PHC Workforce Models

Indigenous Allied Health Australia Conference 2013

QAIHC

Queensland Aboriginal and Islander Health Council

QAIHC Background

- State peak body for all AICCHS across – 27 Full Members and 3 Regional members
- Peak body for drug and alcohol residential rehabilitation services – 14 members
- State peak affiliate of the National Aboriginal Community Controlled Health Organisation (NACCHO)

QAIHC
Queensland Aboriginal and Islander Health Council

QAIHC Role

- Provide strategic policy and advocacy support to all members
- Provide member support services through building capacity of community controlled health services sector
- Undertake negotiations with governments about evolving role of AICCHS

QAIHC
Queensland Aboriginal and Islander Health Council

Data Collection Process

- QAIHC indicators – commenced in 2003
  - Set of primary care indicators based upon research to determine service need
  - Developed extraction tool to support service in data analysis and interpretation
  - Now working with GPQ and IF through APCC
  - Using information to develop local Practice Health Atlases

QAIHC
Queensland Aboriginal and Islander Health Council

Outcomes of New Approach

- Evidence of best practice in CPHC delivery
- Data profiling to understand needs of communities
- Alignment of evidence and data to implement new workforce models

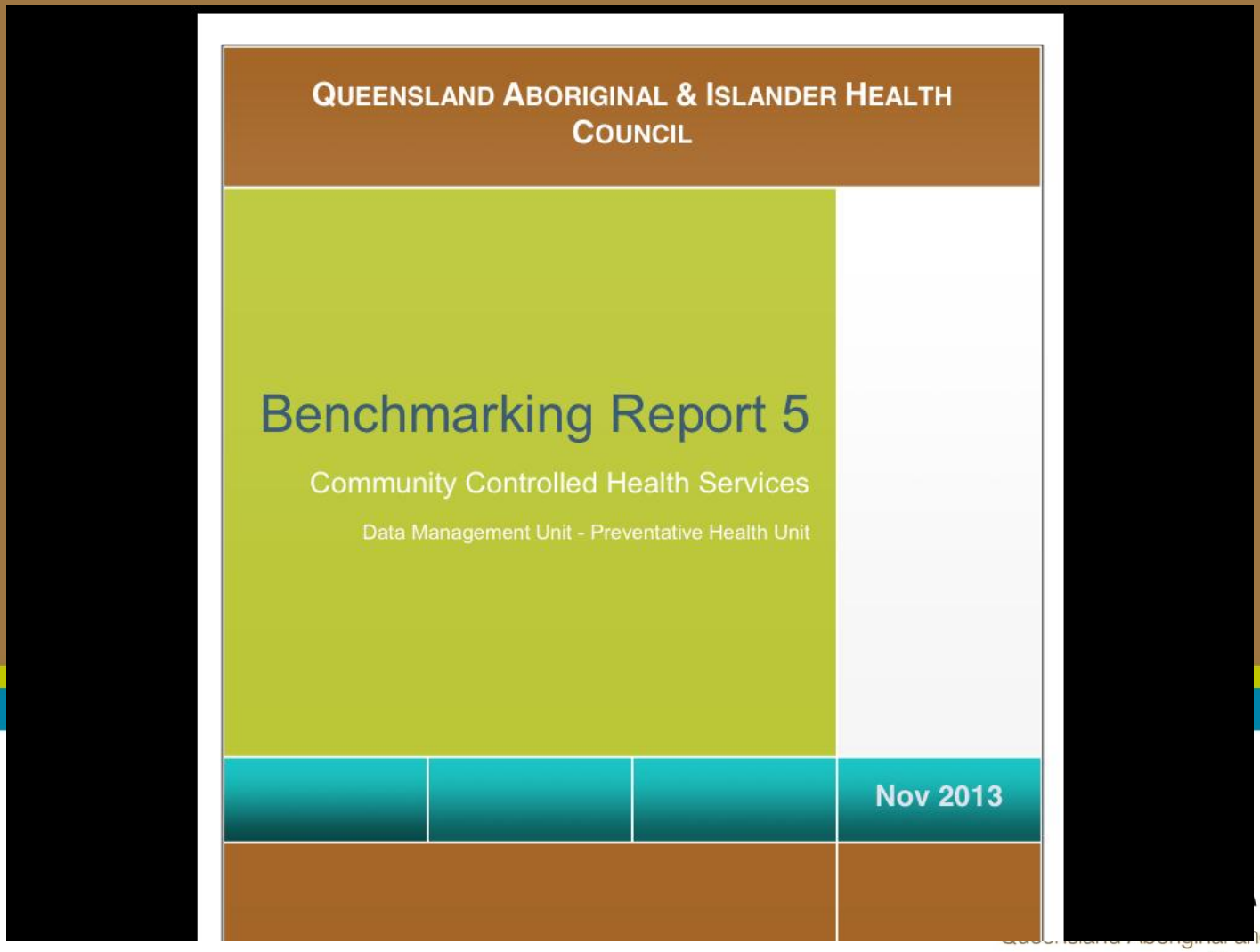
QAIHC
Queensland Aboriginal and Islander Health Council

