Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2018-2021:
Integrated Team Care Funding

Murrumbidgee PHN

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

The strategic vision of Murrumbidgee PHN is to achieve better health for Murrumbidgee communities. It is recognised that the Aboriginal and Torres Strait Islander population in Murrumbidgee carries a large proportion of the burden of disease, and there is a need for the PHN to improve the health outcomes of this population group.

The MPHN will work towards this vision by;

1. Undertaking a health needs assessment that uses an evidence based approach to gathering information that informs the health profile of the Aboriginal and Torres Strait Islander peoples of the Murrumbidgee region. This health needs assessment will undertake to actively listen to the voices of the Aboriginal and Torres Strait Islander peoples of the Murrumbidgee in relation to their health needs and primary health care service needs. MPHN will undertake this in a culturally sensitive manner in conjunction with the Murrumbidgee Aboriginal Health Consortium and in a way that is directed by Aboriginal peoples.
2. Commissioning both the AMS Consortium and mainstream providers to deliver the ITC program to contribute to better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander peoples enrolled on the program. This includes working towards seamless and integrated care, particularly through transition from primary care to acute care and back again and using commissioning levers to maximise use of integration enablers such as digital technologies, shared care planning and healthcare pathways to create efficiencies and improve effectiveness in clinical service delivery.
3. Through the commissioned providers, ensure improved access to appropriate health care through care coordination and provision of supplementary services for eligible Aboriginal and Torres Strait Islander people with chronic disease.
4. Through partnership with the ITC program providers and the MPHN practice support team work towards increasing the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule (MBS) items, including Health Assessments for Aboriginal and Torres Strait Islander peoples and follow up items, maintaining childhood immunisation rates and cancer screening.
5. Undertaking a commitment to improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander peoples by provision of continuous professional development opportunities and by development and implementation of a cultural competency framework with all commissioned providers across the region.
6. Fostering collaboration and support between mainstream providers in primary care and the Aboriginal and Torres Strait Islander health sector. MPHN remains committed to participation in and support of the Murrumbidgee Aboriginal Health Consortium which encourages mainstream, AMS and community to work together with a common purpose to close the gap in health inequity that burdens the Aboriginal and Torres Strait Islander population in the Murrumbidgee.

1. (b) Planned activities funded by the Indigenous Australians' Health Program Schedule for Integrated Team Care Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2018-2021. These activities will be funded under the IAHP Schedule for Integrated Team Care.

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

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Existing, Modified, or New Activity	Existing activity Underspend approval for supplementary services attached
Start date of ITC activity as fully commissioned	1 October 2016
Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?	MPHN has continued to contribute an additional $200,000.00 from PHN Flexible Funding to support the delivery of these services. MPHN initially collaborated with Aboriginal Medical Services within Murrumbidgee to determine the allocation of funding between mainstream and AMS services. The Integrated Team Care Program and Integrated Care Coordination Program are delivered by the same provider and this has resulted in efficiencies in service delivery across the region.
Service delivery and commissioning arrangements	To ensure continuity of service provision existing providers will be directly issued with new contracts to maintain services in existence. Currently services are provided by both a mainstream provider and an AMS Consortium. These providers will both retain contracts for ongoing delivery of the ITC program. Supplementary services are currently managed by MPHN, transition arrangements have been put in place to have both existing contractors manage the supplementary service component of this schedule.
Decommissioning	Nil decommissioning
Decision framework	MPHN health needs assessment highlighted the poorer health outcomes of Murrumbidgee Aboriginal peoples in relation to mental health conditions across the lifespan and chronic diseases such as COPD and diabetes. Additionally there were gaps in cancer screening rates, in particular for women utilising breast screening services. Confirmation of the priority areas for Aboriginal peoples occurred with the endorsement and identification of the same needs through the Murrumbidgee Aboriginal Health Consortium. The MAHC identified four

