



Final Report

Integrated Team Care – Assessment, evaluation and co-design consultation
Northern Queensland Primary Health Network

June 2019

Executive summary

This report presents the results of the assessment, evaluation and co-design project (referred to hereafter as the review) conducted by the consultancy for the Northern Queensland Primary Health Network (NQPHN) to understand the options for the future commissioning of the Integrated Team Care (ITC) program in the region.

The ITC program aims to improve chronic disease outcomes for Aboriginal and Torres Strait Islander people by improving access to primary health care, including culturally appropriate mainstream services, and by providing care coordination and access to brokerage funds (Supplementary Services) for eligible patients.

The ITC program is currently being implemented via a dual commissioning model, through Aboriginal Community Controlled Organisations and mainstream general practices. This approach originally aimed to deliver effective ITC implementation by enabling choice, recognising the diverse service delivery environment in north Queensland, and broadening the reach of the program.

Key findings

The ITC program has two aims: to contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through access to care coordination, multidisciplinary care and support for self-management; and to 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.

The review has found the ITC program is improving chronic disease outcomes for many clients. However, the current approach to implementation has also created elements of fragmented service delivery, led to variation in implementation of the program components and has facilitated areas of over- and under-servicing. While some clients are certainly benefiting from the program and achieving better access to primary health care because of it, access to the program is not consistent or equitable, unmet demand is not being monitored or managed in a systematic way and improvements could be made to the way the ITC workforce is supported and developed to deliver the program.

In most locations, distribution of Supplementary Services funds and provision of transport are the primary functions of the ITC program, and active care coordination is often limited to ad hoc and opportunistic support. This reflects the high level of demand and urgency of needs in many communities. However, the entrenched and systemic reliance on Supplementary Services funds and ITC-funded transport to facilitate ongoing support (for example, regular transport to dialysis) and transition from acute care (for example, to facilitate timely discharge from hospital) for Aboriginal and Torres Strait Islander people is not necessarily consistent with the intent of the ITC program.

The review has also found that the ITC program is not consistently improving the cultural capability of mainstream services across the region.

There are also opportunities to better integrate the ITC program internally and externally (i.e. with other services and programs) in order to deliver greater continuity of care, a more streamlined journey for patients who transition between locations and settings, and to ensure that particularly vulnerable health care consumers do not fall through the gaps.

Finally, the review found the NQPHN has only been able to provide limited oversight and direction to the contract holders. This has contributed to inconsistent access and reach, variation in approaches to service delivery (some of which may be locally appropriate adaptations, but others which probably represent undesirable variation) and limited accountability.

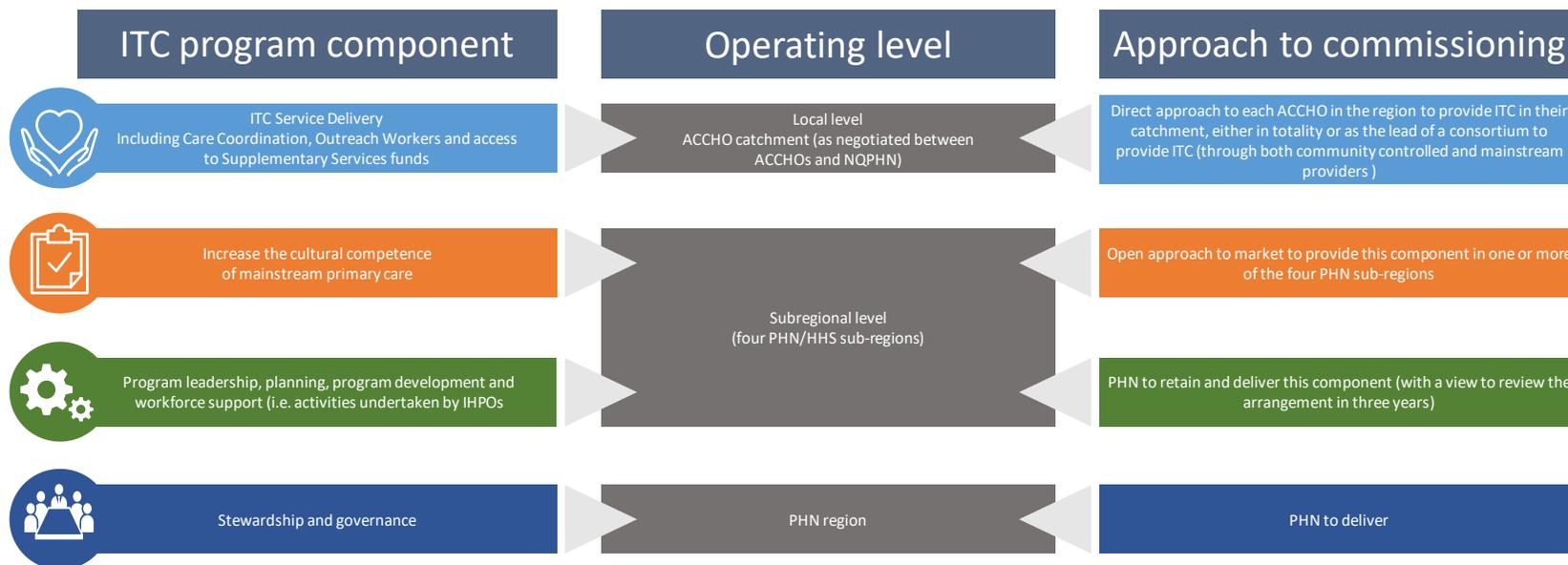
Recommendations

The review has found that current arrangements are not delivering optimal outcomes for the community, and recommends a revised approach to commissioning (recommendation 7) and to the way the PHN governs, guides and supports the ITC program (recommendation 1 to 6). The revised approach organises the elements of the ITC program into the following components, each of which will have bespoke approach to commissioning and delivery:

- **Service delivery**, including employment of Care Coordinators, Outreach Workers and provision of access to Supplementary Services in order to achieve better treatment and management of chronic conditions, better access to appropriate health care and increased uptake of Aboriginal and Torres Strait Islander MBS items;
- Increasing the **cultural competence** of mainstream primary care providers across the region, including but not limited to general practice;
- Provision of sub-regional **program leadership**, planning, program development and workforce support associated with the IHPO role; and
- Provision of **program stewardship and governance**.

Figure 1 summarises the north Queensland ITC program model.

Figure 1: Overview of north Queensland ITC model



In addition to recommending a revised approach to commissioning, the review provides a set of **‘Do regardless’** recommendations (recommendation 1 to 6) which will be critical to support enhanced implementation of the ITC program going forward. The full list of recommendations from the review is set out below.

- 1. It is recommended the NQPHN establishes a governance structure for the ITC program, which includes strategic and operational groups, and that this structure is used to oversee transparent monitoring, shared accountability and to progress other short term enhancements and long term objectives.**
- 2. It is recommended the NQPHN leads the development of local ITC program guidelines (the ‘Northern Queensland ITC Guidelines’) which build on, rather than duplicate, the Commonwealth’s Program Implementation Guidelines, and which describe the local approach to implementation, processes and protocols; that these Guidelines are developed collaboratively between the PHN, local ITC program providers, consumers, community representatives and other significant health sector participants; and that there is a clear process for regular review and updates.**
- 3. It is recommended the NQPHN requires all contract holders to develop Local Implementation Plans (LIMs) which address catchment coverage, local model nuances, standing approvals for Supplementary Services funds (such as freight costs), protocols for transient clients, service mapping and common referral pathways, key contacts and local transport planning; and that NQPHN specifies that the LIMs must be developed in collaboration with consumers and community, IHPOs and other PHN staff, and other locally relevant stakeholders and providers, including Hospital and Health Services (HHSs).**
- 4. It is recommended the NQPHN leads a collaborative process to develop a demand management framework for the ITC program in the region which identifies priority population groups, expected service levels, wait list management and alternative support options.**
- 5. It is recommended the NQPHN develops and implements, or commissions the development and implementation of, a comprehensive ITC program workforce support and development strategy, and that resources are allocated to implement the strategy.**
- 6. It is recommended the NQPHN includes clear, local reporting and data requirements in ITC program provider contracts, providing clear data definitions, service range targets, staffing levels and financial acquittals.**
- 7. It is recommended that the NQPHN progresses to recommissioning of the ITC program in 2019 using a hybrid model which includes the following features: Place-based commissioning of outreach, care coordination and Supplementary Services funds allocation at the level of ACCHO catchment area; delivery of Indigenous Health Project Officers related activities through NQPHN with a sub-regional focus; and sub-regional commissioning of the Improving Cultural Competency of Mainstream Primary Care component of the ITC program.**
- 8. It is recommended the NQPHN reviews its approach to commissioning every three years, to consider whether the model continues to be the most appropriate approach, taking into consideration ITC program progress, maturity and market changes.**
- 9. It is recommended the NQPHN immediately commences transition planning to ensure the smooth transition of service delivery (specifically care coordination and access to Supplementary Services funds) with a focus on ensuring that client impact is minimised. The impact of transition on current ITC program staff, fund holders and referrers should be considered as part of this process.**
- 10. It is recommended the NQPHN develops and implements a detailed communication strategy relevant to the transition which considers the communication needs of key stakeholders including consumers, community, current and incoming providers, referrers, other people and organisations involved in the ITC program.**

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Glossary

AMS	Aboriginal Medical Service
ASR	Age standardised ratio
ATSIOW	Aboriginal and Torres Strait Islander Outreach Worker
ACCHOs	Aboriginal Community Controlled Organisations
CCSS	Care Coordination and Supplementary Services
CSA	Country South Australia
CtG	Closing the Gap
CWA	Country Western Australia
DoH	Department of Health
GP	General Practitioner
GPMP	General Practitioner Management Plan
HHS	Hospital and health services
IAHP	Indigenous Australians' Health Programme
IHPO	Indigenous Health Program Officers
IIAMPC	Improving Indigenous Access to Mainstream Primary Care

ITC	Integrated Team Care
MBS	Medical Benefits Scheme
MOU	Memorandum of Understanding
NATSIHA	Northern Aboriginal and Torres Strait Islander Health Alliance Limited
NAPHL	Northern Area Primary Health Limited
NPAFACS	Northern Peninsula Area Family and Community Services
NOPHN	North Queensland Primary Health Network
NT	Northern Territory
PHN	Primary Health Network
QAIHC	Queensland Aboriginal and Islander Health Council
WNSW	Western New South Wales
WQ	Western Queensland

1 Project overview

1.1 Background

The Integrated Team Care (ITC) program was established to improve chronic disease outcomes for Aboriginal and Torres Strait Islander people by improving access to primary health care, including culturally appropriate mainstream services, and by providing care coordination and access to brokerage funds (Supplementary Services) for eligible patients.

Funded under the Indigenous Australians' Health Programme (IAHP) and commissioned locally by Primary Health Networks (PHNs), the ITC Program aims to:

- contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through access to care coordination, multidisciplinary care and support for self-management; and
- 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.¹

The objectives of the program are to:

- contribute to better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people enrolled in the program;
- improve access to appropriate health care through care coordination and provision of Supplementary Services for eligible Aboriginal and Torres Strait Islander people with chronic disease;
- foster collaboration and support between mainstream primary care providers and the Aboriginal and Torres Strait Islander health sector;
- improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people; and
- increase the uptake of Aboriginal and Torres Strait Islander specific MBS items, including Health Assessments for Aboriginal and Torres Strait Islander people and follow up items.²

The ITC program works towards these aims and objectives through funding teams of Indigenous Health Project Officers (IHPOs), Aboriginal and Torres Strait Islander Outreach Workers (Outreach Workers/ATSIOW) and care coordinators. These teams work across both Aboriginal and Torres Strait Islander and mainstream primary care sectors within their PHN region to assist Aboriginal and Torres Strait Islander people to access primary health care, provide care coordination and brokerage funds (referred to as Supplementary Services funds) to eligible Aboriginal and Torres Strait Islander people with chronic disease/s who require coordinated, multidisciplinary care, and improve access for Aboriginal and Torres Strait Islander people to culturally appropriate primary services.

¹ Department of Health (2019). Integrated Team Care Program Implementation Guidelines.

² Department of Health (2019). Integrated Team Care Program Implementation Guidelines.

1.2 Purpose and scope

The Northern Queensland Primary Health Network (NQPHN) identified various challenges associated with the current local delivery of the ITC program. These challenges include poor access to tertiary health services and transport, lack of understanding by mainstream service providers about the role of the ITC program, knowledge sharing issues and key service type gaps.

The consultancy was engaged by the NQPHN to conduct an assessment, evaluation and co-design consultation process (hereafter referred to as the review) of the ITC program. Given that the current arrangements have been in place for several years, and that a range of challenges associated with the current implementation approach have been identified, the NQPHN is planning to re-commission the ITC program in 2019. The review explores the current state of implementation and provides an overall assessment of the strengths and weaknesses of current processes, as well as informs thinking about a future approach to commissioning and implementation. As such, the purpose of the project is to undertake a comprehensive review of the ITC program, and make recommendations to inform re-commissioning of the program.

The scope of the review included a full and detailed assessment of the current commissioning and delivery of the ITC program within the NQPNH region, with a view to informing future approaches to commissioning and implementation. It is noted that delivery of the ITC program throughout Australia is guided by the Department of Health's Program Implementation Guidelines³, and that PHNs are required to commission and oversee delivery of the program in line with these guidelines. Review of these guidelines was not in-scope for this project.

It is also noted the ITC program straddles a number of components of local health systems, including mainstream primary care, Aboriginal Community Controlled Organisations (ACCHOs) and acute and specialist services, and will be impacted by aspects of that local system. While the review may have identified issues which relate to the Program Implementation Guidelines, or which are primarily relevant to the local service system, the focus of the review was on local implementation and the impact of the ITC program within the NQPHN region.