Benchmark Reports

- Started from internal desire to track progress
- Majority items not required for government performance reports
- Has to lead significant improvements across all AICCHS focussing on things relevant for each community
- Increased level of sophistication in analysis of data and information to support process

QAIHC
Queensland Aboriginal and Islander Health Council

Benchmark Reports



IHC
Health Council

was measured in September 2012, as it was the most complete set.

Demographics of Recent, Regular and All Patients

Recent Patients 40,215	Regular Patients 33,165	All Patients 64,795
Indigenous **28,390 (71%)**	**Indigenous** **23,975 (72%)**	**Indigenous** **44,321 (68%)**
Non-Indigenous 11,825 (29%)	Non-Indigenous 9,190 (28%)	Non-Indigenous 17,405 (27%)

Demographics of Regular Patients

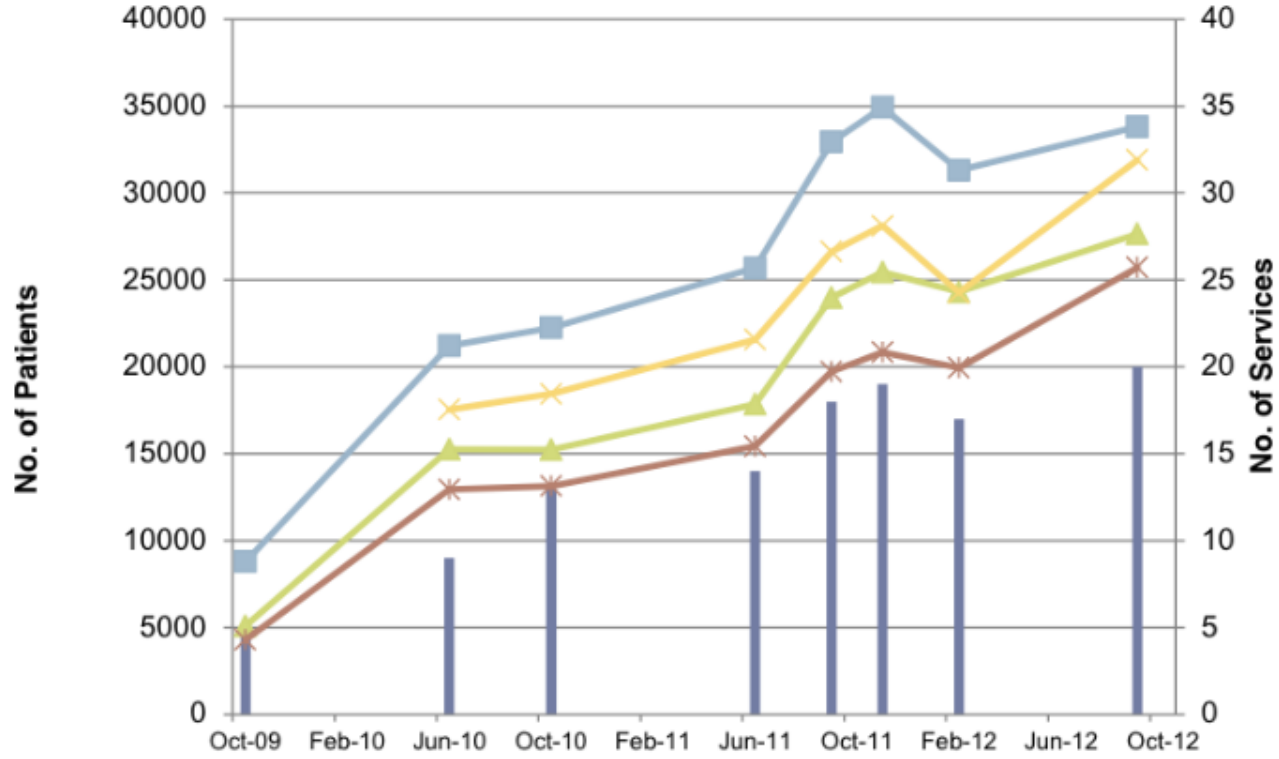
Regular Patients 33,165	Regular Indigenous Patients 23,975	Regular Indigenous Adult Patients 16,283
Indigenous **23,975 (72%)**	**Adults** **16,283 (68%)**	**Female** **9,572 (59%)**
Non-Indigenous 9,190 (28%)	**Children** **7,692 (32%)**	**Male** **6,711 (41%)**

