Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2019-2021:

Integrated Team Care Funding

This Integrated Team Care Activity Work Plan template has the following parts:

1. The Activity Work Plan for the financial years 2019-20 and 2020-2021. Please complete one table for each activity to be undertaken in accordance with the Indigenous Australian's Health Programme Schedule, Item B3 – Integrated Team Care:
    a) Care coordination and supplementary services; and
    b) Culturally competent mainstream services.
2. The Indicative Budget for the financial years 2019-20 and 2020-21. Please attach an excel spreadsheet using the template provided to submit indicative budgets for:
    a) Indigenous Australian's Health Programme Schedule, Item B.3 – Integrated Team Care.

Brisbane North PHN

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

Overview

This Core Activity Work Plan covers the period from 1 July 2019 to 30 June 2022. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of up to 36 months. Regardless of the proposed duration for each activity, the Department of Health will require PHNs to submit updates to the Activity Work Plan on an annual basis.

Important documents to guide planning

The following documents will assist in the preparation of your Activity Work Plan:

- Activity Work Plan guidance material;
- PHN Needs Assessment Guide;
- PHN Program Performance and Quality Framework;
- Primary Health Networks Grant Programme Guidelines;
- Integrated Team Care Program Implementation Guidelines; and
- Clause 3, Financial Provisions of the Standard Funding Agreement.

Formatting requirements

- Submit plans in Microsoft Word format only.
- Submit budgets in Microsoft Excel format only.
- Do not change the orientation of any page in this document.
- Do not add any columns or rows to tables, or insert tables/charts within tables – use attachments if necessary.
- Delete all instructions prior to submission.

1. (a) 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 2019-2021. These activities will be funded under the IAHP Schedule for Integrated Team Care.

Proposed Activity 1	
ACTIVITY TITLE	ITC1 – Care coordination and supplementary services
Program Key Priority Area	Indigenous Health
Needs Assessment Priority	Improve Aboriginal and Torres Strait Islander people's access to high quality, culturally appropriate health care, including care coordination services.
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 Institute for Urban Indigenous Health (IUIH) will be commissioned to continue to deliver all aspects of the ITC program in the PHN region in conjunction with its member Aboriginal and Torres Strait Islander community controlled health services and other primary healthcare services. Program staff are positioned in Aboriginal and Torres Strait Islander community controlled health services and other IUIH premises throughout the region. For a full description of the South East Queensland Integrated Team Care Annual Plan 2019-2021, see included plan (appendix 1). All IUIH staff are put though an intensive five day induction of the IUIH model of care and its member services' practices. Other professional development for Care Coordinators include: • Regional Assessment Service training by My Aged Care • CPAP training • first aid and CPR • executive development training (for some staff) Care Coordinators are also offered numerous trainings sessions to gain Continuous Professional Development (CPD) points. Every month, all Care Coordinators come together and meet as part of the ITC. At these meetings professional development in-services are usually scheduled. Some of the topics include: • continence • mental heath • homelessness services and other social services • alcohol, tobacco other drugs • continuous quality improvement in AMSs training

	**AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services*
Target population cohort	Aboriginal and Torres Strait Islander people with a diagnosed chronic conditions
Indigenous specific	Yes
Coverage	Whole PHN Region
Consultation	Brisbane North PHN continues to engage with Aboriginal and Torres Strait Islander communities. The PHN, IUIH and Metro North Hospital and Health Service have signed a Statement of Intent which aims to collaboratively enhance planning, commissioning and evaluation of health services within the PHN region. In 2017-2018, ITC yarning circles were embedded into the program and will continue into the next contracting period. The purpose of the yarning circles is to provide consumer feedback into the ITC program to improve service quality. These yarning circles have taken place throughout SEQ and have been received positively throughout the differing communities. This positive engagement tool enables participants to openly discuss their experiences and have direct input into the program. Feedback from the yarning circles is presented at the yearly ITC forum and is provided to relevant clinical and non-clinical staff in order to make the necessary community advised changes to service provision. Additionally, all AMSs that have an in-house ITC Care Coordinator are community controlled and therefore have multiple mechanisms that collect community and consumer feedback and embed this information into everyday practises.
Collaboration	IUIH has been delivering the program for many years and is an important part of this collaboration and their advice is always sought and valued. Brisbane North PHN play an important role in bringing the four PHNs in South East Queensland and the IUIH together. As Brisbane North PHN is the lead PHN in this model, the Brisbane North PHN facilitates regular meetings with the steering committee comprised of other PHNs and the IUIH to stay informed and connected to the program. An annual forum is also included in ITC activities to highlight ITC activities and bring stakeholders together to network and build relationships.
Activity milestone details	Activity is valid for full duration of AWP
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.

	☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	There are no plans to decommission the current service provider.