	priority areas; mental health, chronic disease, maternal and child health and cancer screening for the Aboriginal Health Regional Plan 2016-19. MPHN has not used market analysis to test different providers due to a philosophy of ensuring continuity of services where possible unless there is a reason to consider new providers. In particular in relation to the AMS's which are already using a consortium approach to dedicated delivery of Aboriginal Health services to the Aboriginal population. Initial consultations with MPHN Clinical Councils and the Community Advisory Committee were undertaken as part of a framework for decision making relating to the ITC program. In addition the Murrumbidgee Planning and Integration Committee and the AMS Consortium were consulted regarding delivery of the program. No further consultation has occurred in relation to the ongoing nature of this service delivery. Triangulation of health needs identification with the PHN health needs assessment and the Murrumbidgee Aboriginal Health Consortium is the basis for this decision framework. Coupled with the value of continuity of service provision by existing providers and an initial commitment to the decision by the overarching governance mechanisms in the MPHN the decision to continue with services uninterrupted to the local Aboriginal population for Integrated Team Care is considered to be sound.
Indigenous sector engagement	MPHN will use a range of strategies to ensure that engagement with the Aboriginal community, including health care professionals, is a high priority and is valued. MPHN participates in the Murrumbidgee Aboriginal Health Consortium, led by a selected ITC provider. The Consortium includes membership from the three local Aboriginal Medical Services, Land Councils, MLHD, non-government organisations, Family and Community Services, and other government departments. Through a commitment to addressing the six key areas of the Commonwealth, one being Aboriginal Health, MPHN provide assistance to the Murrumbidgee Aboriginal Health Consortium to develop, implement and monitor a Regional Aboriginal Health Plan. The Regional plan includes targeted consultations with community members led by Aboriginal peoples for Aboriginal peoples to have input into the services they need to address the issues that concern them. MPHN encourages Aboriginal peoples, community and health care professionals, to provide feedback about new and emerging issues for Aboriginal peoples including inequitable access to culturally acceptable services. Ensuring that Aboriginal people's voices are heard keeps the process of engagement open. MPHN maintains relationships with AMS and other identified providers of health care services across the region by being culturally sensitive, open and inclusive when assessing health needs and planning delivery of services. Again using an approach which fosters trust and sharing will ensure that the process of engagement with the Aboriginal sector remains open.

	Future focus of contracted commissioned service providers includes the use of a cultural competency framework to ensure that mainstream service provision meets required standards for culturally appropriate service provision. MPHN will support this framework with access to continuous professional development activities fostering engagement with the sector providing Indigenous mainstream services.
Decision framework documentation	Formal documentation of the decision framework has not been developed as yet. The process will be captured within the framework for the Health Needs Assessment in the future.
Description of ITC Activity	In the MPHN the ITC program is delivered by both the AMS Consortium and by a mainstream provider. Both providers will utilise Care Coordinators (CCs) and Indigenous Health Project Officers (IHPOs) to deliver the ITC program. The AMS Consortium will additionally utilise Aboriginal Outreach Workers (AOWs) to deliver the program. IHPO function: The IHPOs will function as team leaders within both the Consortium and the mainstream provider services. These positions will be required to; participate in the Murrumbidgee Aboriginal Health Consortium, to support ongoing needs assessment and planning of services, to develop multi-programme approaches and cross-sector linkages. These positions are required to work closely with the MPHN Practice Support Team and to support both Aboriginal Outreach Workers and Care Coordinators. Aboriginal Outreach Worker function: Aboriginal Outreach Workers will be located within the AMS Consortium and will support and encourage Aboriginal and Torres Strait Islander peoples to access health services. They will have strong links to the community and will be identified positions. Aboriginal Outreach Workers will provide non-clinical practical support, e.g. helping patients to travel to their medical appointments. In this position, 0.5 FTE will be shared with the mainstream ITC provider Care Coordinator function: Care Coordinators will be qualified health workers (for example, nurses, Aboriginal Health Workers) who support eligible patients to access the services they need to treat their chronic disease according to the General Practitioner (GP) care plan. Care coordination services will include the following three phases of care: • Initial assessment • Active Care coordination • Managed exit from the program (handover) Care coordination activities as a minimum must include the following: • Direct engagement with the patient and relevant carers • Direct engagement and case conferencing with GPs • A care plan developed by the care team, led by the client and GP • Direct engagement and case conferencing with specialists where appropriate • Support for clients to cease smoking

	Care coordination services may be delivered through direct contact via scheduled appointments at an appropriate venue. This may include; the provider's office, clients home, general practice surgery or other appropriate facility that is accessible and comfortable for the client. Alternatively, to accommodate the large geographic area; services may also be delivered via telephone or video link, however all initial assessments are to be conducted face to face. Care coordinators will provide access to the supplementary services pool funding where clients meet the criteria for access. Care coordinators will assist clients with applications for supplementary service funding. It is expected that services are well coordinated with other service providers (including social care services) and aligned with the requirements of the client's GP management plan. Where appropriate and with the permission of the client; family and carers of the client should be involved in care coordination activities and, if required, supported to access carer support services. Providers of the ITC service are expected to participate in the evolving Murrumbidgee Integrated Care Strategy – this is likely to include: • Shared Care Planning • Streamlined referral processes and pathways to care; • Active participation in emerging models of care- including the person centred healthcare home; • Uptake and use of information and communication technologies (including tele-health services and home monitoring devices) Provision of client and service level data for ongoing data analytics and service planning are required by providers of the ITC program.
ITC Workforce	**Aboriginal Outreach Worker positions** **Indigenous Health Project Officer Positions** **Care Coordination positions**