Child: 0-14 years of age. Adult: 15 years of age and above.

Achievements in Recording Patient Data and Risk Factors: Looking After Adults

SECTION II PROFILE OF SERVICES

2.1 Recent and regular patients over time and the number of services submitting data



	Oct-09	Jun-10	Oct-10	Jun-11	Sep-11	Nov-11	Feb-12	Sep-12
No. of services	5	9	13	14	18	19	17	20
Recent Patients	8800	21217	22253	25687	32942	34935	31310	33813
Recent Indigenous Patients	5100	15257	15241	17851	23980	25446	24317	27652
Regular Patients		17541	18440	21566	26629	28120	24279	31902
Regular Indigenous Patients	4300	12938	13136	15433	19727	20845	19948	25717

Practice Health Atlas

- Service and community specific profiling
- Using demographic data to compare against clinic data to determine local performance and identify issues
- Uses where available local hospital data to determine impact upon secondary system and strategies for use in PHC clinic

QAIHC
Queensland Aboriginal and Islander Health Council

PRACTICE PROFILE

PATIENT POPULATION OVERVIEW

Characteristics of your patient population	
	Number patients
Your total population:	18626
Your total cleansed population*	17807
15-month patient population^: (19/01/2012 to 19/04/2013)	9389
30-month patient population:	12103
Aboriginal or Torres Strait Islanders:	38
Pensioners:	4185
DVA patients:	52
Patients on 5 or more current medications**:	2916

** Excludes patients with no postcodes or with post boxes, and those where date of birth was not recorded.*
^ This is referred to as your 'patient population' in this report, and is the cohort upon which the majority of the Practice Health Atlas™ analysis is based.
*** Patients seen at least once in the past 15 month period.*

'PATIENT POPULATION' CATCHMENT

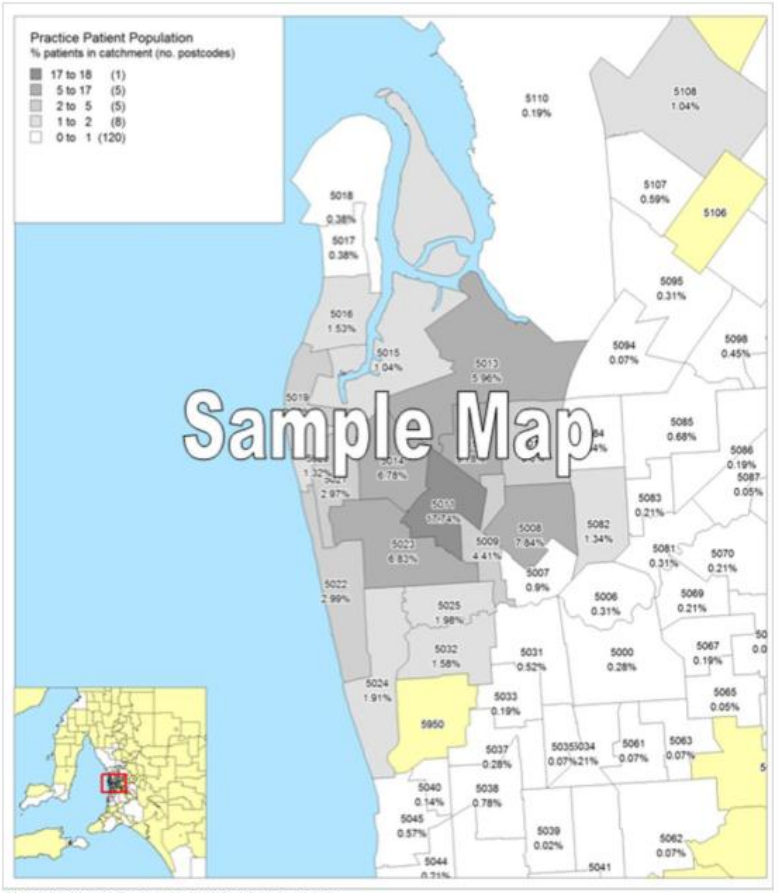
Catchment is measured on the home address postcode of each patient.