1.3 Methodology

The review was undertaken using a mixed methods approach that included accessing both qualitative and quantitative data, and use of a range of analytical techniques. Wherever possible, multiple data sources were used to inform findings, allowing triangulation to enhance the insight and quality of the findings.

As part of the project, a review framework was developed and included consultation and data collection processes. The review framework identified three high level questions (which were broken down into detailed sub-questions):

- What is the current model for ITC program implementation in the north Queensland PHN region?

³ Department of Health (2019). Integrated Team Care Program Implementation Guidelines. Updated April 2019. Available at <https://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-funding-lp>

- What are the strengths and challenges of the current model for ITC program implementation in the north Queensland PHN region? and
- What is the optimal future model for ITC program implementation in the region?

Where appropriate and necessary, these questions and sub-questions were considered in light of whether the implementation is ‘fit for purpose’ according to the following stakeholder groups:

- NQPHN, particularly with reference to the approach to commissioning;
- Current or prospective service providing contract holders;
- Direct service providers, including ACCHOs, mainstream primary health care services, Hospital and Health Services (HHSs) and the ITC workforce; and
- ITC consumers, carers and local communities.

It is also recognised that north Queensland includes large regional centres, rural areas with varying access to health care and remote/very remote communities (including island communities) which may or may not be discrete Aboriginal and/or Torres Strait Islander communities, and which often experience very limited and/or intermittent access to services. Consideration of this diversity informed the analysis and findings against relevant questions and sub-questions.

1.4 Data sources

1.4.1 Documents and data

The following documents and data were obtained to inform the review:

- Relevant documents which included program guidelines, work plans, protocols and policies, narrative reports and other materials identified during the course of the review. The NQPHN provided access to a comprehensive range of relevant documents to inform the review. Some publically available material was also accessed as relevant, for example, the Australian Government Department of Health’s (DoH) commissioning advice to PHNs;
- Contracts, which included a detailed review of the NQPHN’s current and past ITC program contracts;
- Workforce data, including current and past (three year) data relevant to the ITC workforce including the Full Time Equivalent (FTE) and headcount of care coordinators, IHPOs and Aboriginal and Torres Strait Islander Outreach Workers;
- Program activity data including current and past (three year) activity data for the three contract holders; and
- Publically available population data to help inform an understanding of the extent to which current coverage and reach of ITC aligns with the region’s population profile.

1.4.2 Consultations

To inform the review, consultations were conducted across the following stakeholder groups using the methods described below:

- NQPHN staff who have, or have had, a significant role in the commissioning or implementation of the ITC program in the region. These consultations were primarily conducted as individual or small group interviews in line with advice from the PHN. Indicative content analysis was used to analyse the qualitative data gathered through the consultations;
- The three contract holders, being Northern Aboriginal and Torres Strait Islander Health Alliance Limited (NATSIHA), Northern Peninsula Area Family and Children Services (NPAFACS) and Northern Area Primary Health Limited (NAPHL). These consultations informed many of the review questions, and helped inform the approach to the consultation strategy, particularly with their sub-contractors;
- Significant efforts were made to ensure that the ITC workforce had a meaningful opportunity to engage with the review. In line with advice from the contract holders, interviews and focus groups were conducted in many locations, and the ITC workforce also had access to an online survey (see below);
- Other providers/stakeholders including mainstream general practice, ACCHOs and other relevant providers including HHSs. These consultations were conducted through a combination of interviews and an online survey (see below); and
- ITC consumers and community members were provided with opportunities to contribute to the review through interviews and focus groups that were conducted at a range of locations, and through access to the online survey.

A total of 36 face-to-face consultations were conducted with over 100 participants. Feedback, via a brief paper survey, was sought from all consultation participants to ensure that the process was appropriate and to confirm that information was accurately elicited from the sessions. Feedback from consultations indicated that:

- 100 per cent of participants agreed or strongly agreed that they understood the purpose of the consultation, that they were provided with an opportunity to have their say, and that their views were respected and listened to;
- 96 per cent of participants strongly agreed or agreed that the consultation was respectful and culturally appropriate; and
- 48 per cent of face-to-face consultation participants identified as Aboriginal, 17 per cent as Torres Strait Islander and 14 per cent as both Aboriginal and Torres Strait Islander.

1.4.3 Online Survey

An online survey was issued to expand the reach of the review. The primary purpose of the survey was to provide an opportunity for providers and health sector participants to contribute to the review, and the distribution approach focused on that cohort. However, the survey was made publically available. Respondents were asked to identify as:

- People employed in the ITC program;
- Other people involved in the ITC program (specifically mainstream general practice and ACCHOs engaged to deliver/host/support ITC); or
- ITC clients, or family or friends of clients.

The survey included some general and some targeted questions for these different stakeholder groups, and utilised an internal survey logic. The survey primarily (although not exclusively) aimed to address sub-questions relevant to the review question: *What are the strengths and challenges of the current model for ITC implementation in the north Queensland PHN region?*

In total, there were 173 complete responses to the survey. Of the respondents:

- 10 per cent (n=17) were employed in the ITC program;
- 74 per cent (n=128) were being other people involved in the delivery of the ITC program; and
- 16 per cent (n=28) identified as clients, or family or friends of clients.

Separately, it was noted that 66 per cent of respondents (n=114) identified as being neither Aboriginal nor Torres Strait Islander.

1.5 Limitations

The information presented in this report has been based predominately on the qualitative insights provided through consultations. Due to limitations around reliable data, original contracting rationale and information, and the absence of documents which outline the models of implementation for each of the contract holders, the information presented is the most complete gathered from the conducted consultations.

Impact of data limitations

- Data limitations have made it challenging to confirm the strengths and challenges as articulated in the qualitative interviews;
- Although research points to place-based solutions being more integrated and accessible, there is not clear outcome data to support this model type making a clear difference in this context; and
- Limited access to quantitative data provides limitations around the ability of the review to make statements around current implementation, and whether it has been successful, unsuccessful or had no impact.

Other review limitations

- A comprehensive needs assessment across the north Queensland PHN region in relation to the ITC program and chronic disease was not undertaken as part of this review. The recommendations in this report are based predominately on qualitative analysis of current ITC implementation across the region;
- There was limited documentation on the implementation of the ITC program in north Queensland, coupled with turnover in staffing, which has meant that there was limited available knowledge on the decisions that have been made to date around implementation;
- The effectiveness of current models of implementation are not able to be measured due to limited oversight and provision of direction, the absence of regional guidelines, minimal reporting integration, and delayed guidance and governance around the reporting process;
- Staff turnover within NQPHN and initial contracting processes have impacted effective contract management; and
- It was not in scope to conduct a formal audit of budget or expenditure of the current contract holders. Access to financial information was limited to NQPHN material relating to the initial budgeted funding provided to each contract holder.

2 Current implementation of the ITC program

The following chapter describes current implementation of the ITC program in north Queensland as outlined by key stakeholders in consultations, as well as information obtained through the review of documents provided by the NQPHN. This chapter addresses the review question: *What is the current model for ITC program implementation in the north Queensland PHN region?*

2.1 North Queensland Context

The NQPHN region spans an area of 510,000km², and is home to 675,658 people.⁴ Geographically, it is the fourth largest PHN in Australia, covering 30 per cent of Queensland. Although it covers a vast area, the majority of north Queensland's population resides within the regional centres of Cairns, Townsville and Mackay. Some 68,241 citizens of the north Queensland region identify as Aboriginal and/or Torres Strait Islander, representing 10 per cent of the population.⁵ Overall, the population of the NQPHN region suffers greater disadvantage than Queensland as a whole, with approximately 49 per cent of the NQPHN population falling in the first two quintiles of the Index of Relative Socio-Economic Advantage and Disadvantage, representing those who are most disadvantaged.⁶ The region has 31 local government areas, with 21 of these home to people living in very remote areas.

There is a particularly high burden of disease within the Torres Strait and Cape York, and Aboriginal and Torres Strait Islander people in those areas experience very poor outcomes relative to the general population. Behavioural risk factors including diet, smoking and alcohol consumption contribute to the high burden of disease. The NQPHN region has the third highest rate of overweight and obese people in Queensland and has a higher proportion of daily smokers than the rest of the state (highest in Torres Strait and Cape York).⁷

The NQPHN plays an important role in the coordination and commissioning of health care, and works in collaboration with general practitioners (GPs), allied health and other providers to deliver chronic disease management, aged care, mental health and Aboriginal and Torres Strait Islander health services. The sheer size of the NQPHN region, along with the diverse population groups, provides a challenging environment in which to deliver and sustain services.

Access to services and care is also challenging, with many people being required to travel long and difficult distances to access services, and a reliance on fly-in, fly-out services in many locations. The region does have a strong Aboriginal and Torres Strait Islander Community Controlled health sector, including several large and sophisticated organisations which provide a comprehensive suite of health and social services, in addition to smaller and more locally focused organisations.

In 2017, the NQPHN commissioned a review of chronic care services in north Queensland (for the whole population) which highlighted some of these contextual issues. This report outlined the fragmented, poorly coordinated, episodic delivery of allied health services. That review noted that commissioning allied health

⁴ NQPHN (2017), Health Needs Assessment Update 2017-2018.

⁵ *Ibid.*

⁶ *Ibid.*

⁷ *Ibid.*

services, and not allied health care, has led to people in the north Queensland region not getting the care they need. This focus on commissioning for outcomes was noted to be important in this area, due to the geographic and staffing issues affecting the service system. These contextual issues are exacerbated by the siloed approach to service delivery, with lack of integration among services across north Queensland not effectively meeting the needs of a highly dispersed and transient population.

2.2 Current model of implementation in north Queensland

The NQPHN transitioned from delivery of Care Coordination and Supplementary Services (CCSS) and Improving Indigenous Access to Mainstream Primary Care (IIAMPC) programs to commissioning the ITC program from 1 February 2017. The ITC program is part of a suite of programs included in the Indigenous Australian's Health Program which commenced on 1 July 2014. The ITC program aims to build on the success of the CCSS and IIAMPC programs, to strengthen a team-based approach for the provision of coordinated, multi-disciplinary care. The ITC program aims to combine the support offered under CCSS and IIAMPC to form a single, more coordinated activity, and expand access to Supplementary Services.

The current model of implementation within the NQPHN recognises the different primary care service delivery settings within north Queensland being Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) and mainstream, or private, general practice.

The approach to commissioning in 2016 reflected a continuation of existing arrangements, under which CCSS and IIAMPC were traditionally delivered by both mainstream focused organisations (often Medicare Locals) and ACCHOs. This approach reflected that Aboriginal and Torres Strait Islander people access both ACCHO and mainstream services, sometimes due to access and availability issues and sometimes due to personal preferences.

With the move to the new ITC Program arrangements in 2017, the NQPHN commissioned three providers or consortia to deliver ITC services:

- NATSIHA subcontracts ACCHOs to deliver the ITC program;
- NPAFACS delivers the ITC program within the Torres and Northern Peninsula Area region (excluding Thursday Island); and
- NAPHL delivers ITC services in conjunction with mainstream GP services, and delivers services on Thursday Island.

These three contract holders cover the expanse of the NQPHN, delivering ITC services through a mix of location based and remote ITC workforce. Other than NPAFACS, the contracts do not identify or specific catchment areas (although ACCHOs generally have well understood catchments).

ACCHO ITC model

NATSIHA has been in operation since early 2010, and is a consortium of ACCHOs located within north Queensland. NATSIHA currently subcontracts 10 ACCHOs to deliver the ITC program. The current contract between the NQPHN and NATSIHA does not include clear expectations about coverage or reach to be achieved through these sub-contracting arrangements.

Two IHPOs (employed directly by NATSIHA) have responsibility for building the capacity within the consortium, and supporting coordination and working closely with IHPOs in the mainstream general practice model to coordinate the activities and services of the two models. No documentation was provided to the review to detail how funding is allocated between the various subcontractors.

The delivery of services by NPAFACS was delayed somewhat due to the necessary community approvals required for the organisation to deliver services in the Northern Peninsula. NPAFACS has a 20 year history of delivering child and family services in the region, and it has recently expanded its role to include health and wellbeing, which is where the ITC program fits.

Mainstream General Practice ITC model

NAPHL holds the contract for the mainstream general practice ITC model, and provides ITC services to patients of mainstream, or private, GPs across the whole north Queensland region. NAPHL directly employs Care Coordinators, Outreach Workers and IPHOs. Initially, NAPHL worked in a consortium with Health Reimagined to deliver the ITC program in partnership across Cairns, Tablelands, Douglas, Croydon and Etheridge; however, due to the consortium disintegrating and subsequently Health Reimagined ceasing operations, NAPHL is now the sole provider delivering ITC services through mainstream primary care.

Access to Supplementary Services

The Supplementary Services funding pool can be used to assist clients who are enrolled in the ITC program to access medical specialist and allied health services, as well as eligible medical aids. Provision of funds under Supplementary Services needs to align with the client's GP Management Plan (GPMP). Supplementary Services make up a large proportion of the support provided through the ITC program in north Queensland. While the contracts specify that 30 per cent of overall funding shall be allocated to Supplementary Services funds, and 70 per cent to workforce, it is difficult to determine the extent to which that is actually occurring given the lack of detail available from service providers (see further information in section 3.9).

The purpose of Supplementary Services funds is to enable ITC program clients to access services and aids that are required to fulfil their management plan, that they cannot personally fund and which cannot be provided under another existing scheme, program or funding source.

