
Deadly Mob
WELCOME

Birth of the Sector…

REDHILL CLINIC - 1973

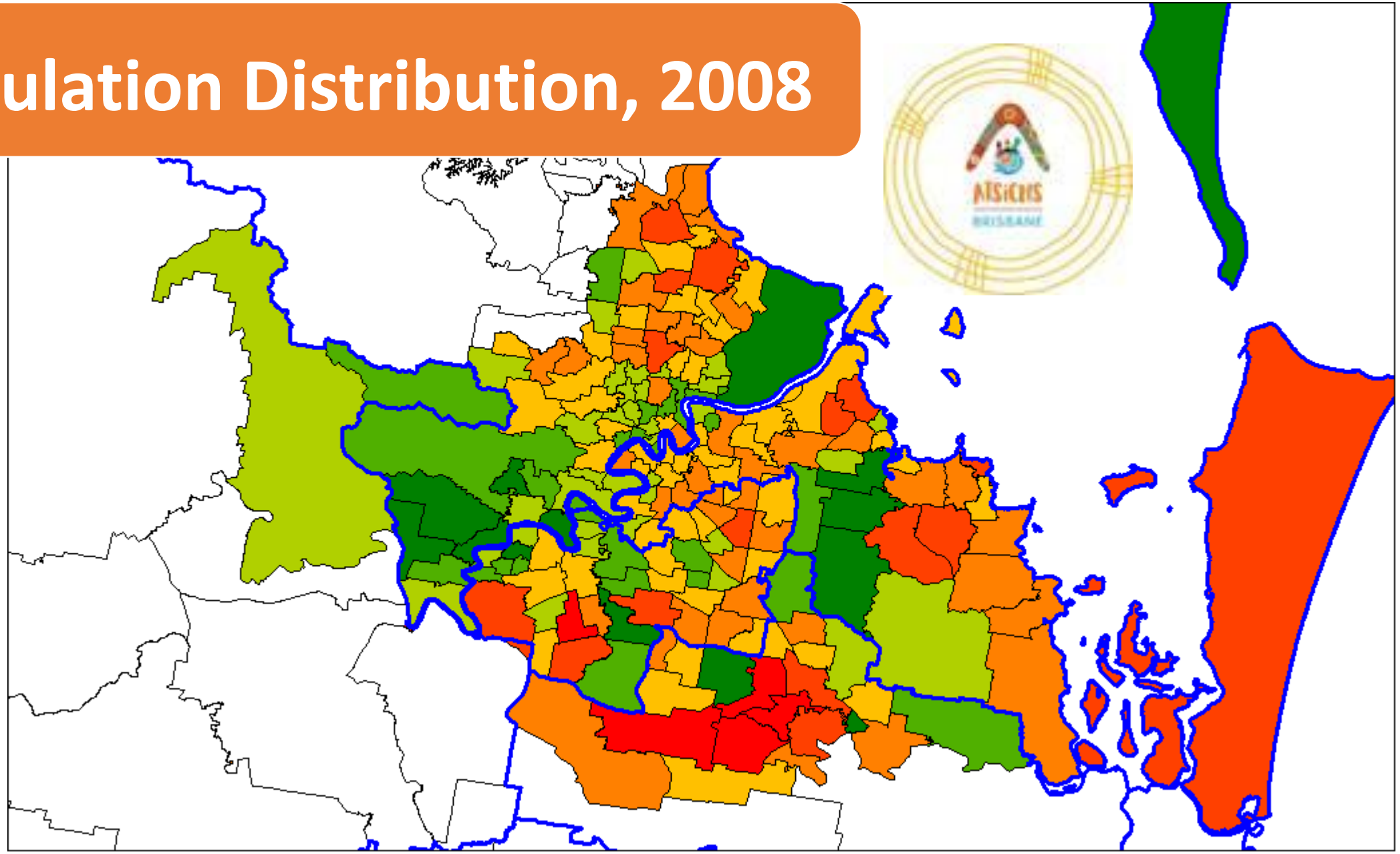
History

- Transfer of policy AND funding responsibility from ATSIC to then Department of Human Services & Health at 30 June 1995 sees additional funding (and regulation) made available to the Sector
- Additional funding AND increasing/disproportionate reporting burden, including ‘body-parts’ funding, along with changes in leadership within CCHSs, sees SEQ CCHSs increasingly focussed internally and (over time) become competitive with other CCHSs for funding and talent
- No new Community Controlled Clinics established AND maintained during the period 1995 – 2008 despite population growth, with four (4) CCHSs operating four (4) Primary Health Care (PHC) Clinics at end 2008
- 2009 sees the first new/full-time Clinic established in Northgate by ATSICHS Brisbane, bringing total number of Clinics in SEQ to five (5)

