Australian Government
Department of Health

An Australian Government Initiative

Web Version - HPRM DOC/17/10428

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.

Gippsland

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

Please outline, in no more than 500 words, an overview of the PHN's strategic vision for the 12 month period covering this Activity Work Plan. The strategic vision should demonstrate how the PHN will achieve the Integrated Team Care objectives, with reference to Needs Assessment as applicable.

The Gippsland PHNs Strategic Objectives underpin all activities commissioned and performed by Gippsland PHN. The strategic objective is defined as 'Improved health outcomes for people with chronic disease and those patients at risk of poor health outcomes'. At a Gippsland PHN level this overall objective will be achieved by improving coordination of care that ensures patients receive the right care in the right place at the right time, a lower prevalence of national and locally prioritised conditions and increased efficiency and effectiveness of medical services and other primary health services. Key Gippsland PHN documents that govern the implementation of our Indigenous Australians Health Programme: Integrated Team Care are:

- Commissioning Framework
- Procurement Framework
- Evaluation Framework
- Project Management Framework

<u>Commissioning of Service Delivery</u>

Gippsland PHN will utilise our Commissioning, Procurement and Evaluation Frameworks to commission services to assist the Indigenous health sector to ensure that eligible patients of both mainstream and Aboriginal Medical Services have access to support for Chronic Diseases via Care Coordination, Outreach Support and Supplementary Services.

After consultation with regional stakeholders including the Department of Health and Human Services, local service providers, General Practitioners, Local Hospital Networks and the Aboriginal Community Controlled Health Organisations it has been determined that the Aboriginal Medical Services are best placed to deliver this service.

Service Delivery will focus on:

- Providing Care Coordination and Outreach Support to Indigenous People experiencing chronic disease
- A team approach so patients will be supported across the full pathway of care
- A limited funding pool for Supplementary Services that will be used to assist patients who are registered under the ITC Activity to access medical specialist and allied health services where these services align with the patient's care plan.
- Equitable access, including transparent referral pathways and service available throughout Gippsland.

- Culturally appropriate treatment and support services for Indigenous people.

Commissioning of services will support organisations providing culturally appropriate, evidence based treatment for clients experiencing a range of chronic diseases.

Regional planning and Sector Development

An Indigenous Health Project Officer (IHPO) has been appointed to effectively implement the objectives and activities of the Integrated Team Care Activity. This position will work with all relevant stakeholders on Indigenous Health, in collaboration with Gippsland PHN teams. This role will focus on:

- Coordination and promotion of the Integrated Team Care Activity
- Assisting the wider mainstream primary care sector through the provision of information, training and resources encouraging the engagement of Indigenous patients.
- Promotion of Mainstream Primary Care providers to the Indigenous community.
- Providing guidance, training and mentoring to the Care Coordinators and Outreach Workers.
- Identify and contribute to development of referral pathways and resources to support and enable the coordination of services at a regional level including cross sectoral and integrated approaches.
- Identify key issues, including patient management, data and discussion points for Gippsland PHN to explore with Clinical Councils and Community Advisory Committee.

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.

Public Accountability	
What are the sensitive components of the PHN's Annual Plan? Please list	Nil.

Proposed Activities	
ITC transition phase	Gippsland PHN commenced full commissioning of the Indigenous Australians Health Program from 1 October 2015.
Start date of ITC activity as fully commissioned	01/07/2016
Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?	Gippsland PHN is committed to working with external stakeholders. When planning the ITC Activity we have worked with the established pool of pre-qualified providers to ensure the Care Coordination and Outreach Worker positions complement existing positions, especially given the time fractions allocated. In each case the providers are committed to providing existing resources, such as funded transport services, to compliment and work with the ITC Activity.
Service delivery and commissioning arrangements	**Service Delivery Arrangements** Due to the size of the Gippsland PHN region it is planned that one Indigenous Health Program Officer will coordinate and provide support for the activity throughout the region. Four Care Coordinators and one Outreach Worker will be commissioned. The placement of these staff is based on the population of Indigenous people per Local Government Area. The allocation of either care coordinator or outreach worker roles has been based on consultation with the Aboriginal Community Controlled Health Organisations, other mainstream services and need in the local regions. Throughout the needs assessment process Gippsland PHN has confirmed no service duplication. These arrangements also ensure that the ITC activity is available throughout Gippsland. Further details in the attached Implementation Plan. **Commissioning Arrangements** A market analysis has been undertaken which have identified no new additions to our established pool of pre-qualified providers. This pool is made up of four Gippsland Aboriginal Community Controlled Health Organisations that operate as Aboriginal Medical Services. These organisations provide appropriate, culturally sensitive clinical care and have strong links to the local community.
Decommissioning	Nil – N/A

