QAIHC

Queensland Aboriginal and Islander Health Council

QAIHC SUBMISSION TO THE DEPARTMENT OF HEALTH

SUBMISSION

Review of the Practice Incentives Program Indigenous Health Incentive (PIP IHI)

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Chief Executive Officer
Queensland Aboriginal
and Islander Health Council
PO Box 3205
South Brisbane, Qld 4101
P: (07) 3328 8500
F: (07) 3844 1544

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About the Queensland Aboriginal and Islander Health Council (QAIHC)

QAIHC was established in 1990 by dedicated and committed Aboriginal and Torres Strait Islander leaders within the Community Controlled Health Sector.

Originally established as QAIHF (Queensland Aboriginal and Islander Health Forum), the organisation provided a voice for the Community Controlled Health Sector in Queensland. This organisation was self-funded until 1996, when the Commonwealth Department of Health commenced funding support. QAIHC has experienced considerable growth in membership and the scope of services provided to those members since its establishment.

In 2004, the organisation was reconstituted under the Australian Investment and Securities Commission (ASIC) and assumed its current form as QAIHC.

Today, QAIHC represents 28 community-controlled health organisations and 14 associate members who share a passion and commitment to addressing the unique health care needs of their communities through specialised, comprehensive and culturally-appropriate primary health care.

QAIHC is the peak body representing the Aboriginal and Torres Strait Islander Community Controlled Health Organisation Sector in Queensland at both a state and national level. Its membership comprises Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) located throughout Queensland. Nationally, QAIHC represents the Community Controlled Health Sector through its affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO) and is regarded as an expert in its field.

QAIHC, as the peak of ATSICCHOs of Queensland, wish to express the collective views on behalf of our state-wide members, in response to the Practice Incentives Program Indigenous Health Incentive (PIP IHI) Consultation.

QAIHC would like to thank the Department of Health for the opportunity to comment on the proposed PIP IHI. The aim of the consultation is "*to improve the efficiency and effectiveness of the PIP IHI to support general practices to provide culturally appropriate health care to Aboriginal and Torres Strait Islander people with chronic disease*".

1. Opening statement

Aboriginal and Torres Strait Islander peoples currently experience chronic health conditions disproportionately to non-Indigenous peoples and often have complex health needs. It can be time consuming (on a clinical and General Practitioner (GP) consultation level) to address these needs during a consult, and it is not always suitable to defer issues to the next visit.

The PIP IHI is one of a range of important tools which enables ATSICCHOs to offer culturally appropriate holistic health care to their clients. It provides an essential level of flexibility in their approach and is fundamental to ATSICCHOs' continued provision of best practice, culturally safe care for Aboriginal and Torres Strait Islander peoples with chronic disease.

The ATSICCHO family-centred, holistic Model of Care (ATSICCHO Model of Care) is effective in addressing the health needs of Aboriginal and Torres Strait Islander peoples, and in reducing the health gap that exists between Aboriginal and Torres Strait Islander peoples and their non-Indigenous counterparts.

Supporting the ATSICCHO Model of Care through PIP IHI payments is essential and will contribute to Closing the Health Gap.

2. Recommendations

Recommendation 1: Retain the PIP IHI and current exemptions in place for ATSICCHOs.

The ATSICCHO Model of Care is effective in addressing the health needs of Aboriginal and Torres Strait Islander clients. The PIP IHI is a central funding stream which enables ATSICCHOs to sustain that Model of Care.

Recommendation 2: Place cultural competency at the heart of the PIP IHI criteria.

The PIP IHI is specifically targeted at improving the management of chronic disease experienced by Aboriginal and Torres Strait Islander clients. It is known that Aboriginal and Torres Strait Islander peoples are more likely to continue to engage with culturally competent health providers. Ensuring the cultural competency of PIP IHI health providers is essential to best practice management of chronic disease for Aboriginal and Torres Strait Islander peoples.

The current criterion for two members of a medical practice to have undergone cultural safety training is insufficient. Cultural competency should be embedded throughout all parts of the practice; from

reception through to GPs. Ensuring the removal or prevention of institutional racism in a medical practice requires the ongoing cultural competence of all staff.

The purpose of the PIP IHI is to encourage medical practices to provide quality care, enhance capacity, and improve access and health outcomes for Aboriginal and Torres Strait Islander clients. A GP cannot provide culturally competent and comprehensive primary health care without the entire practice being a culturally safe environment. Therefore, it is QAIHC's recommendation that medical practices should be required to demonstrate that cultural competency is embedded within the practice, including the requirement that all staff receive local cultural safety training.