The Supplementary Services funding pool is a limited resource, and direction is provided by the Program Implementation Guidelines as to what should be prioritised; however, fund-holders can exercise some discretion, and exceptions can be made by the PHN (referred to as extraordinary circumstances). Currently, access to Supplementary Services is managed by individual contract holders, and a Supplementary Services referral guide has been developed by the NQPHN to assist the ITC workforce and contract holders in the provision of the funds.

The NQPHN has developed the Extraordinary Circumstance Register, which logs requests from service providers (and subsequent approvals by the NQPHN) for extraordinary use of Supplementary Services funds. Analysis of the Extraordinary Circumstances Register shows that parameters that are taken into consideration when making a decision around extraordinary circumstance Supplementary Services funding include the cost of the item, the location of the client including access to services, whether the request was considered clinically appropriate and how the item would contribute to the health outcomes of the client.

ITC Staffing

The ITC program is primarily (although not exclusively) a workforce initiative with a key feature of the program being the deployment of care coordinators, IHPO and ATSIOWs. The Program Implementation Guidelines state that the team will work in conjunction across ACCHO and mainstream primary care sectors to meet the aims and objectives of the ITC program. The guidelines recognise that the mix and number of positions will vary, and workforce composition is not stipulated either within the guidelines, or in the NQPHN contract with service providers. The guidelines outline the roles that the ITC workforce are expected to carry out, as outlined below.

Care coordinators: Care coordinators are required to be qualified health workers with a good working knowledge of the health system to provide clinical care to patients. The central role of the care coordinator is to support eligible clients through one-on-one activities to access the services they need to treat and manage their chronic disease, in line with their GPMP. The role includes providing assistance to arrange services and supports, as well working with the patient to improve their capacity to engage with the health system, and to self-management their chronic disease. The care coordinator plays a role in ensuring the patient’s care team is up to date, including their medical records, and schedules regular reviews of the patient through primary care providers. Where possible, the care coordinator should work to build self-management skills in patients, and engage family and the community as appropriate. The care coordinator works closely with Outreach Workers to ensure coordinated service provision.

Aboriginal and Torres Strait Islander Outreach Workers: ATSIOWs (also referred to as Outreach Workers) have strong links to the community where they work and are able to effectively communicate within the community. The outreach worker’s role is to provide non-clinical services, and does not require clinical qualifications. The role of Outreach Workers should be tailored to meet the needs of the community and might include community liaison, administration and support, and/or practical assistance to access services including transport. The outreach worker should feedback any identified barriers to access experienced within the community.

Indigenous Health Project Officers: IHPOs provide a policy and leadership role with a focus on Indigenous health and improving integration of care. Qualification levels are not outlined for IHPOs. Skills required to fulfil the IHPO role include needs assessment and planning, program development, capacity development and cross-sector linkages. IHPOs are tasked with identifying and addressing barriers faced by Aboriginal and Torres Strait Islander people in accessing mainstream primary care services, promoting providers, delivering and coordinating cultural awareness training and educational events and disseminating information about programs and resources to communities.

Client profile

The ITC program was established to help Aboriginal and Torres Strait Islander people with complex chronic disease who are unable to effectively manage their conditions. To be eligible for the ITC program, participants must be Aboriginal and/or Torres Strait Islander with:

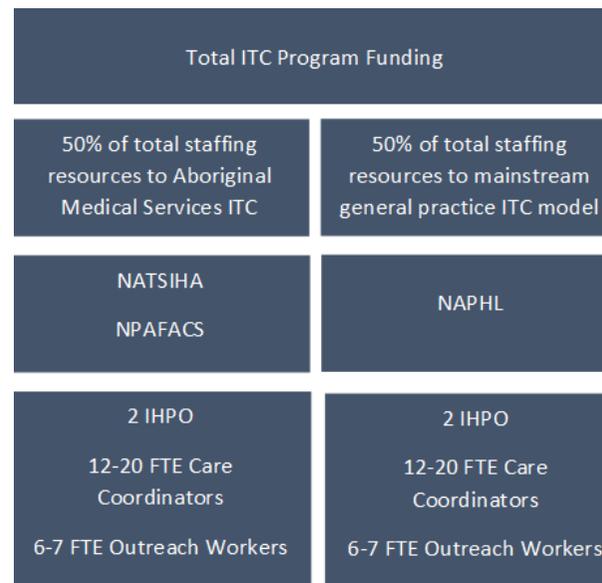
- a chronic disease condition present for at least six months;
- a completed a GPMP, items 715 and 721 under MBS; and
- an ITC program referral form completed and signed by the client and their GP.

There is a high prevalence of chronic disease in the region among the Aboriginal and Torres Strait Islander population, with some communities reporting rates of well over 50 per cent of the population. The review has found that ITC clients come from all parts of the region and, while most clients are older, many young people, including some children, receive support through the program. It appears that more females engage with the ITC program than males. In the 12 month report to the DoH in 2017-2018, the client numbers were reported to be 6,496 females and 5,146 males. In some locations ITC program workers reported that up to 90 per cent of their clients are female, and this was often associated with having an all-female ITC program team in that location.

2.3 ITC program staffing profiles across contract holders

In the ITC activity plan developed by the NQPHN, half of the staffing resources were to be allocated to the community controlled sector and half to the mainstream model, as outlined in Figure 2 below.

Figure 2– Provision of funding for ITC staff as per NQPHN ITC Activity Plan



According to the activity plan, the ITC program across the NQPHN area should employ:

Table 1 – Number of staff as per activity plan across the NQPHN region

Role	FTE staff across NQPHN region
IHPO	4 FTE
Care coordinators	24-40 FTE
Outreach Workers	12-14 FTE

Source: Consultancy analysis of NQPHN ITC Activity work plan

Based on the consultation process, and the workforce data analysis, the current actual staffing profile across the ITC program does not appear to align with these projected numbers. However, it has been difficult to ascertain clear actual staffing numbers due to incomplete and apparently inaccurate data.

Funding was allocated to each of the three contract holders based on factors including population and need; however, there is limited information available to the review to describe how these decisions were made. It was stipulated within contracts that 70 per cent was for ITC staffing, and 30 per cent was for supplementary services. It was reported that contract holders used their funding to meet the needs of their communities, and therefore the staffing varied.

This review did not include a forensic analysis of expenditure and organisation acquittals.

2.4 NATSIHA model

NATSIHA delivers ITC program services through the subcontracting of ACCHOs across the region. Services through these subcontracted organisations are either delivered through:

- the ITC workforce being present within communities; or
- the ITC workforce being located in larger regional centres and delivering the ITC program remotely.

The **use of an intermediary** such as NATSIHA in the delivery of the ITC program was reported differently among stakeholders. NATSIHA was noted to provide a 'buffer' to enable clinical staff to concentrate on service delivery and focus on clients; however, it was also recognised that using an intermediary created another layer of complexity to the program. It is recognised that the current model being delivered by NATSIHA is not entirely as intended through the ITC Program Implementation Guidelines, with current implementation weighted towards providing Supplementary Services and transport, with the provision of care coordination growing over time through the NATSIHA network.

Across the services subcontracted by NATSIHA, there was **variation in the way the ITC program model had been implemented**. This spanned:

- an opportunistic model, using the base of an accommodation service to access clients and expand service provision to include clinical support for chronic disease patients as has happened in Mookai Rosie Bi-Bayan;
- the ITC program being delivered in isolation to other services provided by an organisation, for example in Mamu Health Services;
- the integration of ITC program funding into broader service delivery funding to provide an integrated model across a number of funded services within an organisation for example in Wuchopperen Health Services, Gurriny Yealamucka Health Service and Townsville Aboriginal and Islander Health Services; or
- ITC funding is used to support people when they travel to regional centres in order to access healthcare, rather than support them in their home community, e.g. Apunipima and PIC.

Stakeholders noted that the implementation of the ITC program is restrained by the **funding allocation**. Care coordinators working remotely from the region they were servicing was noted, with the cost of travel limiting – in some circumstances – their ability to visit the communities in which they work. This factor influenced the implementation model of Apunipima in particular, with an acknowledgement that the funding provided would not enable active case coordination across all of Cape York, resulting in the decision to prioritise those travelling to Cairns for treatment. Consultations noted that the inability to locate program staff on the ground in communities also had an impact, as remote workers are not able to engage regularly with the local community, educate staff and services

on the ground including locums, and follow up with clients. Where service providers had staff based in communities, it was consistently reported that the benefits of the ITC program were visible, with more patients being assisted, particularly through Supplementary Services.

Transport was consistently reported as a major element of the ITC program, due to limitations around other transport options for ITC patients. The model implemented by NATSIHA noted that although some patients may not be eligible for care coordination, they would have been considered eligible for the IIMPC measure, creating some confusion for service providers. It is also noted that while transport access was a significant challenge across the NQPHN some local services were able to leverage existing travel such as Mamu, which facilitated the use of their existing client transport for ITC clients. Another service, the Townsville Aboriginal and Islander Health Services (TAIHS) provided transport through outsourcing to an external transport provider.

The **IHPO role** within the NATSIHA model was intended to network across the service system; however, there was variation in the success of this approach reported by stakeholders. With ACCHOs' capacity taken up by core business, the IHPO role within NATSIHA aimed to link services and resolve issues. The role was described 'to bring people together to share issues and streamline problem solving'. There was recognition the ITC program had the capability to give clients a sense of ownership over their care journey, with the IHPO's aim to build capacity and capability to do this. Implementation, however, was being affected by factors such as the development of streamlined referral processes, awareness of the service, and capacity of the services which are tasked as part of the IHPO role. In consultations, the ITC workforce at NATSIHA reported they had experienced the role of the IHPO differently depending on the proximity of the IHPO and the workforce, and the access the workforce had to the IHPO role. Within NATSIHA, the IHPO had predominantly a leadership and management role within the organisation, with limited networking and system integration activities reported by the broader workforce.

Some stakeholders consulted had the view that programs such as the ITC program should not be delivered through Aboriginal Medical Service (AMS) providers. This was a divergent view within consultations.

It was unclear through consultation and provided documents as to the **administration support provision** for the ITC program within NATSIHA. It is noted that in the breakdown of funding allocation within a contract variation for a care coordinator, there was no allocation made to administration support functions. Some stakeholders reported in a number of the sub-contracted organisations that the reporting requirements were completed by administration staff within the organisation and not the front-line worker; however, it is not known how this funding is allocated, or the provision of time for ITC administrative functions. Other stakeholders reported that the care coordinator was responsible for most of the administration, data capture and reporting due to capacity challenges within the organisation. This example highlights the differences in ITC program implementation between service providers under the same contract holder.

Current intake and referral processes for NATSIHA

There is no streamlined process for intake and referral across the NATSIHA ITC service providers. NATSIHA service providers spoke about the evolution of the referral forms in some regions, citing the limited information provided upfront in the referral as an instigator for change. Stakeholders consistently reported the importance of streamlined referral processes due to the transient nature of a portion of the population within north Queensland, as well as ITC patients moving, either short term or permanently, to receive medical treatment. Some service providers reported the initial stages of developing pathways between different ITC service providers, however this was in its infancy.

There was an overall understanding of the eligibility requirements for the ITC program, with stakeholders consistently reporting that the requirement for patients to enter the ITC program is to have a care plan written by a GP (MBS item 721), with some providers highlighting the benefits of having a health check (MBS item 715) as well, although recognising this is not mandatory. It was noted in some remote areas that it could be difficult to gain timely access to GPs to complete care plans due to the rotating workforce, and GPs visiting some locations only sporadically. Where there was knowledge of the ITC program in an

area, referrals were reported from GPs to meet a particular need, for example either care coordination or Supplementary Services. Service providers under NATSHIA reported receiving referrals from mainstream GPs and GPs located within AMSs.

Stakeholders reported that home visits have led to broader identification of family members who would benefit from the ITC program. This identification leads to an alternate referral source into the ITC program, with care coordinator and Outreach Workers then supporting these family members to obtain the required referral documentation at the GP.

2.5 NAPHL model

NAPHL is the sole contract holder under the mainstream general/private practice ITC model. Originally contracted in a consortium with Health Reimagined, NAPHL became the sole contract holder in 2017/2018. NAPHL complements the care provided by GPs through their service provision, increasing capacity to manage complex care needs within the mainstream service system. NAPHL employs a number of care coordinators, Outreach Workers and IHPOs to work with GP clinics across north Queensland to support mainstream services to refer clients to the ITC program, and provide care coordination and outreach support. Each care coordinator provides support across a number of different mainstream GP clinics. Consultations outlined this support generally equate to approximately half a day to one day per fortnight; however, frequency and consistency was dependent on the GP clinic and the care coordinator. Some examples were provided where support was provided completely remotely, with the clinic not physically engaging with the ITC program staff.

The NAPHL contract was signed in January 2017 for the term of 1 February 2017 to 30 June 2018, noting there was no formal documentation cited outlining the basis for the original contracted amount developed. The NAPHL contract has been extended twice under two separate variations for the period 1 July 2018 to 31 December 2018, and 1 January 2019 to 30 June 2019.

NAPHL noted in consultation that it was not unusual for one **care coordinator** to have up to 200 clients. The ITC program within the region has become the 'go-to' where there are no other options for support, and as the program becomes more known throughout the region, demand is growing for the services. NAPHL reported a waitlist for services in some areas, noted in Mackay consultations, and consultations with NAPHL more generally. NAPHL outlined that the provision of the ITC program through the mainstream/private practice model provided options for clients who did not want to engage with an AMS, with some of the ITC workforce reporting that clients believe the mainstream system 'is better because it is more confidential'.