Patient Population Catchment	
Total postcodes:	201
No. postcodes used in report: (Referred to as the 'Top 10')	10
% Patient population covered in these postcodes:	61.61%

PRACTICE PROFILE

The following map and charts show the geographic distribution of your patient population, by the home address postcodes of patients seen in the last 15 months (n=9389).

Map 2. Sample PHA Version 10 patient population (percentage catchment by postal area)



Note: Yellow indicates no data for that postcode

There are 9389 patients in the database who have been seen in the last 15 months.

CHRONIC DISEASE PROFILES

OVERVIEW

Ten chronic disease profiles were identified from the patient population (n=9389). These form the basis for the Business & Clinical Modelling section of the Practice Health Atlas™.

Maps depict the patient catchment of each chronic disease. The profiles are compared to each other visually. Multi-morbidities are briefly addressed, as a basis for understanding the broader health of your chronically ill patients. These are the profiles and numbers of patients identified:

Chronic Disease Profile	Number patients
Asthma profile	866
COPD profile	190
CHD profile	527
CRD/I	110
Stroke	243
Hypertension Profile	2009
Diabetes profile	990
Mental Health profile	1698
Osteoporosis profile	1023
Dementia	110
Osteoarthritis	1250

Each profile was derived from diagnoses assigned to the patients, knowledge about which was informed by the Practice. It is critical to know how a Practice uses its software for clinical coding, because:

- there will be variations between practices with the way that chronic diseases patients are recorded (or 'coded')
- there may be variation within a Practice between different doctors as to how clinical coding is undertaken
- each person who inputs diagnoses may not do this consistently every time

In this sense, it is critical to know all coding and related information management processes for each Practice in order to produce the profiles.

Table 22 shows the estimated *potential new income* that could be derived according to patient numbers in the derived patient profiles shown on the following page.

Please note that for some items, although the MBS allows for a frequency of 12-24 months per patient, your PHA representative is able to alter this in the modelling. The modelling takes into account that the practice will see a proportion of eligible patients and the frequency with which the items are applied to the patients. These frequencies and proportions have been nominated by the practice; have been designed to be conservative, realistic and representative of true practice. The table below estimates the potential income over a 12 month billing period.

IMPORTANT: see the breakdown of these figures on following pages for details

Table 23. Overall estimated potential income

Item description	Actual Earned (A)	^Estimated total value (B)	Estimated potential new income (B-A)
EPC Health Assessment Items	$148,774	$242,414	$93,640
EPC Chronic Disease Management Items GPMP & TCA and Reviews			
Diabetes GPMP/TCA/Review	$145,568	$278,792	$133,224
Asthma GPMP/TCA/Review	$109,838	$146,980	$37,142
Mental Health GPMP/TCA/Review	$155,236	$161,487	$6,252
CHD GPMP/TCA/Review	$41,171	$55,073	$13,902
CRD/I GPMP/TCA/Review	$243	$6,939	$6,695
Stroke GPMP/TCA/Review	$15,733	$21,099	$5,366
COPD GPMP/TCA/Review	$6,233	$7,267	$1,033
Osteoporosis GPMP/TCA/Review	$2,801	$79,318	$76,517
Dementia GPMP/TCA/Review	$1,617	$2,221	$604
Osteoarthritis GPMP/TCA/Review	$39,259	$52,565	$13,306
CDM services by a Practice Nurse (10997/10986/10987)	$9,237	$10,638	$1,401
Sub-Total	$526,937	$822,380	$295,443
PNIP Subsidy (see calculator[3])	$0	$0	$0
Service Incentive Program (SIP) Items	$17,701	$111,733	$94,032
Medication Management Item 900[2]	$12,700	$15,105	$2,406
Aged Care items Item Numbers	$10,899	$14,138	$3,239
Totals	**$717,011**	**$1,205,771**	**$488,760**

