Activity Work Plan 2018-2021: Integrated Team Care Funding

The Activity Work Plan template has the following parts:

1. The Integrated Team Care Annual Plan 2018-2021 which will provide:
   a) The strategic vision of your PHN for achieving the ITC objectives.
   b) A description of planned activities funded by Integrated Team Care funding under the Indigenous Australians’ Health Programme (IAHP) Schedule.

2. The Budget for Integrated Team Care funding for 2018-2021 (attach an excel spreadsheet using template provided).

When submitted this Activity Work Plan 2018-2021 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

The Activity Work Plan must be lodged to your Program Officer via email on or before four (4) weeks after the execution of the Integrated Team Care Funding Schedule Deed of Variation.
1. **(a) Strategic Vision for Integrated Team Care Funding**

**Overview**

The key objectives of Primary Health Networks (PHNs) are:

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care in the right place at the right time.

Each PHN must make informed choices about how best to use its resources to achieve these objectives.

This Activity Work Plan covers the period from 1 July 2018 to 30 June 2019.

1 (a) **Strategic Vision for PHN**


NQPHN’s purpose is to ensure northern Queenslanders access primary health care services that respond to their individual and community needs, and are relevant to their culture, informed by evidence, and delivered by an appropriately skilled, well-integrated workforce.

NQPHN has the following goals:

- To place individuals at the centre of their own health and wellbeing
- To work with communities to understand local needs and design and implement solutions that improve local health and wellbeing
- To ensure an integrated approach to health and wellbeing
- To build local capacity to improve health and wellbeing outcomes.

The following pillars underpin the NQPHN Strategic Plan: People, Cultural Competency, Partnerships, Evidence and Data, Innovation and Integrity.

NQPHN is committed to achieving health outcomes by embedding the quadruple aim approach to measuring health outcomes across all activities and commissioning. Strategic outcomes across all activities where applicable include:

- **Patient Experience of Care**
  - Safe and effective care
  - Timely and equitable access
  - Patient and family needs met

- **Quality and Population Health**
  - Improved health outcomes
  - Reduced disease burden
  - Improvement in individual behavioural and physical health

- **Sustainable Cost and Value**
  - Efficiency and effectiveness of services
  - Increased resourcing to primary care
  - Cost savings and quality-adjusted life-years

- **Provider Satisfaction**
  - Increased clinician and staff satisfaction
  - Evidence of leadership and teamwork
  - Quality improvement culture in practice
NQPHN’s strategic objectives drive initiatives with partners and stakeholders. These include:

- Integrating information, data collection and sharing
- Building workforce capacity and capability for the future
- Strengthening partnerships to maximise collective impact
- Commissioning effective and need-led solutions to improve health outcomes
- Providing collaborative and efficient health system leadership that drives progressive health system reform.

These strategic drivers underpin NQPHN’s regional stakeholder engagement efforts to undertake an environmental scan where local needs and emerging priorities are identified. This enables a local response through an agile workforce that understands and aligns commissioning activities and opportunities to drive change within and support a primary health care system to be responsive to individual and community health needs.

Regional approaches to health system innovation and reform enable efficient integrated care aimed at empowering the patient or consumer in the management of their health. NQPHN recognises that significant socio-economic, cultural, and geographical factors influence the health and wellbeing of people, and therefore encourages place-based engagement and design of activities wherever possible.

There is a need within the NQPHN region to enhance Integrated Team Care to improve treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people. This can be achieved through greater access to the required services and enhanced care coordination, and provision of supplementary services.

The objectives of NQPHN align with those of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023, to make health better that is free of racism and inequality, and to ensure that all Aboriginal and/or Torres Strait Islander people have access to health services that are effective, high quality, culturally appropriate, and affordable.

NQPHN aims to commission a range of Aboriginal and Torres Strait Islander health initiatives that:

- implement innovative and locally-tailored solutions including Aboriginal and Torres Strait Islander health programs and services, based on community need; and
- work with the community to identify and address service gaps in Aboriginal and Torres Strait Islander health service provision, particularly in rural and remote communities in the NQPHN region.
1. **(b) Planned activities funded by the Indigenous Australians’ Health Program Schedule for Integrated Team Care Funding**

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<thead>
<tr>
<th>Integrated Team Care - Proposed Activities</th>
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<tr>
<td><strong>Existing, Modified, or New Activity</strong></td>
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<td><strong>Start date of ITC activity as fully commissioned</strong></td>
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| **Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?** | As per Department of Health Integrated Team Care Activity Implementation Guidelines, NQPHN currently commissions with Aboriginal Medical Services and mainstream General Practices which involve the following service providers:  
  - Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA)  
  - Northern Australia Primary Health Limited (NAPHL); and  
  - Northern Peninsula Area Family and Community Service (NPAFACS).  
  Comprehensive co-design activity is scheduled to occur prior to November 2018 to enable other models to be explored and solutions to be commissioned by June 2019.  
  Other partnerships will be enhanced where appropriate. |
| **Service delivery and commissioning arrangements** | ITC co-design will be occurring concurrently to develop potential models for service delivery for two years. This may result in a different approach to commissioning, including use of a ‘most capable supplier’ model.  
  Consumers, clinicians, service providers and system partners may all potentially be involved in designing and delivering services and systems, using reciprocal relationships in a collective approach. |
| **Decommissioning** | Contracts for current service providers have been extended until June 2019. Notification of the intention to undertake co-design in the interim leading to new arrangements from July 2019 has been provided. Current service providers will be invited to participate in co-design activities, which will result in future arrangements for the provision of ITC in the NQPHN region. |
## Decision framework