Mainstream/private practices which were engaged as part of the consultation noted that the ITC program provided a necessary service for the system; however, the inconsistent and infrequent availability of the ITC workforce in some areas, for example Mossman, was impacting on engagement with the program and the ability to meet the needs of the community. As an example one private GP clinic had requested the ITC service pause for a period of six months, given the worker was often sitting in the clinic but not fully utilised and not receiving adequate referrals. Mainstream/private clinic staff outlined the difficulties with the provision of the ITC program through the NAPHL model, with contextual factors such as a predominately fly-in, fly-out workforce (in some regions) and rotating general practitioners meaning that, if the ITC workforce day at the clinics does not align with a GP, the knowledge of the program by those GPs is impacted.

Transport was raised by NAPHL as one of the biggest benefits of the ITC program, but was impacted by access to accessible vehicles, as well as access to buses and larger cars to enable the service to meet the need.

NAPHL reported that an increasing demand for Supplementary Services has led to a 'significant' overspend. NAPHL also outlined that they had limited feedback from the NQPHN around the implementation of the ITC program.

Current intake and referral processes for NAPHL

Referral and intake for NAPHL ITC services happens through mainstream/private clinics, including GPs and hospitals. All referrals to NAPHL are processed through a central inbox in Townsville, with some ITC program staff stating this can take a number of days to happen, with others stating referrals are only processed twice per week. The centralised referral process enables NAPHL to have an understanding of the provision of ITC program services across the region; however, the benefits of this are unknown due to the ongoing issues with reporting client numbers.

NAPHL staff raised some concern about the centralised referral processing system, noting that it created a delay in service for clients, particularly creating an issue for clients being referred when they are being discharged from hospital. Hospital staff stated they work with NAPHL to get clients linked into services when they are new to their current location, recognising the high numbers of transient clients across the region. The HHSs reported that they use NAPHL to get clients connected to a GP, the provision of transport to attend appointments and get their health 'back on track'.

NAPHL care coordinators consistently reported that a home visit was part of the intake process. Some mainstream providers outlined the concern for the ITC workforce to engage in home visiting on their own, questioning the occupational health and safety and risk assessment processes of the ITC program. NAPHL staff outlined the importance of broader referrals, ensuring that clients were not building a reliance on the ITC program, and using it as a transition to programs within the broader service system. One GP clinic nurse stated that NAPHL staff "are deadly at knowing the local services and how they can bring those in to support vulnerable clients". NAPHL staff spoke about engaging the broader service system for particularly vulnerable clients, with the example of using an accommodation provider for homeless clients noted.

2.6 NPAFACS model

Northern Peninsula Area Family and Community Services (NPAFACS) is an Aboriginal and Torres Strait Islander Community Controlled organisation, which has delivered culturally appropriate social services to communities of the Northern Peninsula Area for more than 20 years. Initially with a focus on supporting women and children who experienced family violence, NPAFACS has expanded its role and focus to include social, health and emotional wellbeing services.

NPAFACS signed its initial ITC program contract in February 2017, for the period 1 February 2017 to 30 June 2018. The ITC program was commenced by Northern Peninsula Area in August 2017, and delivery on Badu Island and Darnley Island did not commence until January and March 2018, respectively. Within the Northern Peninsula Area and Torres Strait Islands, community approval is required to commence service delivery. The NPAFACS contract has been extended twice under two separate variations for the period 1 July 2018 to 31 December 2018, and 1 January 2019-30 June 2019. A further variation was noted for the period of the initial contract for services which increased funding, with no documentation about the reason for this.

The implementation of the ITC program by NPAFACS was supported by the implementation approach which included council and community in the design of the model. It was also noted that the program benefited from staff being from the areas in which they worked, having community ties and trust within the communities.

Community consultation noted that the number of clients per outreach worker was not sustainable, with the need of the program in the region being so high. Consultations with community highlighted the usefulness of the practical education provided by the ITC workforce, including meal programs and cooking

demonstrations. Feedback noted a common theme that the staff were considered to be approachable, caring and smiling. The community noted that the ITC program is invaluable, providing an inclusive environment for people to get the support and help they need for chronic disease.

'When you go to the doctor the doctor gives you a suitcase with all these indigenous programs and they (ITC) help you unpack the suitcase.'

- Community

Within the region covered by NPAFACS, there were difficulties noted in relation to telephone signal. This impacted on the ability for ITC workers to communicate with community and vice versa. The ITC program in the area was also reported to be impacted by limited access to other services such as OBGYN, ophthalmology and endocrinology. Community and ITC workers in the area noted that, despite the success of the ITC program, the rates of chronic disease will continue to rise unless health promotion for the community was prioritised.

Current intake and referral processes for NPAFACS

NPAFACS has developed client process flow charts to guide referral and intake. Through the community consultation, it was noted that the referral process was 'easy and allowed for no excuses' and this was highlighted as one of the strengths of the ITC program in the region. The remote location of the Northern Peninsula Area requires the development of strong links between ITC program staff and other service providers across the region, and this was noted particularly between ITC and GPs. NPAFACS has developed a Memorandum Of Understanding (MOU) with Torres and Cape Hospital and Health Service to ensure that there are clearly defined roles and responsibilities to achieve better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people. Within the MOU, NPAFACS identifies that it would provide two full time care coordinators, and 1.5 full time Outreach Workers; however, it is noted that these numbers are different from those reported in the quantitative reports and through consultation, which outlined one IPHO, three care coordinators and four outreach workers. The MOU sets out ways of working between NPAFACS and the Torres and Cape Hospital and Health Service, including referral pathways, case conferencing, provision of support to allocate Supplementary Services, shared facilities and information management.

Consultations noted that while the MOU has been effective between NPAFACS and the Torres and Cape Hospital and Health Service, stronger referral pathways are needed between Badu, Darnley and the Northern Peninsula Area.

2.7 Supplementary Services

Supplementary Services in the north Queensland region are being utilised consistently across the three contract holders, and used predominately for the provision of transport and medical aids. Most contract holders reported transport was the greatest use for Supplementary Services, except for one service provider who had their own transport services internally. Where transport was used it included the provision of taxi vouchers and flights to enable clients to attend required appointments. People external to the ITC program ranked Supplementary Services as the most valuable part of the ITC program; however, acknowledged that broader transport options were needed to effectively support people living with chronic disease in the region.

'Why not fund a transport unit separate from the ITC care so that more coordination and care can be given.'

- Other person involved in ITC

Some service providers noted that recognition of Supplementary Services funds as a last resort placed an emphasis on sourcing items and ‘getting a good price’ which is very resource intensive. One contract holder reported having developed relationships with certain providers who allowed the contract holder to invoice them to use Supplementary Services, which has streamlined the process on both sides.

The process to use Supplementary Services provided challenges for service providers across north Queensland. It was recognised that although clear, the Program Implementation Guidelines do not ‘accommodate local nuances.’ Supplementary Services funds are not allowed to be used for freight, which has been an issue for getting aids and equipment to people in remote locations. Implementation has been affected by the requirements to get approval consistently for similar needs, which was described as an administrative burden by the ITC workforce. One contract holder formed an extraordinary circumstances form working group to help streamline some of these processes.

Contract holders also noted the high demand for use of Supplementary Services, with many having to shift their focus due to limited funds. One service provider stated “We don’t do podiatry so much anymore because we can’t afford shoes, they cost up to \$900.” There was also a reported disconnect between what some GPs requested and what is eligible equipment under the Program Implementation Guidelines.

All contract holders noted the link between care coordinators and supplementary service funds, with the care coordinators providing access to Supplementary Services. A reported increase in the demand for Supplementary Services was noted, with Supplementary Services enabling clients to get necessary equipment in a more timely manner. It is unknown whether current spending by service providers aligns to the allocated 30 per cent of ITC funding; however, contract holders reported that from month to month their allocated funding for Supplementary Services is exhausted, with one contract variation providing extra supplementary service funding to one contract holder.

‘We have overspent this year largely due to increased demand for Supplementary Services funds.’

- ITC contract holder

2.8 The use of digital technologies

Digital technology is currently being used to varying extents across the ITC program. Contract holders noted that, predominately, client management is done through excel spreadsheets, with one contract holder reporting the ongoing implementation of a new data system, which had mixed reviews from staff. eHealth and MyHealthRecord will provide consistency across the NQPHN when fully implemented, with service providers noting that it would assist in the management of the transient population across north Queensland, and allow patient consultation and medication summaries to be viewed within the patient health record. There is currently no consistent process to utilise GP progress notes across the ITC program.

It was reported there are often connectivity difficulties in the Northern Peninsula and outer islands related to IT systems. It was further reported that this impacted the ability of digital technologies to increase efficiencies, with paper notes needing to be used to document case notes and contact details when systems are unavailable.

All care coordinators had access to a laptop; however, some reported that their use shifted the way staff engaged with clients, which did not assist in building rapport and relationships. Commonly, ‘write ups’ were reported as being completed when ITC staff returned to the office.

The opportunity to gain accreditation under the Royal Australian College of General Practitioners, which enables access to MBS incentives, was noted as a priority across a number of locations. Some organisations were working with the Queensland Aboriginal and Islander Health Council (QAIHC) to achieve this accreditation. One stakeholder noted the importance of this accreditation with respect to accessing government incentives, which would enable sustainability of practices across the NQPHN region.

The use of telehealth, whilst only reported by a few stakeholders, played an important part in enabling the provision of services to a number of areas within the region. Telehealth provided access to specialist appointments in remote communities.

Overall, stakeholders reported an inconsistent use of technology across contract holders and locations, with opportunities to streamline the use of technology, and capitalise on the implementation of MyHealthRecord to bolster the continuity of care provided to clients of the ITC program.

2.9 The use of other funding sources

Minimal information was available to understand the funding sources outside the ITC program being used in implementation. A number of service providers under one contract holder noted that they had pooled their ITC funding with other programs delivered at the service to provide a more holistic and integrated outcome.

As mentioned above, Supplementary Services are used as funds of last resort. Care coordinators investigated access to funding through other State and Commonwealth initiatives including the Medical Aids Subsidy Scheme (MASS), MyAgedCare, National Disability Insurance Scheme (NDIS) and the National Diabetes Services Scheme (NDSS). It was noted that although these other funding sources and supports were available, access to Supplementary Services funding was generally more efficient, and therefore enabled clients to have their needs met in a more timely manner. In some instances, Supplementary Services funding was used to bridge the gap through renting equipment while funding through other sources was processed.

The transition to NDIS within the north Queensland region has provided an opportunity to assist some clients under the ITC program. One contract holder outlined a process to engage their Director of Allied Health to assist the ITC workforce to sign patients up to the NDIS and make referrals. Due to the broader implementation issues with the NDIS rollout, the impact of this on ITC service provision is not yet known.

In respect to travel, the patient travel subsidy scheme through the Queensland Government provides financial assistance for patients who are referred to specialist medical services not available at their local public hospital or health facility. Although useful, a number of stakeholders noted that the paperwork and processing time impacted its uptake for ITC program clients.

'We are currently funding 35 trips a day to the airport as PTS (patient travel subsidy) doesn't fund this.'

- ITC workforce

2.10 The ITC Program Implementation Guidelines

All ITC workforce consulted reported that they were implementing the model in line with the Program Implementation Guidelines. One contract holder reported using the guidelines as a basis for induction, ensuring that staff understand program requirements. Stakeholders consistently reported that the Program Implementation Guidelines were better suited to an urban model of implementation, and do not provide enough flexibility to meet the complex needs of chronic disease clients in north Queensland. A number of stakeholders reported the need to 'balance the guidelines with the needs of the community', with the unique context of north Queensland impacting on elements of the model, for example the high need for Supplementary Services funds for transport.

Although reportedly guiding implementation, the extent to which the ITC workforce has implemented all aspects of the ITC model is variable across the region. For the most part, the ITC program is delivering access to Supplementary Services funding across the region. This has enabled clients to access required medical aids and transport to manage chronic conditions. The care coordination element of the ITC model has been implemented in a more variable way across the region, being used predominately as a gateway for clients to access Supplementary Services. The concept of care coordination within the north Queensland region may differ from other urban centres, due to access issues and the large geography.

The Program Implementation Guidelines state that priority for the ITC program should be given to clients with complex chronic care needs who require multidisciplinary coordinated care to manage their conditions. Stakeholders clearly understood that dental conditions are ineligible for ITC support, and this was noted as a gap. Other conditions which were reportedly not covered under the ITC program included Rheumatic Heart Disease, which is identified as a condition of higher prevalence across the Aboriginal and Torres Strait Islander populations and therefore relatively more common in the population of north Queensland. Although the guidelines include the coordinated care for mental health conditions, this was not explored by stakeholders, and is recognised to be a large area of unmet demand for the ITC program in north Queensland.

2.11 Coverage and reach

Data from the Public Health Information Development Unit (PHIDU) shows a high proportion of need for the support and management of chronic disease within north Queensland. Figure 3 illustrates the alignment between potentially preventable admissions due to chronic conditions and the location of Aboriginal and Torres Strait Islander persons across the region. Figure 4 shows potentially preventable hospitalisations for a chronic condition based on an average annual Age Standardised Ratio (ASR) per 100,000 people. ASR eliminates the effect of differences in population age structures, and allows populations to be compared when age profiles of populations are different. Including an ASR comparison enables data to be compared across regions. The information provided in Figure 3 provides a sense of the volume of admissions; however Figure 4, through standardising size and age of the population, provides an understanding of better and worse areas for admissions across the region. This shows a shift from alignment between population density and potentially preventable admissions. What this data shows is that when using ASR, the number of preventable hospitalisations for chronic conditions increases in Cape York, and remains high in the areas around Cairns.