*Derived from figures in Table 20. Current item number utilisation

^Based on numbers inTable 21. Patient population profiles

1. Based on applying item numbers to the Chronic disease population profiles.
2. Note: This does not include item 903 - that is included in the Aged Care items
3. See PNIP calculator at http://www.medicareaustralia.gov.au/provider/incentives/pnip/calculator.jsp

Regional Profiles

- Commenced development of Regional Profiles across QAIHC boundaries using all available info from each area
- Used to support better integration of planning development an delivery of regional services
- Identifying and resolving duplication of efforts from AICCHS in regions and where to focus
- Builds stronger business case for ongoing regional investments to support local needs

QAIHC
Queensland Aboriginal and Islander Health Council

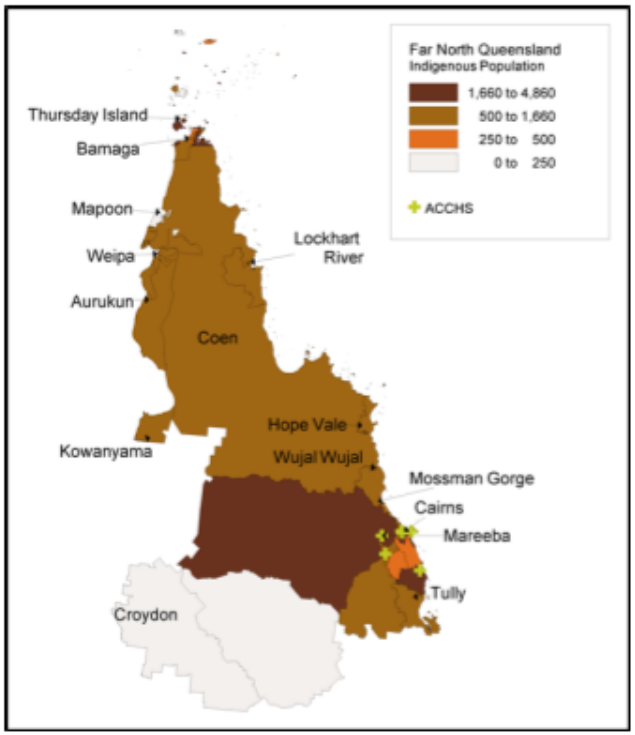
QAIHC Regional Profile Report 2013

Far North Queensland

Apunipima Cape York Health Council, Gurriny Yealamucka Health Service Aboriginal Corporation, Mamu Health Service, Mulungu Aboriginal Corporation , Wuchopperen Health Service

Far North Queensland Aboriginal and Torres Strait Islander population by Age Group and Sex, 2010

Age Group	Female	Male	Total
0-4	2821	2778	5599
5-9	2365	2403	4768
10-14	2205	2215	4420
Sub Total	**7391**	**7396**	**14787**
15-19	1887	1931	3818
20-24	1652	1630	3282
25-29	1446	1373	2819
30-34	1260	1308	2568
35-39	1350	1322	2672
40-44	1267	1132	2399
45-49	1026	903	1929
50-54	823	735	1558
55-59	668	594	1262
Sub Total	**10711**	**10334**	**21045**
60-64	489	432	921
65-69	309	239	548
70-74	244	142	386
75-79	151	107	258
80-84	93	51	144
85+	72	49	121
Total	**20128**	**19344**	**39472**



Population by QAIHC Region and Indigenous Status, 2010

QAIHC Region	Central Queensland	Far North Queensland	North & North West Queensland	South & South West Queensland	South East Queensland	Total QLD
Indigenous	17,280	39,472	32,998	14,041	56,855	160,646
Indigenous Region %	11%	25%	21%	9%	35%	100%
Non-Indigenous	415,248	233,434	423,588	289,067	2,991,872	4,353,209
Non-Indigenous Region%	10%	5%	10%	7%	69%	100%