<table>
<tr><td>Decision framework</td><td>Baseline needs assessment has identified Indigenous health priorities hence Gippsland PHN has taken a population based approach in terms of service distribution. Following consultation and discussion with the three Gippsland Clinical Councils, a commissioning approach, which is in line with the GPHN commissioning framework and decision tree, lead to services for this program being commissioned from the established pool of pre-qualified providers.</td></tr>
<tr><td>Indigenous sector engagement</td><td>• Clinical Council membership – indigenous person is member of East Gippsland/Wellington Clinical Council
• Gippsland PHN membership on the Gippsland Aboriginal Health Advisory Committee (convened by Victorian Department of Health and Human Services)
• Regular formal and informal attendance and communication with key indigenous groups and elders, e.g., Djillay Ngalu collaborative, local government Aboriginal community groups</td></tr>
<tr><td>Decision framework documentation</td><td>Yes, a procurement plan has been approved within organisational governance. Details previously provided to the Department of Health.</td></tr>
<tr><td>Description of ITC Activity</td><td>As attached.</td></tr>
<tr><td>ITC Workforce</td><td>
<table>
<tr><th>Role</th><th>Location</th><th>FTE</th><th>Commissioned/ Employed</th><th>AMS or Mainstream</th></tr>
<tr><td>Indigenous Health Project Officer</td><td>Moe- Providing support Gippsland wide</td><td>1.0FTE</td><td>Employed</td><td>Mainstream</td></tr>
<tr><td>outreach worker</td><td>Outer East Gippsland</td><td>0.4FTE</td><td>Commissioned</td><td>AMS</td></tr>
<tr><td>Care Coordinator</td><td>Lakes Entrance- East Gippsland</td><td>0.6FTE</td><td>Commissioned</td><td>AMS</td></tr>
<tr><td>Care Coordinator</td><td>Bairnsdale- East Gippsland</td><td>0.6FTE</td><td>Commissioned</td><td>AMS</td></tr>
<tr><td>Care Coordinator</td><td>Sale- Wellington Shire</td><td>0.8FTE</td><td>Commissioned</td><td>AMS</td></tr>
<tr><td>Care Coordinator</td><td>Morwell- Latrobe Valley</td><td>0.8FTE</td><td>Commissioned</td><td>AMS</td></tr>
<tr><td>Outreach Worker</td><td>Drouin- Baw Baw Shire providing outreach to South Gippsland and Bass Coast</td><td>0.8FTE</td><td>Commissioned</td><td>AMS</td></tr>
<tr><td colspan="2">Total FTE</td><td colspan="3">5.0 FTE</td></tr>
</table>
*AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services
</td></tr>
</table>

Implementation Plan:

Indigenous Australians Health Programme: Integrated Team Care Activity (ITC) 2017/18

Project Background

Gippsland has a high proportion of Aboriginal and Torres Strait Islander people representing 1.56% of the Gippsland population compared to 0.74% of the Victorian population. The highest proportions of Aboriginal and Torres Strait Islander populations across Gippsland reside in East Gippsland, Latrobe, and Wellington representing 3.33%, 1.53% and 1.49% of the population respectively.

Across Gippsland Aboriginal and Torres Strait Islander people present to emergency department and are hospitalised at over twice the rate of the broader community, due to the greater impact of chronic disease on this population.

On 1 July 2015, the Australian Government established the Indigenous Australians' Health Programme (incorporating the 'Care Coordination and Supplementary Service (CCSS)' and the 'Improving Indigenous Access to Mainstream Primary Care (IIAMPC)' services). From July 1 2016 the CCSS service and the IIAMPC program consolidated to become the **Integrated Team Care Activity (ITC)**. Gippsland PHN has managed this activity throughout the Gippsland area for the 2016/17 period.

Project Objectives

The Programme aims to improve the health of all Aboriginal and Torres Strait Islander people through a variety of comprehensive activities focused on local health needs as well as targeted activities addressing geographic and specific disease processes. The overarching objective of the Programme is to provide primary health care services, including chronic disease prevention, detection and management, and to support access to specialist and allied health professionals for Aboriginal and Torres Strait Islander people. It also aims to build a health system that continually improves quality and is responsive to the health needs of Aboriginal and Torres Strait Islander people.

The aim of **Integrated Team Care Activity (ITC)** is to contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care. Care Coordination and Outreach Support will be provided by qualified health workers (for example specialist nurses, Aboriginal Health Workers) to ensure that patients are accessing services consistent with the care plan prepared by their GP. Activities will include provision of appropriate clinical care, arranging the services required, assisting the patient to attend appointments, ensuring medical records are complete and current, and ensuring regular reviews are undertaken by the patient's primary care

providers. Supplementary Services is also included in the ITC program. Supplementary Services will include a flexible funding pool available for use by the Care Coordinators when they need to expedite a patient's access to an urgent and essential allied health or specialist service (including certain approved medical aids), where the services are not otherwise available in a clinically acceptable timeframe. Supplementary services can be used to fund the necessary local transport to access the service, where not publicly available.

In addition to the clinical objectives of the ITC program, additional objectives will be undertaken by the Indigenous Health Project Officer. These will include fostering collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors; improving the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people; increasing 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; supporting mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify; and increasing awareness and understanding of measures relevant to mainstream primary care.