Permanent ITC staff locations have been overlaid on Figure 4, which shows the location of ITC program staff, and the need within north Queensland. The current service delivery model has created pockets of under- and over-servicing in different areas, which is being embedded through lack of coordination and

integration of ITC service delivery across contract holders. ITC program staff are located predominately on the east coast of the NQPHN region, potentially over-servicing in ITC program participants in Cairns, with reduced numbers of ITC program staff and therefore potential under-servicing of ITC program participants throughout the Cape and Western area of the NQPHN region. Over-servicing creates a number of options, with stakeholders reporting that ‘people get lost not knowing who is looking out for them’ in some of these over-serviced areas. It is noted that one contract holder subcontracts a service provider to deliver the ITC program to Cape York; however staff are based in Cairns. Although this theoretically means ITC is delivered in these areas, coverage and reach of the service is impacted through this delivery method. Consultations consistently reported the benefits of implementing the ITC program with staff based on the ground in communities. Other factors impacting the current coverage and reach of service delivery were reported to include the ability to find suitable staff and the funding provided to contract holders to service large geographic areas.

Consultations also outlined the impact broader service system access has on ITC program supports. Areas with a more developed service system, such as Cairns or Townsville, were supported in the delivery of the ITC program. This related to foundational requirements for the ITC program such as access to GP services and to broader infrastructure such as public transport options for appointments. Smaller, more remote communities were impacted by lack of service system access, with some consultations exploring intermittent access to GPs, as well as the ability of clients to engage with allied health professionals, being impacted by allied health visits scheduled for the same day as dialysis. Access to mental health services were consistently reported across the region to be a challenge, as they were limited, as well as intermittent due to the fly in, fly out nature of those services.

A number of examples were provided in consultations with stakeholders which outline under- and over-servicing in certain areas.

In Mossman, ITC services are duplicated by two separate contract holders; however, due to service level constraints, neither provider reported the ability to implement the ITC program to its intended purpose. One service is supported by a care coordinator approximately one hour and 15 minutes away, and is implementing the ITC program among other work with an Aboriginal community. Although supportive, the fact that the care coordinator is not located on site has reportedly placed extra pressure on the workers within this ACCHO. The other service provider is supporting the provision of the ITC program through a mainstream medical service. The ITC care coordinator is scheduled to attend the service for half a day each fortnight; however, due to a number of reasons has reportedly been unable to consistently attend. This has affected the awareness of the ITC program within the service.

In Bowen, further resources were required to meet the community need for the ITC program. Originally the ITC workforce in this area only included a part-time outreach worker. The NQPHN, through a contract variation, increased service funding to employ a full time care coordinator to meet the need. Townsville and surrounds have reportedly experienced similar issues, with demand for the ITC service greater than the capacity due to the area being a hub for the north-west region.

Figure 3 – Total number of potentially preventable hospital admissions due to chronic conditions with inset of population density

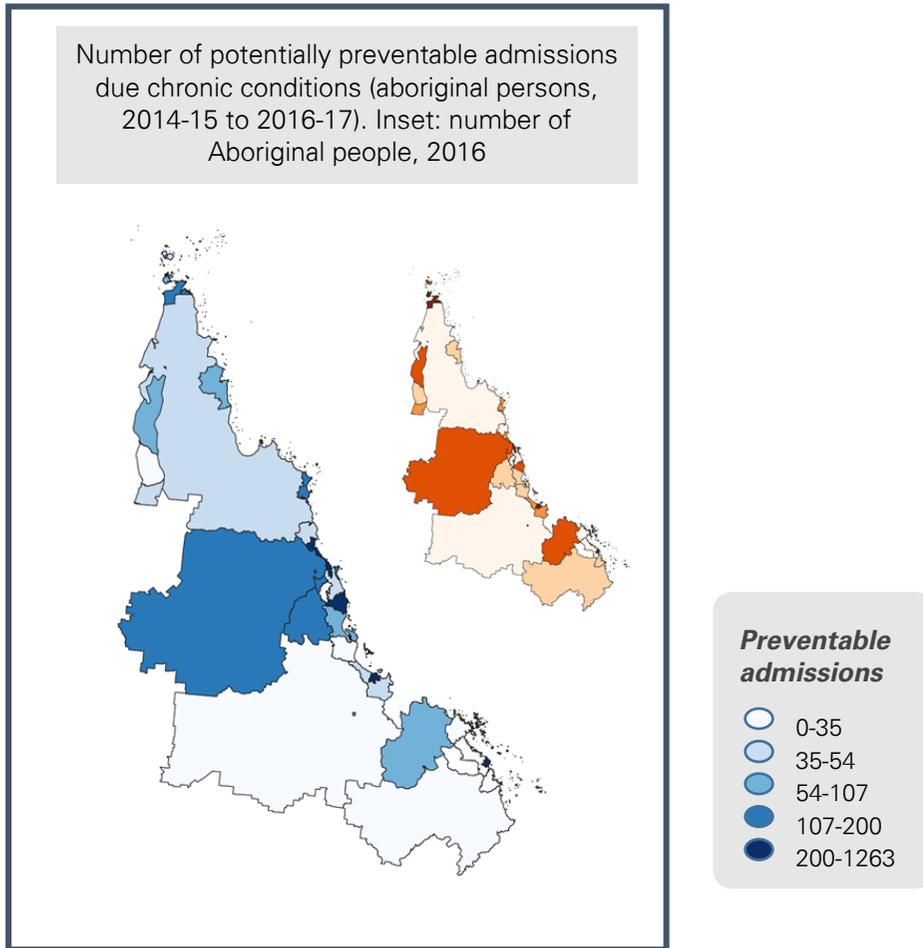
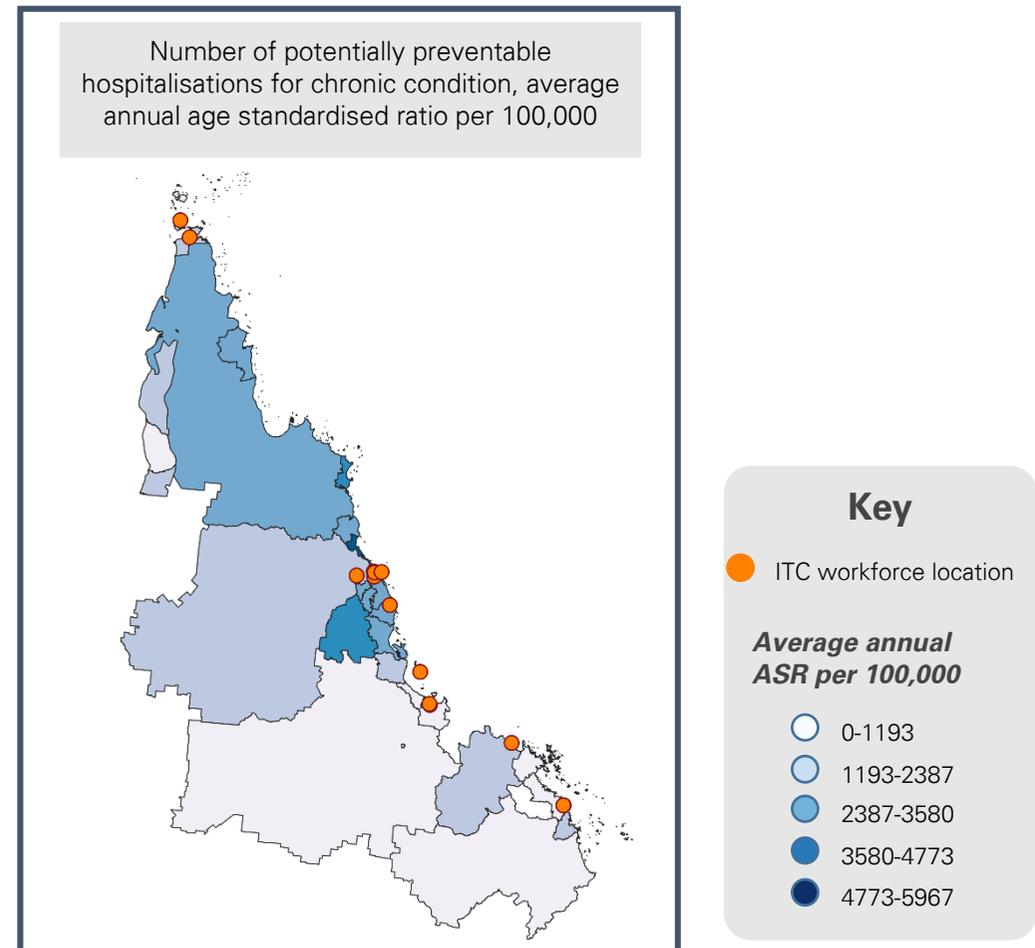


Figure 4 – Number of potentially preventable hospitalisations from chronic conditions through average ASR, with overlay of ITC staff locations



2.12 Workforce supports

The provision of workforce supports across the service providers delivering the ITC program is dependent on the location of the workforce, access to an IHPO and broader demand for other aspects of the program. Stakeholders clearly identified professional development opportunities and access to leadership support and debriefing as necessary for the provision of the ITC program; however the consistency in which they were provided was dependant on contextual issues. Some stakeholders reported access to a wide range of professional development supports, whereas others have experienced limited access to formal and informal development and support options. Larger service providers linked the ITC program staff into broader workforce development opportunities offered by their organisation.

Formal professional development opportunities for the ITC workforce have been provided through the implementation of the ITC program in north Queensland. Formal professional development and training were expressed in two different ways, both proactive and reactive training opportunities. Examples were provided across the three contract holders of the workforce attending training held by the contract holders themselves, or other organisations sub-contracted to deliver the ITC program. Available reports show generally positive feedback to workshops offered, with a focus on highlighting best practice.

Outreach Workers were highlighted as a workforce group where support and development were particularly important, as this group may not have had a lot of other training prior to engagement with the ITC program. Examples were provided of a number of Outreach Workers being supported by an organisation to complete their Certificate IV in Primary Health Care, which included access to study leave. Outreach Workers were being supported to link into broader financial supports, including those offered by TAFE to support this endeavour. Other examples of formal training that have been provided include mental health first aid and chronic disease education.

'We are supporting seven workers to do their Certificate IV in Primary Health Care, including study leave.'

- ITC contract holder

Broadly, other ITC staff were reported to have been provided, where appropriate and a need is identified, opportunities to complete formal qualifications. Staff are supported to attend training through study leave. An example provided is a Care coordinator supported to complete a Certificate IV in Primary and Community Health Care. Although understood to be an important part of ITC program development, it was recognised that training and professional development opportunities that take staff away from their service delivery requirements places extra pressure on other staff members, or has an impact on the ability of the ITC program to be delivered more broadly during that time.

The provision of debriefing for staff also varied across location and contractor. Through consultations it was clear that staff engaged with the ITC program generally work in high pressure roles, with significant community expectation as well as high levels of vicarious trauma due to the situations to which they often respond. With the complexities of ITC program delivery with patients and a reported absence of leadership support in some areas, stakeholders identified various impacts on implementation.

Across the region ITC support groups was noted as a current implementation gap. Working to build the capacity of ITC workers on the ground to resolve issues as they arise would enable a more streamlined approach to service provision. Stakeholders outlined access to information and guidance in relation to implementation was limited, and the ability to learn and problem solve with other ITC workers would be beneficial.

A number of factors were reported to effect the implementation of workforce supports. Throughout implementation, reported high staff turnover made up-skilling and development difficult in some areas. Factors influencing turnover were reported as:

- the pressures of the role;
- other career opportunities;
- organisational politics;
- staff burn out; and
- personal and community pressure.

Alongside high staff turnover, demand on the service and high caseloads was noted to make it challenging to prioritise time for development opportunities.

Funding was raised by contract holders as an impediment to workforce development and support. This included both access to funding for the provision of training, but also funding to enable travel and support for staff debriefing. One example was provided in which an outreach worker was supported to undertake a Certificate III from funding specifically allocated to the care coordinator through a direct contract with the NQPHN.

Broader workforce professional development, notably the provision of training to increase the cultural appropriateness of mainstream services, was reported as inconsistent across the region. Some organisations reported the provision of cultural awareness training; however, all stakeholders recognised this has not been a focus of their ITC program provision. An example was provided of one contract holder working with a service delivery organisation to deliver cultural induction training which was tailored to working with local communities being delivered in 2018, in which 40-45 nurses, GPs, practice managers and nurse navigators attended.

The role of the IHPO in relation to workforce supports was often not clear among stakeholders, with the provision of management and team leader responsibilities being prioritised over training and sector development. It was recognised that the IHPO had a role in communicating opportunities for external training opportunities to the ITC workforce. An example was provided of an IHPO offering two workshop sessions, one which brought together organisations in one area to increase the understanding of the ITC program and the other about chronic disease. The purpose of this session was to up-skill new staff.

2.13 Examples of ITC implementation across Australia

The Program Implementation Guidelines encourage PHNs to develop “flexible approaches to ensure Aboriginal and Torres Strait Islander people are able to access high quality care.” As such, the 31 PHNs across Australia have developed ITC Activity Plans that respond to the individual needs of their PHN region. A review of six PHNs in rural and remote areas of Australia found different approaches to commissioning, the model of care and the location of ITC staff.

Approaches to commissioning

Two broad categories of commissioning approaches emerged from the practice scan. Western NSW (WNSW) PHN and Country South Australia (CSA) PHN adopt a single / most capable provider approach. In contrast, Northern Territory (NT) PHN, Western Queensland (WQ) PHN, Country Western Australia (CWA) PHN, and Gippsland PHN adopt more ‘flexible’ approaches that consider a range of contextual factors not limited to demographics, service demand and service continuity.

The nature of commissioned service providers also differ between the PHNs examined. A subset of PHNs commissioned ACCHOs only, or to a large extent. These include WNSW PHN (through a consortium arrangement), NT PHN (up to 90% ACCHOs), WQ PHN (through four ACCHOs) and Gippsland PHN (also through four ACCHOs). Other PHNs commissioned a combination of ACCHOs and mainstream service providers. These include CSA PHN (six ACCHOs and four mainstream providers) and CWA PHN (six ACCHOs and five mainstream providers).