Synthetic Population Estimates by Indigenous Status, 2010, (2008 Australian Standard Geographical Classification)

Far North Queensland Population Breakdown seen at an Aboriginal Medical Service, 2012

Patient Classification	Indigenous Clients	Non-Indigenous Clients	Indigenous Adults	Indigenous Adult Women	Indigenous Adult Men	Indigenous Children
Regular	9,002	1,067	5,905	3,532	2,373	3,097
Recent	10,614	1,388	6,765	3,984	2,781	3,849
All	17,777	2,034	11,170	6,326	4,839	6,607

QAIHC Regional Profile Report 2013

Far North Queensland

Primary Health Care (Aboriginal Community Controlled Health Services)

	Indigenous				
	n	%	Range	Recorded (%)	Recorded Range
Total Service Contacts	62,413	-	(1,589 to 23,941)	-	-
Smoking					
Smoking Prevalence	2,506	50%	(45% to 55%)	86%	(80% to 95%)
Alcohol					
Prevalence of 'At Risk' Alcohol Consumption	1,252	54%	(45% to 68%)	71%	(53% to 89%)
Obesity					
Males overweight (BMI 25 to 30)	474	28%	(19% to 31%)	72%	(42% to 81%)
Males obese (BMI 30+)	573	33%	(23% to 39%)	72%	(42% to 81%)
Females overweight (BMI 25 to 30)	668	25%	(22% to 27%)	76%	(48% to 84%)
Females obese (BMI 30+)	1,181	44%	(38% to 48%)	76%	(48% to 84%)
Indigenous Health Assessments					
Adults 15-54 Years	2,087	44%	(7% to 65%)	-	-
Adults 55+ Years	661	58%	(9% to 86%)	-	-
Children 0-5 Years	818	52%	(7% to 69%)	-	-
Children 6-14 Years	745	49%	(8% to 83%)	-	-
Diabetes					
Prevalence of Type 2 Diabetes	1,224	21%	(15% to 25%)	-	-
Type 2 Diabetic Clients on GP Management Plans	464	42%	(17% to 60%)	-	-
Type 2 Diabetic Clients Glycaemic Control: HbA1c Values (HbA1c > 10%)	231	24%	(18% to 30%)	78%	(59% to 83%)
Cardiovascular Disease					
Prevalence of Hypertension	1,464	25%	(20% to 31%)	84%	(82% to 89%)
Hypertensive Patients with a Blood Pressure Recording (6 months)	1,302	89%	(83% to 91%)	-	-
Hypertensive Patients on Best Practice Medication	1,004	69%*	(54% to 77%)	-	-
CHD Clients on GP Management Plans	124	38%	(18% to 56%)	-	-
Kidney Function					
eGFR Values (< 60 mls/min)	262	15%	(7% to 20%)	30%	(19% to 40%)
eGFR Values (>= 60 mls/min to <= 90 mls/min)	636	35%	(32% to 40%)	30%	(19% to 40%)
ACR Values (ACR >3.5 g/mol)	490	45%	(22% to 62%)	19%**	(6% to 24%)
Maternal & Child Health					
Under-height Children Aged Less Than 5 years	226	30%	(26% to 53%)	58%	(28% to 72%)
Under-weight Children Aged Less Than 5 years	115	13%	(9% to 25%)	69%	(43% to 85%)
Under-weight Children Aged 5 to 14 Years	91	10%	(6% to 17%)	54%	(42% to 77%)
Overweight Children Aged 5 to 14 Years	153	17%	(11% to 20%)	54%	(42% to 77%)
Indigenous Women Who Gave Birth	142	-	-	-	-