Recommendation 3: Strengthen the link between payment and delivery of quality chronic disease management provision of care, facilitating client movement.

The ability to claim a payment prior to undertaking a service does not incentivise the fulfilment of that commitment. If, for whatever reason, that commitment is unable to be fulfilled, the client's chronic disease management is compromised. Strengthening the link between the provision of care and PIP IHI payment, for example by weighting Tier 1 and Tier 2 payments more heavily and linking payment to service provision, would reduce the risk that providers claim payment without providing a service.

The intention of the PIP IHI is to improve chronic disease care for clients, as such, the financial incentives of the PIP IHI need to remain focused on the individual's needs and should include flexibility where a client is transient. Aboriginal and Torres Strait Islander clients have higher levels of geographical movement. This means that these clients may see a number of medical practices for the management of their chronic disease. The regulations of the PIP IHI need to account for transient populations and how this may impact service provision. Linking payment to the provision of care will better support transient populations, maintaining quality chronic disease care.

3. Response to consultation questions

The table below outlines the questions posed in the PIP IHI consultation document and the response from QAIHC.

Ref #	Question	QAIHC's response
Cultural competency		
1	Do the current PIP IHI guidelines facilitate culturally appropriate care for Aboriginal and Torres Strait Islander patients?	• For ATSICCHOs, 'culturally appropriate care' is core business. QAIHC support the requirement that "Practices under the management of an Aboriginal Board of Directors or a committee made up mainly of Aboriginal community representatives" are exempt from the requirement to undertake cultural awareness training within 12 months of sign-on to the incentive.
2	Is a requirement that cultural awareness training be undertaken appropriate for health practices?	• Yes, it is appropriate that mainstream medical practices (i.e. non-ATSICCHOs) complete 'cultural awareness' training as a requisite for receiving the PIP IHI. • The current requirement for "two staff members from the medical practice, one of which must be a GP" to complete cultural awareness training for the medical practice to be considered to have completed cultural awareness training is inadequate. • All practice staff within mainstream medical practices should be required to complete 'cultural awareness' training in order to embed cultural competency. Culturally competent staff will provide better quality care and understand the impact of certain chronic disease management processes on Aboriginal and Torres Strait patients. Evidence of compliance with training requirements should be provided prior to registration for the PIP IHI program. • In addition, the requirement that cultural awareness training only occur as a one-off when the medical practice is signing on to the incentive is inadequate. Cultural awareness training should evolve with the practice and be delivered regularly, ideally annually, to achieve system change. • Cultural awareness training should be to an agreed standard, for example to include courses that offer Continued Professional Development points or which are endorsed by the National Aboriginal Community Controlled Health Organisation (NACCHO)

		or its State Affiliates (such as QAIHC) or local members (ATSICCHOs). • Cultural awareness training should be conducted at the local Aboriginal and Torres Strait Islander community level. • There should be a further requirement to demonstrate the medical practices' operations and processes are culturally safe.
3	How can we monitor the cultural competence of registered PIP IHI practices?	• Require each medical practice to provide confirmation of the proportion of current staff who have completed cultural awareness training to the standard of this program prior to each quarterly payment. • Request a signed declaration, similar to other government documents, stating that the cultural awareness training information provided is true and correct. • Conduct regular audits. • Withhold payments until training has been completed. • Monitor the training organisations that are endorsed to operate the training, ensuring that they train from a local perspective.
Streamlining administration		
4	How does the patient registration process improve or impede chronic disease management and care?	• In many instances, ATSICCHOs have said that this process is an administrative burden and the time could be better spent providing care to the client. • In some instances, ATSICCHOs have identified that the requirement to recall a client sometimes reconnects them with the client, providing opportunity to talk further about managing their chronic disease. • The current form is confusing as it combines the PIP IHI and PBS Co-payment measures. Member Service feedback is that this can lead to errors in form filling where staff tick the incorrect box. Separation of the forms and programs would resolve this issue.
5	Is the current financial incentive for patient registration contributing to better	• The act of providing a $250 payment to a medical practice who say they will provide care to a client in the following 12 months does not guarantee that the medical practice will actually provide the client with any care. While the payment is not triggered until some type of care is *offered,* there is not a requirement for the care to be provided. Linking the registration process to the provision of

	management of chronic disease?	care would be a better way to contribute to better management of chronic disease.
		• The medical practice should be required to demonstrate that the client is accessing care. The medical practice could demonstrate this through:
		  ○ Aboriginal and Torres Strait Islander Health Check - MBS item 715
		  ○ GP Management Plan (GPMP) - MBS item 721
		  ○ Team Care Arrangement (TCA) - MBS item 723
		  ○ Reviews of a GPMP & TCA – MBS item 732
		  ○ Other team care arrangements