Current model of care

Patient-centricity, specifically an emphasis on culturally appropriate service delivery sits at the core of all ITC service delivery models examined. Notably, the WNSW PHN has a brokerage model of care for both Aboriginal Medical Services (AMSs) and mainstream general practitioners through its consortium arrangement. The brokerage model is reported to increase effectiveness in sharing resources (ultimately leading to cost savings that could be reinvested towards patients), improved access, improved health outcomes, and increased cultural safety. Another notable model of care is found in WQ PHN, where a hub-and-spoke model of delivery is adopted. In Gippsland PHN, the model of care is dependent on the funded service provider, with considerations given to the most appropriate way to meet local needs.

Location of ITC staff

The Program Implementation Guidelines allow for strategic workforce placement across a region to suit local community needs. The flexibility extends to the location of Indigenous Health Project Officers (IHPOs), who can be engaged externally (through the commissioned service providers) or internally (as part of the PHN). The ITC Activity Plan of WNSW PHN, CSA PHN and Gippsland PHN specifically describes workforce placement based on strategic considerations, such as service need, workforce (availability and capability), ITC activity objectives, and population density. The ITC Activity Plan of other PHNs examined are silent on this matter, but this does not preclude those PHNs from having applied a strategic, or other approach to workforce placement.

The location and number of the IHPO role vary across the PHNs examined. The IHPO role is included in both the external, commissioned workforce and internal, PHN workforce for WNSW PHN (1 FTE external IHPO Program Coordinator and 1 FTE internal IHPO Program Manager), WQ PHN (1 FTE external IHPO and 2 FTE internal IHPOs located in North West and South West respectively), and CWA PHN (7.8 FTE external IHPO and 1 FTE internal IHPO). In CSA PHN, there are 4 FTE IHPOs, all engaged within the external workforce. Notably, the placement of IHPOs exclusively within the external workforce in the case of CSA PHN has been questioned by an ITC Evaluation. Stemming from the evaluation findings, CSA PHN has committed to monitoring IHPO activities and review its service model (as well as commissioning arrangement), into the future. In Gippsland PHN, there is 1 FTE IHPO only, who is engaged within the internal workforce. Details of the IHPO role is not provided in the ITC Activity Plan of NT PHN.

2.14 Summary

The current model of ITC program implementation is a dual commissioning approach, and recognises the unique contextual factors of the north Queensland region. The current model implements the ITC program through ACCHOs and mainstream general and private practices, which has created fragmentation in service provision, and reported over- and under-servicing across the region. Variation was evident across the region, particularly in relation to:

- Staffing profile between contract holders;
- Funding provided to contract holders;

- Intake and referral processes;
- Coverage and reach of service provision, including the provision of services through staff within communities or remotely;
- Administrative support provisions;
- Workforce development and supports; and
- The use of digital technologies.

This has affected elements of the program including access for consumers, continuity of care, and service integration. Contextual factors have also influenced ITC implementation, with the geographical size, and need of the target cohort impacting on the implementation of all objectives of the ITC program. The current model of implementation exacerbates these contextual factors through the fragmented delivery of ITC services.

A consistent model for the provision of Supplementary Services was reported by all stakeholders, highlighting that this has not been impacted by the current model of implementation. Supplementary Services are, however, being impacted by restrictions outlined in the Program Implementation Guidelines, which are skewed towards the delivery of ITC in an urban setting.

3 Strengths and challenges of current implementation of ITC in north Queensland

The implementation of the ITC program in north Queensland has led to a number of strengths and challenges, explored below. This chapter addresses the review question: *What are the strengths and challenges of the current model for ITC program implementation in the north Queensland PHN region?*

3.1 Care Coordination and Supplementary Services

Although a strength of the ITC program, the provision of care coordination and Supplementary Services as intended by the Program Implementation Guidelines is impacted in north Queensland by the complexity of clients and other contextual factors. Accordingly, implementation has been variable between locations. Predominately care coordination is being used as a gateway to Supplementary Services funds. The intent of the ITC program is for Supplementary Services to support the provision of care coordination; however, qualitative evidence gathered shows that, presently, access to Supplementary Services is the principal outcome from the ITC program in north Queensland. Some stakeholders noted the difference between the use of Supplementary Services in the NQPHN region, for transport and medical aids, over access to allied health and specialist services in more urban settings. It appears the need and contextual factors within the region has contributed to Supplementary Services being the predominate essence of the ITC program in the region. A strength of Supplementary Services was consistently reported to be the timely access to medical aids and specialist appointments.

'ITC is a means to get the necessary equipment for patients quicker.'

- Other person involved in ITC

It is also recognised that the deployment of nurse navigators across the region has created some duplication in the services for this cohort within north Queensland, and therefore the ITC program has shifted to fill the gap of access and aids through provision of Supplementary Services.

'From a Nurse Navigator (Aboriginal and Torres Strait Islander) point of view, we are already providing care coordination which is often quite intensive.'

- Other person involved in ITC

A challenge to accessing care coordination and Supplementary Services is not having ITC program staff permanently located in communities, which reduced the visibility of the service. Consultations consistently reported that having staff located in communities was beneficial to develop relationships and follow up clients. It is reported that across the region, ITC service provision is reaching, or has met, capacity in a number of locations.

Flow through the ITC program was raised as an implementation issue, with patient discharge in the NQPHN context difficult due to limitations in options of the broader service system in some locations, as well as the complexity and need of the chronic disease population. Recognised in its purest form one stakeholder described the ITC program as a short term solution to provide linkages to the broader service system for patients with long term disease. Due to the context of north Queensland, stakeholders consistently reported that 'people don't get better and don't stop needing help.' This sentiment was echoed in the Health

Policy Analysis 'Review of Care Coordination within the Integrated Team Care program Summary Report'⁸. The limited options in some regions in particular has meant that as understanding of the program develops and demand grows, there is limited client throughput, placing strain of the ITC workforce. This issue is exacerbated by hospitals directly referring to ITC programs in time pressured situations such as discharge. Patients are not able to leave the hospital until aids are obtained through the use of Supplementary Services, placing pressure on the broader service system.

These compounding issues have led to high care coordination client ratios across the NQPHN, with care coordinators across the region reporting client numbers from 60-200. This creates a challenge for the provision of effective care coordination.

Regional nuances in relation to freight costs which are not eligible to be paid out of Supplementary Services created challenges. In a region such as that covered by the NQPHN, freight costs are a requirement to get items to clients. Another difficulty was reported to be the purchase of non-PBS medications, with one example provided where oncology patients could not pay for their medication. The requirement to apply for extraordinary circumstances provisions for similar, or the same, items regularly was highlighted as an administrative burden for service providers. There is an opportunity to implement standing approvals for some items which are required regularly across the region.

3.2 Enhancing access to care

The needs of the population cohort with chronic disease in north Queensland has impacted on the ability of the ITC program to enhance access to care. Stakeholders consistently reported that Supplementary Services and care coordination were routinely prioritised over increasing the capacity of mainstream services to deliver culturally appropriate services, and impacted their ability to implement the ITC workforce roles to the full scope of practice. Limited evidence of mainstream service capacity building and cultural awareness training was provided throughout consultations. Where initiatives had been developed and delivered, it did not appear to be followed up or built on in order to continually increase capacity and therefore enhance access to care. Initiatives were also largely dependent on location, and were variable across the region. There was limited evidence provided through consultations of a strategic and coordinated approach to building capacity of mainstream services, which impacted on the effectiveness of the program meeting its aim in relation to this.

The role of IHPO, as articulated in the Program Implementation Guidelines, is to provide leadership on Indigenous health issues. The IHPO role includes:

- leadership to other ITC staff;
- coordinating a team based approach to Aboriginal and Torres Strait Islander health;
- implementing strategies to improve the capacity of mainstream primary care providers to deliver primary care services;
- increasing links and awareness between services; and
- facilitating collaboration and working relationships between mainstream services and ACCHOs.

The model of implementation has influenced the role of the IHPO, with the limited IHPO numbers, the vast geographical spans of contract holders' current service delivery areas, and limited access of care coordinators and Outreach Workers to other workforce supports impacting on the ability of the role to move

⁸ Health Policy Analysis, Department of Health, 'Review of Care Coordination within the Integrated Team Care program Summary Report', access provided by NQPHN.

beyond the leadership portion of the job. The limited capacity to date of the ITC workforce to concentrate on the elements of their role to enhance access to care has had a flow on effect to the workload of care coordinators and Outreach Workers.

Culturally safe service provision was consistently reported to enhance access to care; however, the limited numbers of male ITC workers impacted the ability to provide appropriate engagement with the male Aboriginal and Torres Strait Islander population in some areas, which may be a reason for the lower male client numbers in annual reports.

The language barrier for some clients understanding information presented to them via mainstream and private services continues to be a challenge. One care coordinator stated, 'People walk away from appointments with the doctor and you ask them, what did the doctor say and they say...I don't know...this means for some clients we have to attend most appointments with them.'

It appears the ITC program is able to meet the needs of particularly vulnerable populations when required; however, there is a question as to whether the current model of ITC delivery is reaching these groups at the same rate as the general population with chronic disease conditions. The appropriateness of the ITC program servicing particularly vulnerable clients was questioned by the ITC workforce in regional centres, stating that where possible they would refer to more specialised services. Where the capacity of the service system did not allow this, for example in more remote areas, the ITC program would deliver services where possible, however were impeded by issues such as accessible transport options. The demand for the ITC program is high across the region and, as such, current intake and referrals is based on those who present to GPs and other health services for referral. It is reasonable to suggest that, in its current implementation, there is a large amount of unmet demand, a proportion of which is likely to include particularly vulnerable, remote populations.

3.3 Integration and continuity

The ITC program across north Queensland is reported to be impacted by a lack of integration and continuity across contract holders and service providers as a result of the current commissioning model. Limited coordination activities have been undertaken to develop processes for clients to move seamlessly between AMS and mainstream services, with stakeholders reporting the services continue to 'feel a bit siloed.' A number of examples were provided throughout consultations of situations where ITC program clients from one region had moved to an area covered by another contract holder and experienced challenges in relation to service continuity in these situations. Within organisations there was some difficulty in transferring clients from one area to another, with responsibility for the provision of the ITC program unclear in these situations. Broadly, these issues are impacting access to care for ITC clients, and the ability of the ITC program to improve health outcomes through care continuity.

'A more simplified referral process and better communication between NGO, public health sector and the ITC coordinators is needed with less red tape for service providers to access medical aids etc.'

- Other person involved in ITC

Stakeholders reported a view that there has been limited strategic level input provided by the NQPHN, which has impacted the integration and continuity of the ITC program. It was indicated by stakeholders that limited direction initially meant that contract holders developed individual processes, and the absence of any communication channels between contract holders to streamline these processes continues to impact implementation.

Stakeholders also noted the impact of broader service provision throughout north Queensland, with factors such as limited GP access in remote communities impacting on the ability for some members of the community to be referred to the ITC program. An example was provided in one town where dialysis days happened concurrently with the visiting GP. This meant that those clients receiving dialysis missed the opportunity to engage with the GP, and therefore missed the opportunity to obtain the necessary management plan for referral into the ITC program.

Across the service system as a whole, confusion about the roles and responsibilities for patients involved in the ITC program was apparent. In high service areas, stakeholders reported confusion among patients as to who held what responsibility in relation to their care. Examples include:

- a discharge letter from a large regional hospital being sent straight to a remote hospital and not the ITC worker even though the patient was not a client of the remote hospital. This confusion highlights the necessity of a more coordinated intake and referral system; and
- an ITC service provider stating their aim was to increase the understanding of the ITC program by nurse navigators in order for them to identify the relevant agency for referral thereby assisting the client.

Although barriers such as these have been recognised by the ITC workforce, there was limited momentum to develop and implement any changes due to competing demands.

Some service providers who have been subcontracted to deliver the ITC program integrated their ITC funding into their broader organisational funds, integrating funding from a number of programs to enable more holistic, person-centred service provision. This was reportedly to enable more client focused care; however, blurs the understanding of the impact of the ITC program on its own, and means that those service providers who do not have access to other funding sources may be delivering a different service.

3.4 Collaboration and integration

Stakeholders consistently reported barriers to the integration of the ITC program across the whole NQPHN region. Limited strategic input and direction in the initial implementation of the ITC program across the three contract holders resulted in each provider developing their own intake and referral processes. To date, there has been no coordinated referral and intake process developed across the NQPHN region.

The difficulties in providing consistent ITC program coordination for the portion of the population who were transient was consistently reported by stakeholders, particularly those members of the population who have moved between contract holders due to a varied range of factors. An example was provided when clients from the Torres Strait were required to permanently move to Cairns for ongoing medical treatment, and current implementation does not assist this.

Within the service system broadly, staff turnover was noted as a challenge for ITC program collaboration and integration, as it meant a constant re-education of staff. One organisation explained the development of communication tools and flow diagrams to assist broader service system providers to understand the ITC program, particularly around intake and referral processes, to varying success.

3.5 Meeting community needs

“Demand is growing and it’s becoming harder to meet expectations... we must be meeting a community need.”

- ITC workforce

The ITC program was consistently reported to meet the needs of the community members it engaged, with 60 per cent of service users/friends who responded to the survey stating they ‘strongly agreed’ that the ITC program was helping Aboriginal and Torres Strait Islander people get the health care they need. Alongside this, 46 per cent of ITC workers who responded to the survey believe that the ITC program is ‘very good’ at contributing to better treatment and management of chronic conditions and improving access to appropriate health care through care coordination and provision of Supplementary Services.