Workforce models

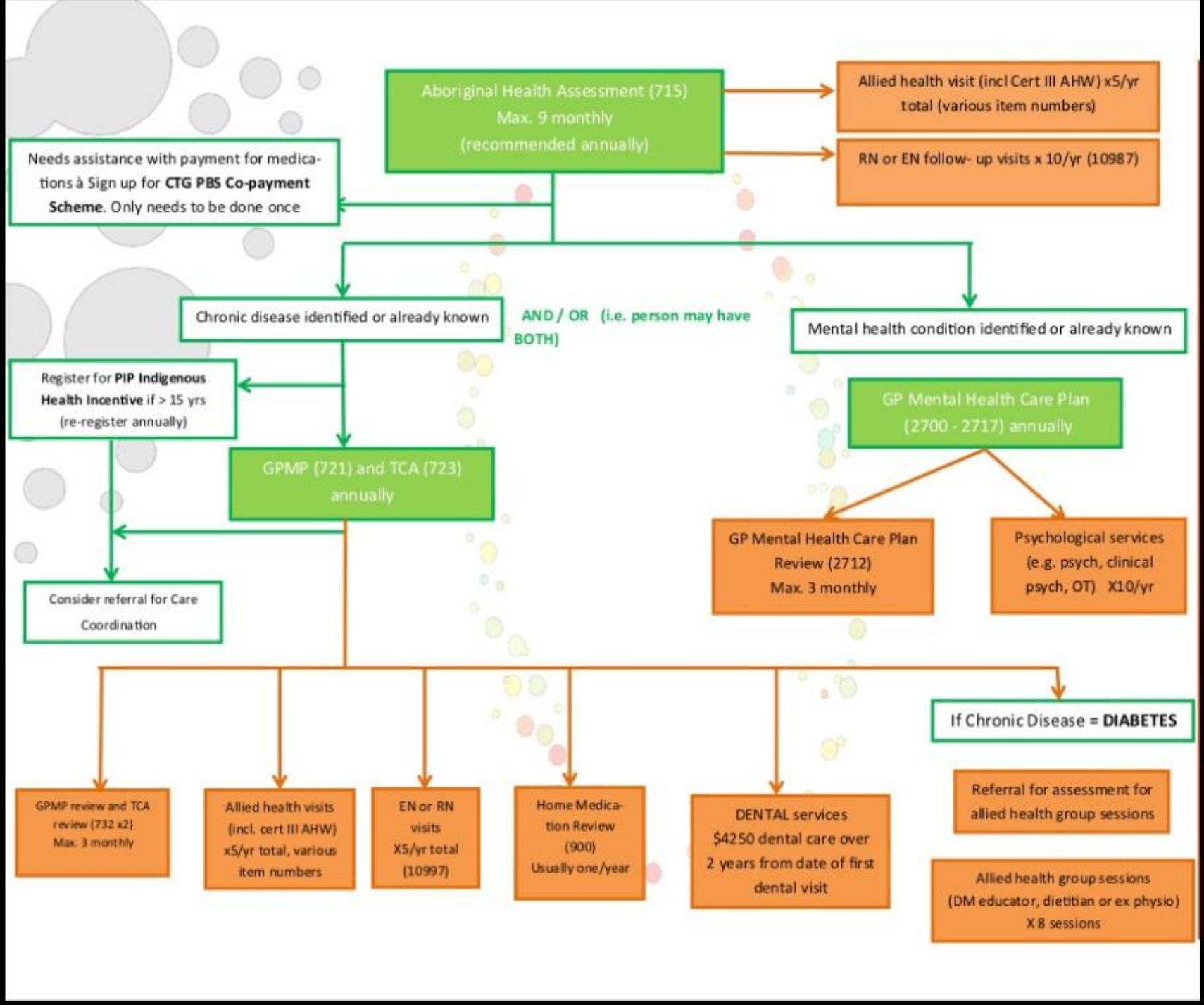
- Commissioned work through IUIH to develop Workforce Plan across SEQ AICCHS with view to utilising as foundation for other regions
- Workforce Planning based upon best practice delivery of CPHC services
- Maximizing use of system enablers to support better care including Medicare

QAIHC
Queensland Aboriginal and Islander Health Council

Workforce should be for every **one GP*** there is:

- 1 Community Liaison Officer
- 1 Transport Officer
- 2 Receptionists
- 1 Clinic Registered Nurse
- 1 Chronic Disease Nurse
- 1 Aboriginal or Torres Strait Islander Health Worker
- 1 Care Coordinator
- 1 Practice Manager

*(*Note: An additional GP does not mean doubling every role except for the RN. Ratio of GP to RN (or Senior HW) is 1:2)*