Proposed Activity 2	
ACTIVITY TITLE	ITC2 – Culturally competent mainstream services
Program Key Priority Area	Indigenous Health
Needs Assessment Priority	Improve Aboriginal and Torres Strait Islander people's access to high quality, culturally appropriate health care, including care coordination services.
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	The Institute for Urban Indigenous Health (IUIH) will be commissioned to continue to deliver all aspects of the ITC program in the PHN region For a full description of the South East Queensland Integrated Team Care Annual Plan 2019-2021, see included plan (appendix 1). All IUIH staff are put though an intensive five day induction of the IUIH model of care and its member services' practices. Other professional development for Care Coordinators include: • cultural awareness training • first aid and CPR • executive development training (for some staff) Every month, all Outreach Workers and Project Officers come together and meet as part of the ITC. At these meetings professional development in-services are usually scheduled. Some of the topics include: • community services • MBS information • transit services • other government and non-government services *AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services
Target population cohort	Aboriginal and Torres Strait Islander people with a diagnosed chronic condition
Indigenous specific	Yes
Coverage	Whole PHN region
Consultation	The PHN continues to engage with the Aboriginal and Torres Strait Islander communities. The PHN, IUIH and Metro North Hospital and Health Service have signed a Statement of Intent which aims to enhance collaborative planning, commissioning and evaluation of health services within the PHN region. In 2017-2018, ITC yarning circles were embedded into the program and will continue into the next contracting period. The purpose of the yarning circles is to provide consumer feedback into the ITC program to improve service quality. These yarning circles have taken place throughout SEQ and have been received positively throughout the differing communities. This positive engagement tool enables participants to openly discuss their experiences

	and have direct input into the program. Feedback from the yarning circles is presented at the yearly ITC forum and is provided to relevant clinical and non-clinical staff in order to make the necessary community advised changes to service provision. A consultation method that has been used for a while and will continue to be used is an Outreach worker survey that is given to Outreach worker clients that access mainstream services. This survey asks about client satisfaction and barriers to access and is used to both evaluate the ITC service as well as perceptions of the mainstream services attended.
Collaboration	*List stakeholders that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services. Describe the role of each party.* IUIH has been delivering this aspect of the program for many years and they are an important part of the collaboration and their advice is always sought and valued. Brisbane North PHN play an important role in bringing the four PHNs in South East Queensland and the IUIH together. As Brisbane North PHN is the lead PHN in this model, the Brisbane North PHN facilitates regular meetings with the steering committee comprised of other PHNs and the IUIH to stay informed and connected to the program. An annual forum is also included in ITC activities to highlight ITC activities and bring stakeholders together to network and build relationships. IUIH has been delivering the program for many years and is an important part of this collaboration and their advice is always sought and valued.
Activity milestone details	Activity is valid for full duration of AWP
Commissioning method and approach to market	*1. Please identify your intended procurement approach for commissioning services under this activity:* ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) *2a. Is this activity being co-designed?* Yes *2b. Is this activity this result of a previous co-design process?* Yes *3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?*

	No *3b. Has this activity previously been co-commissioned or joint-commissioned?* No
Decommissioning	There are no plans to decommission the current service provider.

Appendix 1

South East Queensland

Integrated Team Care (ITC) Annual Plan 2019-20

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 six key objectives of the 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.

Objective	Actions
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	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
	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
	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
	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
	Maintain a strength-based approach by Care Coordinators, focussing 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
	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
	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
	Maintain 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

Objective	Actions
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 C0-pyament scheme educational resources and tools

Objective	Actions
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	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
Objective 5: Support mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify	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
Objective 6: Increase awareness and understanding of measures relevant to mainstream primary care	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

Reporting measures

A. Quantitative report

1. Number of Care Coordinators employed*

2. Number of Outreach Workers employed*

3. Number of IHPOs employed*

* Full-time equivalent numbers and number of individuals, plus location of individuals.

Care coordination

4. Number of patients receiving care coordination:

    4.1. By gender.

5. Number of unique services provided for patients receiving care coordination:

    5.1. Care coordination services

    5.2. Supplementary Services

    5.3. Clinical services accessed

    5.4. Other

6. Is there a waiting list for care coordination? If so, number of patients on waiting list.

7. Number of new patients in the reporting period.

8. Number of patients discharged in the reporting period.

    8.1. Number of patients now self-managing

Supplementary Services

9. Allied health – number of services purchased and brokered

    9.1. List the top three Allied health services used

10. Specialists – number of services purchased and brokered

    10.1. List the top three Specialist services used

11. Transport – number of services purchased and brokered

12. Number of Medical aids:

    12.1. Assisted breathing equipment

    12.2. Blood sugar/glucose monitoring equipment

    12.3. Dose administration aids

    12.4. Medical footwear

    12.5. Mobility aids (e.g. crutches, walking frames or wheel chairs) or shower chairs

    12.6. Exceptional circumstances.

Outreach Worker assistance

13. Total number of patients assisted by Outreach Workers

14. Breakdown of number of patients assisted by Outreach Workers:

    14.1. Attendance to GP and/or practice nurse appointments

    14.2. Specialist appointments

    14.3. Care coordination appointments

    14.4. Allied health appointments

    14.5. Collecting prescriptions from the pharmacy.

    14.6. Other

B. Qualitative report

15. Describe some of the activities undertaken in the PHN region to meet the needs of Aboriginal and Torres Strait Islander people receiving care coordination under the ITC Activity. What have been the successes, challenges, and outcomes?

16. Describe how your referral, intake and discharge processes are supporting Aboriginal and Torres Strait Islander people receiving care coordination under the ITC Activity. What have been the successes, challenges, and outcomes?

17. What work has been done to address barriers to accessing mainstream services for Aboriginal and Torres Strait Islander people, including help them to become more culturally appropriate? What have been the successes, challenges, and outcomes?

18. What activities and approaches have been implemented to improve culturally safe workplaces and services, for example, cultural awareness training? What have been the successes, challenges, and outcomes?