The Program Implementation Guidelines provided some challenges in meeting community need, being not entirely fit for purpose in rural and remote settings. Stakeholders noted the need to balance the guidelines with the needs of the community, enabling more flexibility to meet the complex needs of the north Queensland population. It is recognised that the guidelines are implemented through the DoH and not part of the scope of this review; however, the development of regional ITC implementation guidelines would provide context specific guidance to contract holders and support implementation.

The ability of the ITC program to meet the needs of particularly vulnerable populations was dependent on location. Stakeholders in larger regional areas with access to a more diverse range of services were able to engage more appropriate specialised services for vulnerable populations. Stakeholders provided examples of engaging homelessness services and women’s services where appropriate. In areas with a less mature service system, ITC workers were required to broaden the assistance provided, with some providers outlining ‘scope creep’ due to the needs of the population. All areas noted the challenges around providing services to clients who were housebound. These challenges were exacerbated if the area had no home visiting GP. In Badu, it was noted that the ITC program had particularly helped vulnerable people living with disabilities, with the program helping community members travel between appointments.

It was also noted that the ITC program provided the community access to information that they previously did not have. Community consultations noted that the ability of the ITC workers to break down the information that ITC clients were receiving from medical professionals made that information more accessible, and also enabled them to understand they had options. One example was provided of side effects from medications. In the example, it was noted that people would previously continue to take medications regardless of their condition; however, the ITC program empowering them to understand they had options.

“Some didn’t know what disease/condition they had. We (ITC workers) had to put the medication on the table and work it out.”

- ITC workforce

Stakeholders noted the increase in clients wanting services at home, which placed pressure on the workforce as well as the current funding allocation. One example noted that some clients did not have electricity in their home, and therefore the environment was not suitable for home dialysis, even though this was requested by the client. These broader barriers impacting ITC service provision have had an impact on the ITC program to meet particularly vulnerable populations, and consideration should be given to initiatives which would open the program to broader populations, particularly in relation to accessible transport options in the region. Other service providers had not promoted their service due to overwhelming demand without promotion, which suggests a high portion of unmet demand, and therefore need, in some service areas of north Queensland.

3.6 Workforce supports

The Program Implementation Guidelines stipulate that each PHN has responsibility to oversee the ITC workforce across its region, including ensuring the workforce receives appropriate support and development. This includes formal training, peer support, professional guidance and mentoring to enhance on the job learning and quality of service. The Program Implementation Guidelines note that up to three per cent of program funds should be allocated to support and development of the ITC workforce.

Currently, the provision of workforce development across the contract holders is variable, as outlined in section 2.12. There are examples of some of the workforce being supported to access formal qualifications and training, as well as some examples of training being offered to mainstream services. Some stakeholders reported they had engaged with a number of development opportunities, and noted this as a strength of the program; however, the majority had not accessed any training through the ITC program. Through discussions with stakeholders, it was unclear what proportion of the accessed training was developed specifically for the ITC workforce, and what proportion was broader service system training that was attended by the ITC workforce.

Although a small sample size, the ITC workforce who responded to the survey showed variation in access to workforce development, with two of 13 respondents stating they had not accessed any workforce supports. Responses from other people involved in the ITC program ranked cultural awareness training and support as the least valuable part of the program alongside improved uptake of MBS items. A total of 47 per cent of other people involved with the ITC program said the program 'fairly well' or 'very well' improved the capacity of mainstream primary care services to deliver culturally appropriate services. Stakeholders recognised the importance of training mainstream services in the ITC program and culturally appropriate care as the demand on the program was growing, with one ITC staff member saying "they can't be reliant on us all the time when we are not here."

Due to the commissioning model, and the geographic area the ITC program is delivered in north Queensland, support for the workforce was reported as minimal across the majority of providers. Direct access to leadership and support, including reflective practice and debriefing, was noted as lacking across the NQPHN region. The high cultural load and demand on ITC workforce was noted as a challenge, and means that regular access to support was necessary for the longevity of staff. High staff turnover in some areas was reported, however the connection between this and access to workforce supports is not known.

'There needs to be local support and leadership for staff.'

- ITC workforce

Where possible, it was noted as beneficial to have ITC workforce supports integrated and part of a broader team environment to enable the development of informal peer supports, greater leadership locally, as well as greater capacity for backfilling when required, for example when ITC workforce has training and development opportunities.

3.7 Cultural Safety

The ITC program was consistently reported to deliver culturally safe and appropriate services as it was delivered by Aboriginal and Torres Strait Islander people across the region. The ITC program was reported to benefit from being delivered by a mix of male and female workforce where this was happening, as well as capacity for the workforce to embed and make connections within communities.

Where possible across ITC program implementation, contract holders employed local staff, with stakeholders consistently reporting that cultural safety for the community was strengthened through the delivery of the ITC program by local staff. For clients of the ITC program, the ITC workforce bridged a gap in communication and understanding between mainstream and private health services, ensuring that information given to the client was understood, and able to be implemented to manage their chronic condition. This was particularly relevant for clients where English was their second or third language, with ITC staff reporting a high number of client who leave appointments with doctors and other practitioners with limited understanding of the information, advice and direction provided.

The limited number of male workers was consistently reported as a factor impacting the delivering of culturally safe and appropriate care by the ITC workforce. An example of a female ITC worker providing care coordination to a male ITC worker was explored by one stakeholder, where the wife of the client and other members of the family were required to be at all appointments to make the working relationship more appropriate. Factors such as this increased the cultural load being carried by the ITC workforce, with the demands on the workforce wide-ranging due to community ties and relationships. The expectations placed on the ITC workforce due to their connection with the community meant that in some instances the workforce was going outside their prescribed roles to support clients in broader ways. This increases the necessity of effective workforce supports, as discussed in the previous section.

'Especially hard (for the ITC program to engage) with our brothers.'

- Community

It was reported that having ITC workers at appointments increased the cultural safety of the interaction with mainstream services; however, due to high service demand, and limited staff, the ability to consistently attend appointments with ITC clients was reportedly impacted. In the program design, this would be balanced by ITC increasing the cultural awareness of mainstream and private practices to deliver appropriate service; however, this element of the ITC program has reportedly not been effectively coordinated and implemented across the region.

'We are not doing a lot to build cultural awareness with mainstream services, but some informal up-skilling.'

- ITC Workforce

Examples were provided of Outreach Workers acting as cultural mentors to GPs in some regions, looking to increase the cultural safety and appropriateness of service provision. This cultural mentor role, although important and beneficial, was not coordinated or systematic, meaning that initiatives were not impacting mainstream and private services as a whole, but capitalising on opportunities presented in day to day work.

3.8 Contract management

Stakeholders indicated the broad view that the current contracting of the ITC program in NQPHN has not enabled clarity, accountability and monitoring of quality and outcomes due to the limited information included in the original contracts, the lack of documentation to outline original contracting decisions, and the consistently poor data quality used for reporting throughout ITC implementation. The current contracting of services has also led to the over- and under-servicing in areas across the NQPHN region according to some stakeholders, with the current model not enabling local implementation responses.

'I think there are opportunities to explore models that are more regionalised to support the specific areas such as Cape York and Torres compared to Cairns or Townsville.'

- Other person involved in ITC

Although the Program Implementation Guidelines provide parameters for ITC implementation, contract holders consistently reported they were unclear about how to implement the ITC program in north Queensland and responded to issues as they arose. This has created three distinctly different systems which, as outlined in section 3.3 is impacting the integration and continuity of service provision across the region. In consultations, contract holders clearly called for more direction from the NQPHN, particularly in respect to the integration of contract holders and the strategic direction of the ITC program implementation across the region.

During consultation the broad view was noted that original contracts did not enable effective accountability for contract holders, as they did not clearly articulate the required outputs or outcomes expected from the commissioned service. It can be hypothesised that the initial commissioning approach was developed to enable contract holder's flexibility in the delivery of the ITC program; however, it provided limited guidance. The limited guidance was then exacerbated by the NQPHN not engaging or providing support that it was reported was requested by contract holders. This has created an environment of limited oversight, and minimal accountability.

The use of intermediaries was noted to increase inefficiencies in service provision. The benefits of this model were questioned by service providers, who noted the reduction of funding in the administration of this tiered approach to implementation. The model of separating mainstream and community controlled organisations was also questioned, with this impacting service integration, and the ability to enhance access to culturally appropriate care.

The length of contracts, and staff security was also noted as an influencing factor for program continuity.

3.9 Data and reporting

Data and reporting has impacted ITC program implementation through poor quality data collection, limited clarity on data definitions and placing an administrative burden on the ITC workforce. Through analysis of reported data from contract holders, and then from the NQPHN to the DoH, a number of inconsistencies and inaccuracies in the data were evident. These challenges were visible in the data from early 2017, right up until the latest reporting in December 2018. Although the NQPHN has developed a 'how to' guide to increase the quality of the provided data, it appears limited improvements have been made throughout ITC program implementation. This makes it difficult to understand the demand on the service and the proportionate provision of different elements of the service to inform future planning. Data reporting is currently guided by the template provided by the DoH, and is predominately looking at the outputs of the program, with no provision to quantitatively collect outcomes data. Outcomes data is currently collected through the qualitative reports, which show minimal change across the reporting periods.

'The reporting tool is confusing, and we don't always get support to fill it in.'

- ITC workforce

Service providers and contract holders all had different processes for the provision of data, both between each other, but also within their organisations between each data reporting period. Some organisations stated that the care coordinator was tasked with data and reporting; however, in other organisations the administrative staff entered the numbers. Alongside this, it was reported that different people completed the data template each quarter, which added to inconsistencies.

The development of more supported reporting processes are required to improve data quality, and therefore gain quantitative insights on current ITC program implementation. The current reporting tool was described as 'confusing' with agencies explaining that they have limited support to complete it. This has led to service providers developing their own methods to collect data, which are generally not based on overarching and streamlined data definitions. Service providers explained that the data currently being collected is not meaningful, with some questions not relevant.

'Our organisation is collecting chronic disease numbers to understand prevalence in our community.'

- ITC workforce

3.10 Facilitators and barriers

A number of facilitators and barriers to the effective implementation of the ITC program in the region have been identified. These facilitators and barriers are both internal, meaning the structures set up through the NQPHN and contract holders, as well as external, based on the context of north Queensland, the geography and broader service system access.

The **aims and objectives** of the ITC program outline the parameters of the program, providing the foundational aspects for the NQPHN and contracts to build on during implementation. Although providing parameters, as outlined above, the Program Implementation Guidelines are more conducive to effective urban

implementation, and have created some challenges within north Queensland. Survey data from the majority of other people involved in the ITC program noted that the current implementation is only ‘somewhat’ meeting the program’s aims and objectives.

The location of staff in community was consistently reported as a facilitator to implementation. This enabled the community, and mainstream/private health services within the community, to have visibility of the ITC program, and increased its uptake. Staff located within community were also reported to have connections and ties, which was an enabler to having the community on board with the program. In the converse, where there was minimal staff on the ground with high demand, the ability of the workforce to effectively deliver on the aims of the ITC program was reduced.

‘The service needs to make themselves better known, what they do, who is eligible, how to refer and who to contact.’

- Other person involved in ITC

GPs, as an essential part of the ITC program through the provision of a GPMP as a program requirement, were considered a facilitator. Where GPs engaged with the ITC program and implemented changes in their practice to facilitate the aims and objectives of the program, implementation was assisted. A number of medical practices outlined a change where they bulk bill all Aboriginal and Torres Strait Islander clients, in turn increasing access to the GP service and therefore flow on referrals to the ITC program. Conversely, in some areas, stakeholders reported difficulty in finding bulk billing doctors, impacting on the ability of potential ITC program clients to obtain the required referral documentation. Once the documentation is obtained, the inflexibility of the GPMP and the fact that it is connected to one GP was reported to impact service continuity, because updates to the plan from a different GP were reported as difficult to access.

The **limited promotion and inconsistent branding** of the ITC program was consistently reported as a barrier. A number of stakeholders who were consulted, and a number who received the survey had not heard of the ITC program, and were not sure why they were included. This is due to the evolution of the ITC program from CCSS and Closing the Gap (CtG), which are better known in the region. The implementation model has had an effect on this, as there was not a coordinated approach developed by the contract holders through the NQPHN to effectively communicate the program to the community. Stakeholders broadly hold the view that the NQPHN seems to have not taken on a stewardship role of the ITC program within the region, leaving a gap for contract holders to develop reactive strategy to meet the needs of the community.

‘I don’t know much about the program, I have been a nurse and practice manager for ten years and don’t know much about it, we don’t do anything with ITC in my workplace as I wouldn’t know where to start’

- Other person involved in ITC

The **complexity of implementation** of the ITC program in north Queensland has created a barrier to its success. There are a number of different parties involved, and layers to implementation, including but not limited to, the DoH, NQPHN, ACCHOs, consortiums, mainstream and private health services and the ITC workforce. These layers cause confusion among the community, and those engaging with the ITC program, and exacerbate issues around inconsistent branding, processes and promotion.

This is further influenced by the **over servicing** in some areas, with multiple providers in communities creating confusion around roles and responsibilities for both service providers and service users. Broader than ITC specifically, a more mature service system enables the ITC program to utilise the breadth of health service providers to meet the needs of clients. Where there are minimal options, the ITC workforce experiences ‘scope creep’ to ensure the needs of the client are met.

'Have only one ITC provider for a whole area- it is very confusing when there is up to four ITC funded service providers- all with differing referral pathways and systems.'

- Other person involved in ITC

A number of stakeholders spoke about the evolving delivery of chronic disease services through the region, with **funding cycles** and the reinvention of programs impacting the uptake and the continuity of service, particularly for other people involved in service delivery. Stakeholders noted the benefits of longer funding cycles, enabling strategic linkages and implementation processes to be developed and embedded across the region, benefiting clients and also the broader service system. The short length of contracts within the ITC program was highlighted as a factor which restricted the buy in of some external parties, and that strategic funding cycles may assist in the implementation moving forward. Funding cycles are a policy lever which could have benefits to those with chronic conditions across the NQPHN.