Aboriginal Health Assessment (715)
Max. 9 monthly
(recommended annually)
Allied health visit (incl Cert III AHW) x5/yr total (various item numbers)
RN or EN follow- up visits x 10/yr (10987)
Needs assistance with payment for medications à Sign up for CTG PBS Co-payment Scheme. Only needs to be done once
Chronic disease identified or already known
AND / OR (i.e. person may have BOTH)
Mental health condition identified or already known
Register for PIP Indigenous Health Incentive if > 15 yrs (re-register annually)
GPMP (721) and TCA (723) annually
GP Mental Health Care Plan (2700 - 2717) annually
GP Mental Health Care Plan Review (2712) Max. 3 monthly
Psychological services (e.g. psych, clinical psych, OT) X10/yr
Consider referral for Care Coordination
If Chronic Disease = DIABETES
GPMP review and TCA review (732 x2) Max. 3 monthly
Allied health visits (incl. cert III AHW) x5/yr total, various item numbers
EN or RN visits X5/yr total (10997)
Home Medication Review (900) Usually one/year
DENTAL services $4250 dental care over 2 years from date of first dental visit
Referral for assessment for allied health group sessions
Allied health group sessions (DM educator, dietitian or ex physio) X 8 sessions

Benefits for clients and staff

- Easier articulation of patient flow and support through clinic
- Maximising use of all staff time and scope of practice
- Clearer pathways for clients to navigate and support their own care needs
- Support delineation of roles across clinic avoiding duplication and wasted energy

QAIHC
Queensland Aboriginal and Islander Health Council

Role of Allied Health

- Simpler structures to know and understand client needs for support and care management
- Greater alignment with clinic care provision and shared care arrangements
- Greater efficiencies in time to support clients needs based upon early assessment rather than going over old ground

QAIHC
Queensland Aboriginal and Islander Health Council

Allied Health Assistants

- Support mechanism for Allied Health staff to provide care
- Similar in concept to role of IHW supporting clients to understand treatment and connection to broader care coordination
- Provides a constant link between visiting Allied Health specialists and community
- Supports future workforce capacity providing students with options for entry into health industry

QAIHC
Queensland Aboriginal and Islander Health Council

How is it being implemented?

- IUIH SEQ models through ‘Work it Out’
  - Samara Dargan presentation at conference
- Outreach Services program across Qld
  - CheckUp and QAIHC partnership administering RHOF and MOICDP programs across Qld

QAIHC
Queensland Aboriginal and Islander Health Council

Outreach Services

- Two separate funding streams previously in Qld
  - CheckUp formerly GPQ
  - Qld Health
- Majority of funds previously were going towards Medical Specialists
- Change in scope through new contract to support enhanced multi-disciplinary care

QAIHC
Queensland Aboriginal and Islander Health Council

QAIHC's role?

- Data analysis to determine demand for services and identification of specialists required to support better care
- Using all current and future data sources to determine need
- Better workforce profiling to support client care
- Greater alignment of workforce skillsets to ensure multi-disciplinary approach to CPHC

QAIHC
Queensland Aboriginal and Islander Health Council

What does this mean for Allied Health Workforce?

- Increases in:
  - contracting arrangements for Allied Health professionals in AICCHS through Outreach
  - employment arrangements for Allied Health professionals in AICCHS
  - uptake of Allied Health Assistants by AICCHS to support connection between community, clinics and specialists

QAIHC
Queensland Aboriginal and Islander Health Council

How do we know this?

- Allied Health expenditure in Qld -
  - 2011/2012 - $1,180,183
  - 2013/2014 - $2,186,141

QAIHC
Queensland Aboriginal and Islander Health Council

How do we know this?

- High frequency Allied Health services in Qld -
  - Diabetic educators
  - Dietitians
  - Physiotherapists
  - Podiatrists
  - Exercise physiologists

QAIHC
Queensland Aboriginal and Islander Health Council

Where to from here?

- Greater level of sophistication that exists now in AICCHS
- Notion of evidence-based approaches is now second nature for AICCHS workforce planning
- Outreach Services and other programs provide opportunity for enhanced care through a variety of specialists in AICCHS

QAIHC
Queensland Aboriginal and Islander Health Council