Project Outputs

Clinical Work (Care Coordinators & Outreach Workers)

- Aboriginal and Torres Strait Islander people receiving increased support and access to treatment and management of chronic health conditions (better access to the required services in a range of disciplines and allied health services, and better care coordination and provision of supplementary services via contracted care coordination and transport). This will be achieved via the provision of Care Coordinators and Outreach Workers throughout the Gippsland Region. The placement of these staff has been based on the population of Indigenous people per Local Government Area. The allocation of either care coordinator or outreach worker roles has been based on consultation with the Aboriginal Community Controlled Health Organisations and need in the local regions and services currently available to ensure no duplication.

Area (LGA)	Role	FTE	Population %
East Gippsland	Care Coordinators Outreach Worker	1.2 FTE 0.4 FTE	40%
Wellington Shire	Care Coordinator	0.8 FTE	20%
Latrobe City	Care Coordinator	0.8 FTE	20%
Baw Baw Shire (outreach to South Gippsland and Bass Cost Shire)	Outreach Worker	0.8 FTE	20% (total of 3 LGA'S)

- Funded services and medical aids where appropriate via the Supplementary Services funding pool.

- Increased networking with Aboriginal and Torres Strait Islander communities leading to collaboration and innovation to identify need and address service gaps.

Project/Coordination Work (Indigenous Health Project Officer)

- Fostering collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors. In addition to the meeting attendance and general networking across sectors the Indigenous Health Project Officer will continue to support mainstream organisations to acknowledge and celebrate significant calendar events for the Indigenous Community. This will include NAIDOC Week and National Close the Gap Day. In building on the 'Spotlight Study' success Gippsland PHN also plans to undertake/commission an additional study in 2017/18 focused on Indigenous chronic disease and holistic health care. This document will be available to the public with the aim of sharing findings and stimulating discussions between the sectors.
- Improving the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people. This will include delivering three cultural safety training events to a total of 60 professionals throughout the Gippsland region.
- Increasing 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. In collaboration with the Gippsland PHN Practice Support team and local Indigenous support agencies Gippsland PHN plans to run a 715 health check campaign. This will feature the health pathways portal providing details to GP's on how to complete the 715 health checks and follow up items. The campaign will then focus on the "have you had your 715 health check?" question. This will be promoted throughout all communities via mainstream media, social media, and word of mouth.
- Supporting mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify. This will include the reprinting of the 'Gippsland Black Pages' Indigenous Services Directory including other promotional material featuring mainstream service providers details to encourage access. Community friendly resources will also be developed and printed in consultation with the Indigenous community to encourage self-identification and reception staff to ask about cultural identity.
- Increasing awareness and understanding of measures relevant to mainstream primary care. Indigenous health professionals were consulted for the 2016/17 PHN Needs Assessment. This year Gippsland PHN plans to engage professionals and community members on a more comprehensive assessment and discussion of health needs in the Gippsland Region.

Project Governance

The ITC Program will be governed in line with the Gippsland PHN Project Management Framework which is based on the PRINCE 2 best practice project management methodologies.

The Framework ensures that projects are aligned with organisational strategic direction, appropriately resourced in terms of time, money and competency and that appropriate approvals processes, risk management, stakeholder engagement, communication, budgetary control and reporting mechanisms are built in to project governance.

Operational project coordination for this project will be the responsibility of the Indigenous Health Project Officer, with line management and oversight from the Manager Vulnerable Communities. The scope for this project is defined by the project objectives and stated outputs, as per the Project Management Framework. Reporting will be in line with organisational governance, with authorisation by CEO and Executive. Performance monitoring will include data from contracted agencies in consultation with supporting members and external stakeholders. Any proposed changes or issues will be managed in accordance with the Project Management Framework, and as documented in the Project Plan.

Project Communication

Stage	Key Messages	Audience	Format
1	Overview of new program	Commissioned services	Letter from CEO
2	Discussions regarding funding for commissioned services & Contracts	Commissioned services	Letter from CEO
3	Update regarding program Inc. referral pathways.	ALL	GPHN Link, Email, Phone, Webpage.
4	Ongoing staff updates	Internal	Plexus, staff meetings.
5	Promotion of Indigenous health including relevant program updates	External	Practice Support, Visits to services, Informal Networking, GPHN Link.
6	Various communication regarding project work	Various	Various

Project Evaluation

Gippsland PHN will undertake a targeted evaluation within the available funding. External evaluation involving academic partners is welcome, but additional funding requirements would need to be met from other sources.

It is expected that the evaluation will be conducted as a quality assurance exercise against a separate document titled 'Integrated Team Care Evaluation Framework 2017/18', to check that the requirements of the funding were met and if the program continued to strive towards the GPHN vision and objectives of a measurably healthier Gippsland through better care, better health and better value. The evaluation will focus on the following elements featuring both qualitative and quantitative data;

1. The success of engagement strategies. This will be measured by keeping a log of each event/strategy, the purpose of the engagement and a log of key themes/outcomes identified.
2. The enablers and barriers to engagement of community members, ACCHO's and health professionals. This will be recorded from qualitative feedback gathered at networking meetings, community events and one on one meetings occurring quarterly.
3. Successful delivery of Care Coordination services to community members throughout the Gippsland region.
4. Successful provision of supplementary services to community members throughout the Gippsland region.
5. Successful delivery of small projects within this program as detailed above and in the Budget.