The decision-making framework reflects information gathered through the annual Health Needs Assessment processes adopted by NQPHN, and subsequent updates. The information in the HNA confirms the significance of the Aboriginal and Torres Strait Islander needs in this PHN region. It is recognised that 11 per cent of the NQPHN population identify as Aboriginal and Torres Strait Islander, while 11 per cent of the whole Australian Aboriginal and Torres Strait Islander population reside in the NQPHN region. This includes a disproportionate number of remote Indigenous communities and more socially-disadvantaged Indigenous people. Most Aboriginal and Torres Strait Islander communities within NQPHN’s region are in the most disadvantaged quartiles, with high unemployment rates, low income earners and higher rates of people whose highest level of education was Year 8 or below, or did not go to school.

The Health Needs Assessment also identifies service availability and gaps. Ongoing intelligence gathering and observation from currently implemented services increases the granularity of information, and is also supplemented by partner/stakeholder information sharing. Market analysis will be examined through intelligence and substantiated through co-design methodologies.

Clinical and consumer input will also be facilitated. The Clinical Councils will have a role in verifying the analysis to ensure the choice of service delivery arrangements most effectively and efficiently meet the needs of Aboriginal and Torres Strait Islander people in the region. Indigenous workers intimately familiar with patient experiences may be asked and/or invited to supplement or act as proxies for consumers in the co-design process. The co-design methodology will be informed by other similar experiences from NQPHN, and best practice. A suitably-qualified Indigenous facilitator will be engaged to manage the process.

The Department of Health Integrated Team Care Program implementation guidelines provide the basis for the development of the decision framework. Co-design will explore more effective implementation and support for chronic disease management, while improving evaluation of contract management and reporting processes. This will contribute to improved national consistency of reporting. The use of a decision support tool from the document will be assessed in guiding how the allocation of the care co-ordination funding and support services will be applied. The co-design process may also contribute to a better overall framework, as well as improved model(s).

The Commonwealth Department of Health’s *Health Policy Analysis 2018 – Review of care coordination within Integrated Team Care (ITC) program summary report* recommendations will also contribute to the decision-making framework.
### Indigenous sector engagement

Engagement with Aboriginal and Torres Strait Islander people and communities will be central to the design and delivery of programs and services. It will be guided by the Australian Health Ministers’ Advisory Council’s *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026 – A national approach to building a culturally respectful health system*. The co-design process will ensure appropriate representation.

NQPHN has and will continue to engage successful service providers continuously over the life of the revised ITC program to support ongoing review of data and learnings, and share successes and challenges via:

- regular participation in an ITC Providers Advisory Group
- embedding opportunities for strategic continuous improvement (CI), including ongoing service provider support and feedback
- provider and patient feedback, which will form part of the program KPIs and metrics, and assess the efficiency and safety of patient pathways
- other engagement mechanisms identified or advised as appropriate through the co-design process, and regular stakeholder engagement.

NQPHN will also be guided by its Reflect Reconciliation Action Plan, as endorsed by Reconciliation Australia in 2018.

### Decision framework documentation

New framework documentation will be developed.

Complex decisions will be referred to NQPHN.

### Description of ITC Activity

The ITC activities will assist Aboriginal and Torres Strait Islander community-controlled health services and mainstream health service providers to:

- deliver culturally-safe, high-quality, comprehensive primary health care services
- increase the access to primary health care services by Aboriginal and Torres Strait Islander people with chronic disease, and increase the uptake of Aboriginal and Torres Strait Islander specifically-designed Medicare Benefits Scheme (MBS) arrangements, including Health Assessments.

Co-design will focus on the improvement of the implementation of ITC using the national framework focusing on enhancing integration, specifically:

- delivering seamless continuity of care and access across mainstream and Indigenous services, allied health, and specialists
- effectiveness of GP management plans and review processes
- improved triage
- application of supplementary services
- placing patients at the centre of care.

Uptake of Indigenous MBS items, including 715 health checks, and follow-up services will be facilitated and coordinated.
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<tr>
<th>ITC Workforce</th>
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<td>Supplementary services will contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to co-ordinated and multidisciplinary care, and support for self-management.</td>
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<td>The strategic role of the Indigenous Health Project Officers (IHPOs) is particularly critical to the success of ITC. IHPOs will collaborate to improve the integration of care across the region, including supporting links to the GP management plans. Remuneration also must be addressed to enable successful recruitment and retention of qualified staff to this key role, particularly in very remote areas.</td>
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