Australian Government
Department of Health

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An Australian Government Initiative

Primary Health Networks:
Integrated Team Care Funding

Activity Work Plan 2016-2017:

- # Annual Plan 2016-2017

Gold Coast Primary Health Network

When submitting this Activity Work Plan 2016-2017 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 15 July 2016.

Introduction

Overview

The aims of Integrated Team Care 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 of Integrated Team Care are to:

- 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;
- foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors;
- improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people;
- 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;
- support mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify; and
- increase awareness and understanding of measures relevant to mainstream primary care.

Each PHN must make informed choices about how best to use its resources to achieve these objectives. PHNs will outline activities to meet the Integrated Team Care objectives in this document, the Activity Work Plan template.

This Activity Work Plan covers the period from 1 July 2016 to 30 June 2017. To assist with PHN planning, each 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 2017-18 at a later date.

The Activity Work Plan template has the following parts:

1. The Integrated Team Care Annual Plan 2016-2017 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.

Activity Planning

PHNs need to ensure the activities identified in this Annual Plan correspond with the:

- ITC aims and objectives;
- Item B.3 in the Integrated Team Care Activity in the IAHP Schedule;
- Local priorities identified in the Needs Assessment;
- ITC Implementation Guidelines; and
- Requirement to work with the Indigenous health sector when planning and delivering the ITC Activity.

Annual Plan 2016-2017

Annual plans for 2016-2017 must:

- base decisions about the ITC service delivery, workforce needs, workforce placement and whether a direct, targeted or open approach to the market is undertaken, upon a framework that includes needs assessment, market analyses, and clinical and consumer input including through Clinical Councils and Community Advisory Committees. Decisions must be transparent, defensible, well documented and made available to the Commonwealth upon request; and
- articulate a set of activities that each PHN will undertake to achieve the ITC objectives.

Activity Work Plan Reporting Period and Public Accessibility

The Activity Work Plan will cover the period 1 July 2016 to 30 June 2017. A review of the Activity Work Plan will be undertaken in 2017 and resubmitted as required under Item F.7 of the ITC Activity in the IAHP Schedule.

Once the Annual Plan has been approved by the Department, the PHN is required to perform the ITC Activity in accordance with the Annual Plan.

Useful information

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

- Item B.3 of Schedule: Primary Health Networks Integrated Team Care Funding;
- PHN Needs Assessment;
- Integrated Team Care Activity Implementation Guidelines; and
- Improving Access to Primary Health Care for Aboriginal and Torres Strait Islander People theme in the IAHP Guidelines.

Please contact your Grants Officer if you are having any difficulties completing this document.

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

Aboriginal and Torres Strait Islander health is one of the 6 national priority areas for PHN's. Encouragingly, the Gold Coast has seen an increase in Aboriginal and Torres Strait Islander health checks (715) between 2012 and 2014. This was in addition to the number of services provided to a person by a practice nurse or Aboriginal and Torres Strait Islander health practitioner almost doubling over the same period. Indigenous health checks are essential to effectively identify chronic disease at an early stage and improve self-management.

Over the next 5 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 discussed in this plan.

Commencing July 1 2016, GCPHN will collaborate with Kalwun Health in a phase one activity 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 be 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 strong working partnership will be required between IUIH, GCPHN, Kalwun Health and other providers of A&TSI services including mainstream providers within the Gold Coast region. A desired outcome to support implementation would be the development of a regional collaborative service plan.

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 2016-17. These activities will be funded under the IAHP Schedule for Integrated Team Care.

Proposed Activities	
Six-month transition phase	GCPHN extend current arrangements for 3 months to 30 September 2016 then contract with Kalwun Health from 1 October 2016 to June 30 2018.
Anticipated start date of ITC activity	1st July 2016
Will the PHN be working with other organisations and/or pooling resources for ITC?	In collaboration with the Karulbo Partnership, the A&TSI community, Kalwun Development Corporation (AMS), and other health and social service providers to complete a comprehensive needs assessment and determine locally appropriate and integrated service solutions. For the CCSS service delivery component GCPHN is contracting IUIH through Brisbane North PHN from July 1st 2016, this will result in pooling of supplementary service funds.
Service delivery and commissioning arrangements	GCPHN will extend current arrangements for 3 months to 30 September 2016 then contract with Kalwun Health from 1 October 2016 to June 30 2018. The CCSS service delivery will be commissioned to IUIH through Brisbane North PHN from July 1st 2016 to June 30 2018.
Decision framework	Needs assessment, and market analyses was conducted through the GCPHN Needs assessment. This was developed in consultation 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. In regards to the contracting of the CCSS to Institute of Urban Indigenous Health (IUIH) DoH stipulated contracting IUIH through Brisbane North PHN. The decision to contact Kalwun Helath Service was based on this being the only AMS on the Gold Coast, and its current function of delivering the care coordination component of the CCSS program under contract from IUIH.
Decision framework documentation	GCPHN Needs assessment, and market analyses

Description of ITC Activity	ITC program team will work within the GC PHN region to improve health equity for Aboriginal and Torres Strait Islander people through culturally appropriate mainstream primary care, assist Aboriginal and Torres Strait Islander people to obtain primary health care as required, and provide care coordination services to eligible people with chronic disease/s who require coordinated, multidisciplinary care. **GCPHN** • 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 • 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. • De-identified data collection, analysis and report generation on the clinical indicators(Diabetes, CKD, COPD, and CHD) • Improvement plans for the practices developed that target suggested activities and interventions to bring the clinical indicators within optimal range **IUIH** • Provision of strategic team leader role within the GCPHN region, including regional guidance and strategic direction for the team • Developing and implementing a coordinated team-based approach to Aboriginal and Torres Strait Islander health • Providing SEQ team leader & supporting Care Coordinators and Outreach Workers; • 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** • Operational team leader within the GCPHN region, including guidance and direction for the local team • Developing and implementing a regional GC coordinated team-based approach to Aboriginal and Torres Strait Islander health • Regional support to Care Coordinators and Outreach Workers. • 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 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
	• 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.