6	Is the current registration processes burdensome and how can it be streamlined?	• The annual registration process for the PIP IHI is burdensome and can distract from the delivery of client care (for both administration and clinical staff). • Registration could be centralised, as has been suggested in regard to the Indigenous Pharmacy Programs (IPP) review (see QAIHC's attached IPP Review submission), and linked to the client's Medicare card, or potentially completed as a one-off (rather than annual) registration process. If the client moves to a new medical practice then they should have to re-register at the new medical practice. • The PIP IHI registration is currently linked to the PBS Co-payment registration, and QAIHC supports separating these two processes (see QAIHC's IPP submission). • Registration could be simplified by creating an online application form, with sign on via an iPad at the front desk. • The requirement to keep PIP forms on file for six years for audit purposes is burdensome, particularly in larger practices. Consider accepting alternative evidence (e.g. patient medical records) for audit purposes.
7	Should the payment be linked to the provision of care rather than an administrative process?	• Yes, payment should be linked to the provision of care. • There should be greater remuneration for Tier 1 and Tier 2 outcome payments than for the initial sign up payment. • This should discourage the inappropriate registration of clients for the PIP IHI by medical practices who are actually not the 'usual GP', and who then do not provide any of the follow up care.

		• There needs to be a system in place so that medical practices, primarily ATSICCHOs, are not disadvantaged in terms of incentive payments due to their more mobile and often more complex client base.
Best practice management of chronic disease		
8	What does good chronic disease management and care look like in a primary health care setting?	• Good chronic disease management and care in a primary health care setting often requires a multidisciplinary team approach. When supporting a client's physical health, a comprehensive GPMP and TCA (if required), with reviews, follow-up activities and referrals assists with the management of the client's chronic disease. • In Aboriginal and Torres Strait Islander health, recognition and management of the client's family, social and emotional wellbeing is often equally (if not more) important as managing their physical health. ATSICCHOs are the leaders in this practice. • Trust needs to be established with the practice before genuine primary care is even possible and this is aligned with cultural safety aspects above.
9	Should all Indigenous patients with a chronic disease have a GPMP?	• GPMPs and TCAs certainly play a role in chronic disease management; however, it is important that primary health care provision is patient-centred and individualised. • The aim is for all chronic disease patients to have a GPMP as long as it is explained – education is a critical part of the plan.
11	Should all PIP IHI registered patients receive a Health Check (MBS 715)?	• The purpose of the MBS item 715 is as a preventative health assessment; to identify risk factors and create opportunity to intervene and prevent progression to chronic disease. • The MBS item 715 does have a role for clients already diagnosed with a chronic disease. A health check could identify actions to prevent a client's condition progressing to another chronic disease. The MBS item 715 also provides access to an additional five MBS-funded allied health sessions per year. • Undergoing a health check may not, however, be a priority for all clients. A client who has a limited prognosis because of their chronic disease may not be a suitable candidate for MBS item 715.

		• An option that incentivises completion of MBS item 715 for clients who are PIP IHI registered (e.g. a bonus payment on top of the Tier 1 and Tier 2 payments) could be one solution.
12	Are multiple visits to the GP an indication of good management of chronic disease?	• Multiple visits to ATSICCHOs can be indicative of good engagement and thus better opportunities for ATSICCHOs to support a client's management of their chronic disease. However, the volume of interactions does not reflect or measure the quality of interactions; just because there is an interaction does not mean that the management is good or that the client's needs are looked after. • ATSICCHOs practice opportunistic care by addressing the (sometimes) multiple needs of the patient (and their family) in the most time effective way. It is the ATSICCHO Model of Care to provide as much support as possible at *every* visit to maximise impact and reduce barriers should access be a concern.
13	Are there measurable approaches / health care activities that support chronic disease management for Indigenous patients?	• It needs to be acknowledged that Aboriginal and Torres Strait Islander peoples have complex health needs and experience chronic health conditions disproportionately to non-Indigenous people. • It can also be time consuming (on a clinic and GP consultation level) to try and address these needs during a consult, and it is not always suitable to defer issues to the next visit. • The option of greater financial incentives through the PIP IHI program should be explored for ATSICCHOs due to the more complex consultations that can occur in these settings and the inherently culturally competent manner in which services are provided. • The PIP IHI currently makes no distinction between care provided by an ATSICCHO and care provided by a mainstream medical practice. ATSICCHOs are providing superior care to Aboriginal and Torres Strait Islander peoples through their community-driven Model of Care. • Feedback from one QAIHC Member Service who works closely with mainstream medical practice is that there are issues around the quality of mainstream provision of care under the PIP IHI. The QAIHC Member Service identify these gaps through PHN-funded activities (such as the Integrated Team Care program) and they actively chase the mainstream medical practice to ensure that MBS items 715, 721, 723 and / or 732 are completed correctly.