3.11 Delivering on the aims and objectives

As noted above, the aims and objectives of the ITC program outlined in the Program Implementation Guidelines provided the foundation of implementation of the ITC program. This section of the report outlines how current implementation is meeting the stated aims and objectives of the program.

The aims of the ITC program are to:

- contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through access to care coordination, multidisciplinary care, and support for self-management; and
- 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.⁹

These aims provide the overarching goals of the ITC program, the end state which will be evident if the objectives of the program are met. Through the implementation of the ITC program in north Queensland, the interconnectedness of the objectives in meeting the aims has become evident. Current implementation has shown that without combined effort to implement all objectives, the aims of the program will not be met. The provision of predominately care coordination and Supplementary Services, without the capacity development of mainstream services, does not enable the full potential of the program.

The objectives of the program are to:

- **Contribute to better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people enrolled on the program.**
The ITC program was consistently reported by the ITC workforce to contribute to better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people. Of respondents to the survey, 47 per cent of other people involved in the ITC program reported that current implementation 'fairly well' and 'very well' meets this objective. There is no comparison group within this review to understand the management of chronic conditions for community outside the ITC program; however, data around throughput with the current client group shows minimal numbers of clients being discharged

⁹ Department of Health (2019). Integrated Team Care Program Implementation Guidelines. Updated April 2019. Available at <https://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-funding-lp>

from the program. This could point to either the complexity of the client group engaging with ITC, that the program is filling a gap for the community or that as it is currently being implemented the program is not leading to better treatment and management of chronic conditions;

- **Improve access to appropriate health care through care coordination and provision of Supplementary Services for eligible Aboriginal and Torres Strait Islander people with chronic disease.** Throughout consultation, the provision of Supplementary Services was consistently reported to improve access to appropriate health care and aids through more timely provision of what was required for the client to manage their chronic disease. The provision of care coordination predominately was aligned to clients accessing Supplementary Services, and providing clients what they required. Limited examples were provided of care coordination without supplementary service funding. Of respondents to the survey, 54 per cent of other people involved in the ITC program reported that current implementation ‘fairly well’ and ‘very well’ meets this objective;
- **Foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sector.** The ability of the ITC workforce to foster collaboration and support between mainstream primary care and the community controlled health sector has been impacted by the demand for the ITC program from clients. The ITC workforce has predominately responded to the needs of the communities in which they work, and the element of collaboration has become a secondary priority. Without the development of collaboration and support, enhanced access to health services will not be enabled through the ITC program. Implementation has been reportedly affected by the limited numbers of ITC staff, and the unclear allocation of roles within the workforce. The tangible engagement and immediate results ITC can provide to clients has been prioritised over the less visual development of longer term collaboration. Of respondents to the survey, 47 per cent of other people involved in the ITC program reported that current implementation ‘fairly well’ and ‘very well’ meets this objective.
- **Improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people.** Currently, the provision of capacity building activities by the ITC workforce has been impacted by the demand on the ITC service for provision of care coordination and Supplementary Services. According to the most recent Aboriginal and Torres Strait Islander Health survey, approximately half of those surveyed reported visiting a mainstream GP when they sought medical care.¹⁰ This highlights the importance of a culturally appropriate and responsive health system to meet the needs of Aboriginal and Torres Strait Islander peoples. According to the Program Implementation Guidelines, the ITC program will undertake activities such as cultural awareness training, encouraging the update of Indigenous MBS items and helping practices create a more welcoming environment to improve the cultural competency of mainstream primary care. Not outlined as an exhaustive list, these activities represent the minimum activities required to be conducted by the ITC workforce. The Program Implementation Guidelines note the IHPO role would lead the improvement of cultural competency. As noted in this report, within the implementation of the ITC program in north Queensland, the IHPO role has reportedly predominately involved team leader activities and the capacity to implement cultural competency has been effected by this. The Program Implementation Guidelines also note that the PHN has overarching responsibility to ensure that this objective is met. Stakeholders noted that the guidance and strategic input from the NQPHN has been limited in some areas. There is mention of the increase of cultural competency in the contract; however, there is no guidance or measurement provided around this. Of respondents to the survey, 47 per cent of other people involved in the ITC program reported that current implementation ‘fairly well’ and ‘very well’ meets this objective.

¹⁰ Department of Health (2019). Integrated Team Care Program Implementation Guidelines. Updated April 2019. Available at <https://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-funding-lp>

- **Increase the uptake of Aboriginal and Torres Strait Islander specific MBS items, including Health Assessments for Aboriginal and Torres Strait Islander people and follow up items**¹¹. Of respondents to the survey, 46 per cent of other people involved in the ITC program reported that current implementation increases the uptake of specific MBS items. A number of stakeholders reported that medical practices were intending to get accreditation under the Royal Australian College of General Practitioners, which would enable access to CtG incentives, and increase the sustainability of medical practices in remote areas. This was described by one stakeholder as a foundational requirement for the delivery of health care in the north Queensland region, and once these foundational aspects of health care are embedded, the system could then leverage off programs such as the ITC program. On a strategic level in a remote area of the region, one executive level stakeholder noted that the link between the ITC program and 715's has increased the uptake of this plan within the community, which is a benefit of the program.

3.12 Summary

Overall, due to the context of the north Queensland region and the significant need for Supplementary Services, the implementation of the ITC program has used care coordination to access Supplementary Services. This has presented a challenge for the ITC program as intended through the Program Implementation Guidelines, but is a strength as it is enabling ITC to meet community need.

The ITC program is staffed by passionate and committed staff, providing culturally safe and quality care. The ITC workforce has been challenged by the demand for the program in the region, as well as the service fragmentation that has resulted from the current implementation model. It is evident that the current model has impacted service integration and continuity of care, resulting in challenges for the provision of service, particularly around intake and referral processes between contract holders, as well as mainstream services.

The demand for the service in the region is impacting on the provision of all components of the ITC program, with care coordination and outreach roles being prioritised over the service coordination and capacity building role of the IHPO. This is impacting on the ability of the ITC program to deliver its full scope of practice, and all the program objectives. The variation of service systems within the region also has an impact on the ability for ITC contract holders to consistently implement the program across the region as a whole, with challenges such as access to transport, quality staff and the broader service system critical factors in the level of implementation success.

¹¹ Department of Health (2019). Integrated Team Care Program Implementation Guidelines. Updated April 2019. Available at <https://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-funding-lp>

4 Conclusion

The review identified a number of challenges which have constrained the implementation and limited the impact of the ITC program in north Queensland. These challenges relate to:

- limited collaborative governance or support;
- limited guidance to help respond to regional nuances, or to address more localised challenges;
- poorly understood and managed demand, including latent demand, for ITC services;
- limited and inconsistent workforce supports; and
- poor quality data and reporting.

Addressing these issues is critical for the program to deliver on the aims and objectives going forward, and will be relevant and necessary regardless of the specific approach to commissioning taken, and are therefore referred to as the ‘do regardless’ recommendations. Collectively implemented these recommendations will help to create a culture of transparency and accountability, a clear, consistent and locally appropriate operating environment for those delivering ITC and a consistent, equitable and high quality experience for ITC consumers.

As discussed in chapters two and three of this report, current implementation of the ITC program in north Queensland is achieving some of the program’s aims and objectives, but issues around equitable access, consistency and progress against all objectives of the program have been identified by the review. While progress against the recommendations in the previous section would help address many of the challenges and issues the review has identified, some issues are inherent in the commissioning model and justify a revised approach to commissioning.

Five options for future commissioning of the program were identified and assessed. This section provides a high level description of the options, the considerations and criteria relevant to informing a preferred option. The options developed for consideration were:

- **Option 1 (status quo):** The NQPHN makes no material changes to contracting arrangements and reengages all current ITC providers, maintaining a provider focused on ITC program provision through the community controlled sector and a provider focused on the private general practice sector. The addition of a location-based contract in the Torres Strait could be included if it is foreseeable that there would be an adequate market response.
- **Option 2 (single provider/contractor):** The NQPHN releases a tender which specifies that only a single provider, or single contractor (potentially with one or more sub-contractors), will be engaged to provide the ITC program across the entire north Queensland region. The single provider/contractor would be required to engage with both the community controlled and private general practice sectors. The single provider/contractor would be required to develop local implementation plans which detail how they will ensure appropriate access across the entire region, as well as equitable access for eligible people regardless of whether they access the ITC program through community controlled organisations or private general practices.
- **Option 3 (place-based):** The NQPHN takes a place-based approach, dividing the region into sub-regions, and commissioning each sub-region separately. The sub-regions could map to the Hospital and Health Service regions (meaning there would be four) or to ACCHO regions (to be determined in consultation with the community controlled sector). Sub-regional providers would have exclusive rights to provide the ITC program in their nominated sub-region/s and would be required to engage with both the community controlled and private general practice sectors. Sub-regional providers would be required to develop

local work plans which detail how they would ensure appropriate access across the sub-region, as well as equitable access for eligible people regardless of whether they access the ITC program through community controlled organisations or private general practices.

- **Option 4 (component-based):** The NQPHN takes a component-based approach, dividing the program into component parts. While the components could be separated out in different ways, the most logical approach would be:
 - Care Coordination and access to Supplementary Services funds;
 - IHPO related duties such as policy and leadership, improving integration of care, needs assessment and planning, developing multi-program approaches and cross-sector linkages, and supporting Outreach Workers and care coordinators; and
 - Improving the Cultural Competency of Mainstream Primary Care.

Each component would be commissioned separately (although one provider could potentially tender for and be awarded contracts for more than one component).

- **Option 5 (hybrid):** The NQPHN takes a place based approach to service delivery components (i.e. care coordination and allocation of Supplementary Services funds), and tenders separately for the Improving the Cultural Competency of Mainstream Primary Care component and/or the IHPO component.

Identification of the preferred option was undertaken through a three step process:

- A validation workshop, during which the options were presented, and assessed against criteria. The validation workshop was attended by senior PHN staff and identified stakeholders.
- Further deliberation by the stakeholders, and development of advice back to the consultancy about additional considerations and contextual information; and
- A final discussion between the consultancy and key NQPHN staff to agree to a preferred model.

Deliberations recognised that all of the options had strengths and limitations. The identification of the preferred option took into consideration the likely and potential impact on consumers and community, providers and the market, the PHN and Australian Government as the commissioners and funders. There was a sharp focus on the local service system and context.

Through this process it was agreed that the preferred model is the hybrid model described in Option 5.

Changes to provider arrangements will require intensive transition planning which will require engagement of the NQPHN, current and future providers with a view to minimise any unintended consequences for (most importantly) consumers, (also very importantly) ITC workers and providers.

4.1 Recommendations

Presented below are the complete list of recommendations as informed by the analysis provided in previous chapters.

- 1. It is recommended the NQPHN establishes a governance structure for the ITC program, which includes strategic and operational groups, and that this structure is used to oversee transparent monitoring, shared accountability and to progress other short term enhancements and long term objectives.**
- 2. It is recommended the NQPHN leads the development of local ITC program guidelines (the ‘Northern Queensland ITC Guidelines’) which build on, rather than duplicate, the Commonwealth’s Program Implementation Guidelines, and which describe the local approach to implementation, processes and protocols; that these Guidelines are developed collaboratively between the PHN, local ITC program providers, consumers, community representatives and other significant health sector participants; and that there is a clear process for regular review and updates.**
- 3. It is recommended the NQPHN requires all contract holders to develop Local Implementation Plans (LIMs) which address catchment coverage, local model nuances, standing approvals for Supplementary Services funds (such as freight costs), protocols for transient clients, service mapping and common referral pathways, key contacts and local transport planning; and that NQPHN specifies that the LIMs must be developed in collaboration with consumers and community, IHPOs and other PHN staff, and other locally relevant stakeholders and providers, including Hospital and Health Services (HHSs).**
- 4. It is recommended the NQPHN leads a collaborative process to develop a demand management framework for the ITC program in the region which identifies priority population groups, expected service levels, wait list management and alternative support options.**
- 5. It is recommended the NQPHN develops and implements, or commissions the development and implementation of, a comprehensive ITC program workforce support and development strategy, and that resources are allocated to implement the strategy.**
- 6. It is recommended the NQPHN includes clear local reporting and data requirements in ITC program provider contracts, providing clear data definitions, service range targets, staffing levels and financial acquittals.**
- 7. It is recommended that the NQPHN progresses to recommissioning of the ITC program in 2019 using a hybrid model which includes the following features: Place-based commissioning of outreach, care coordination and Supplementary Services funds allocation at the level of ACCHO catchment area; delivery of Indigenous Health Project Officers related activities through NQPHN with a sub-regional focus; and sub-regional commissioning of the Improving Cultural Competency of Mainstream Primary Care component of the ITC program.**
- 8. It is recommended the NQPHN reviews its approach to commissioning every three years, to consider whether the model continues to be the most appropriate approach, taking into consideration ITC program progress, maturity and market changes.**
- 9. It is recommended the NQPHN immediately commences transition planning to ensure the smooth transition of service delivery (specifically care coordination and access to Supplementary Services funds) with a focus on ensuring that client impact is minimised. The impact of transition on current ITC program staff, fund holders and referrers should be considered as part of this process.**

- 10. It is recommended the NQPHN develops and implements a detailed communication strategy relevant to the transition which considers the communication needs of key stakeholders including consumers, community, current and incoming providers, referrers, other people and organisations involved in the ITC program.**

Appendix A: : Bibliography

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