Aboriginal Health Worker (AHW) and Project Officer (PO) components of the program.
	
	• Operational team leader within the GCPHN region, including guidance and direction for the local team
	• 2FTE positions
	  ○ IHPO mainstream
	  ○ Outreach worker
	• Increasing awareness of and maximising links between services for Aboriginal and Torres Strait Islander people, including those provided by Commonwealth and state/territory governments, AMSs, and other organisations, including developing and implementing strategies to improve access to mainstream primary care for Aboriginal and Torres Strait Islander people
	• Developing and implementing strategies to improve the capacity of mainstream primary care providers to deliver culturally appropriate primary care services to Aboriginal and Torres Strait Islander people, including:
	  ○ self-identification

	○ uptake of Aboriginal and Torres Strait Islander specific MBS items including item 715 - Health Assessments for Aboriginal and Torres Strait Islander People, care planning and follow up items • Improvement plans for the practices developed that target suggested activities and interventions to bring the clinical indicators within optimal range • Collaborating with local Indigenous health services and mainstream health services in a partnership approach for the delivery of primary care services. Results Deliverables required align with the PHN Performance Framework and include but not limited to; Improving Access • Increase of PIP IHI General Practices in the Gold Coast PHN region. • Maintain or Increase number of 715 Health Checks • Deliver (Gold Coast PHN region) at least four large group Cultural Awareness training sessions per year, which will have at least 40 individuals complete the course. • Deliver one Yarning circles each year to collect patient feedback. One in each PHN region Quality • 100% of participants who engage in the program are given a 715 health Check • 100% of participants have GPMP with goals established • 80% of participant at Yarning Circles would "recommend the program to Family and Friends" Value for Money • Supplementary Services Funding is bundled together to buy bulk goods at a discounted rate. CPAP machines are obtained at 60% of retail price. • Cost effectiveness is demonstrated through high levels of services obtained though brokerage vs paid for from Supplementary Services funding. • Cost effectiveness is demonstrated through high levels of services obtained though brokerage vs paid for from Supplementary Services funding. **Number of Supplementary Services funded is less than 10% of overall services obtained (brokered + paid).** • AMS in SEQ provide the Care Coordination Service free of charge to the participant. Addressing Need • 3.6 Care Coordination FTE is allocated to Mainstream patients throughout SEQ. • 100% of clients are linked to GPs and other health services **Evaluation** GCPHN is negotiating with Kalwun (AMS) to implement a formal external evaluation of the ITC and mental Health Clinical Care Co-ordination Services. This will be completed by CQU between 2018 – 2021.

	The evaluation questions are; How does the care co-ordination model influence self-management of patients living with long term conditions or complex needs in the community Are there difference in co-ordination between levels of staffing , context of practice and speciality areas (ie mental health, aged-specific, disease specific etc) What are the patient characteristics (eg demographic variables, wellness) and treatment variables that can assist to identify " at risk patients) What variables may predict a patient's wellness with a view to future planning of co-ordinated care What is the impact, of the Care Coordinator role on well-being and resilience of the CC over time. GCPHN is also using this to evaluate it Mental Health Mainstream Clinical Care Co-ordination and Queensland Health is using it to evaluate its nurse navigator roles within the public hospital settings. Gold Coast has the Largest cohurt of nurse navigators in QLD.
ITC Workforce	**IUIH** 3.6 FTE Care Coordinators **Kalwun (AMS)** 1.0 FTE IHPO 1.0 FTE IOW
Planned Expenditure **2018-19** (GST Exc) – Commonwealth funding	
Planned Expenditure **2018-19** (GST Exc) – Funding from other sources	
Planned Expenditure **2019-20** (GST Exc) – Commonwealth funding	
Planned Expenditure **2019-20** (GST Exc) – Funding from other sources	
Planned Expenditure **2020-21** (GST Exc) – Commonwealth funding	
Planned Expenditure **2020-21** (GST Exc) –	

Funding from other sources	
Funding from other sources	