		• Medicare has a range of training and support available online and in person which supports medical practices to understand and meet Medicare standards and PIP Programs. For mainstream medical practices, where only a small percentage of clients may be Aboriginal and Torres Strait Islander peoples, additional effort is required to ensure they understand the importance of providing these additional services to Aboriginal and Torres Strait Islander peoples, particularly when claiming the PIP IHI. • For the PIP IHI to be equal, the standards expected of both parties should also be equal. For example: ATSICCHOs are required to submit data against the national Key Performance Indicators (nKPIs) to demonstrate health care effectiveness and manage health advancement. There is currently no comparable expectation on mainstream medical practices. It could be proposed that to receive the PIP IHI, all medical practices should be required to submit data against the nKPIs. • Measurable activities could include consistent follow up care, group preventative health activities, connection to country activities and holistic care support. The extent to which a medical practice has links to chronic disease support groups e.g. Diabetes Foundation, Heart Foundation, Cancer Council, other chronic disease networks could also be measured. • Consumer feedback is currently missing from PIP IHI review process. Opportunity to ask the consumer if they feel they are receiving better treatment/care for their chronic condition would add value to the PIP IHI.
Responding better to patient mobility		
14	How can PIP IHI best respond to Indigenous patients who need to move around for personal / family reasons?	• Where possible, it is preferable that a client has a 'usual' primary health care provider where the client has the bulk of their chronic disease / primary health care needs met. • Many Aboriginal and Torres Strait Islander peoples are transient. For example, a notable proportion of Cairns ATSICCHO clients are from the Cape or Torres and regularly travel between Cairns and their home community in the Cape. Additionally, in urban locations, with multiple ATSICCHO care options, patients often move between medical practices. • An option to share incentives between medical practices that jointly provide chronic disease care to a transient client could better respond to client mobility.

15	Does the Calendar Year rule disadvantage practices and patients who are mobile?	• Yes. The calendar year rule is confusing and should be brought in line with the recommendations for the GPMP and TCA, where it states that these services are recommended once every two years though Medicare will pay every 12 months (rolling period from date of registration) if it is clinically required. • Currently PIP IHI payment periods are February, May, August and November. Any registration after 1 November counts as the following year, but activities undertaken for that client in November or December do not count for payment. This does not incentivise chronic disease care management. It is also confusing for services and patients alike.
16	How can practices maintain continuity and consistency of care in light of patient mobility?	• The intention of the PIP IHI is to improve chronic disease care / management for clients. As such, the financial incentives of the PIP IHI needs to remain focused on the individual's needs. • Linking the payment more closely to service provision (for example by weighting Tier 1 and Tier 2 payments more heavily) will enable practices to provide care to mobile clients. • Handover protocols to encourage continuity of care for the client could be included as a requirement of PIP IHI payments. Electronic management records (such as myhealthrecord) could support this.

4. Conclusion

QAIHC thanks the Department for the opportunity to comment on the current PIP IHI and would welcome the opportunity to discuss this further with the Department or facilitate an opportunity for the Department to workshop program or policy development with our Members.

For further information please contact QAIHC Policy Team via phone 3328 8500 or email Policyteam@qaihc.com.au.

5. Attachments

QAIHC Submission: Policy options for reforming the Indigenous Pharmacy Programs (IPP), Sept 2018.

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QAIHC

Queensland Aboriginal and Islander Health Council

36 Russell Street
South Brisbane Q 4101

PO Box 3205
South Brisbane Q 4101

T. **07 3328 8500**

www.qaihc.com.au

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