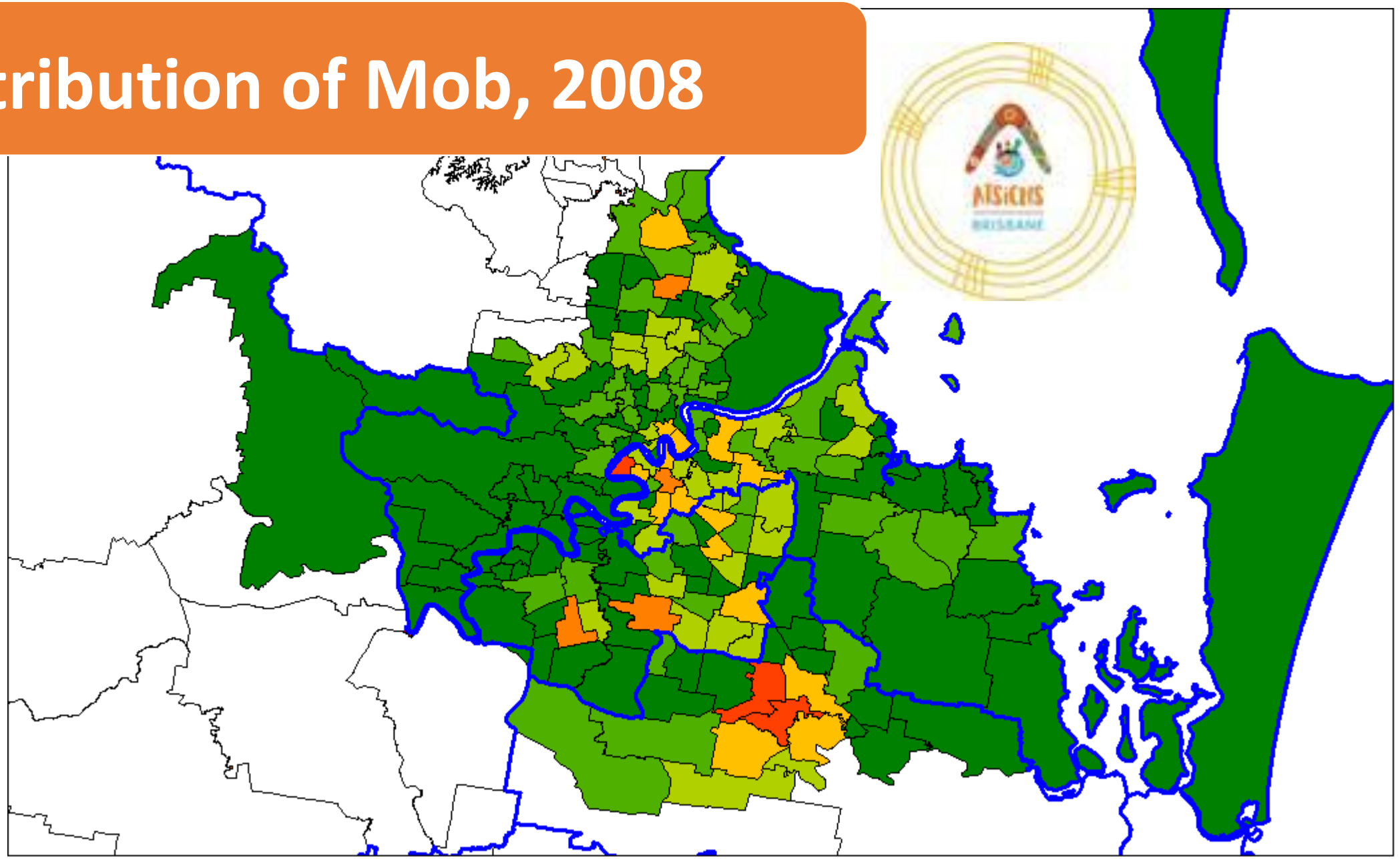
History

- Late 2008 ATSICHS Brisbane analysis of patient access AND population data identifies misalignment of current services with population growth AND movement
- ATSICHS Brisbane identifies ‘expansion strategy’ and regional approach to as response to the above in its Strategic Plan 2009-2012
- December 2007 the COAG commitment to ‘close the gap in life expectancy within a generation’ – by 2031. Historic announcement of $1.6billion by C’wealth ($806million) and states and territories ($772million)
- February 2008 the Prime Minister states that funding would be “largely distributed through the mainstream health system, because that is where 70% of Indigenous people are treated”

Population Distribution, 2008



Distribution of Mob, 2008

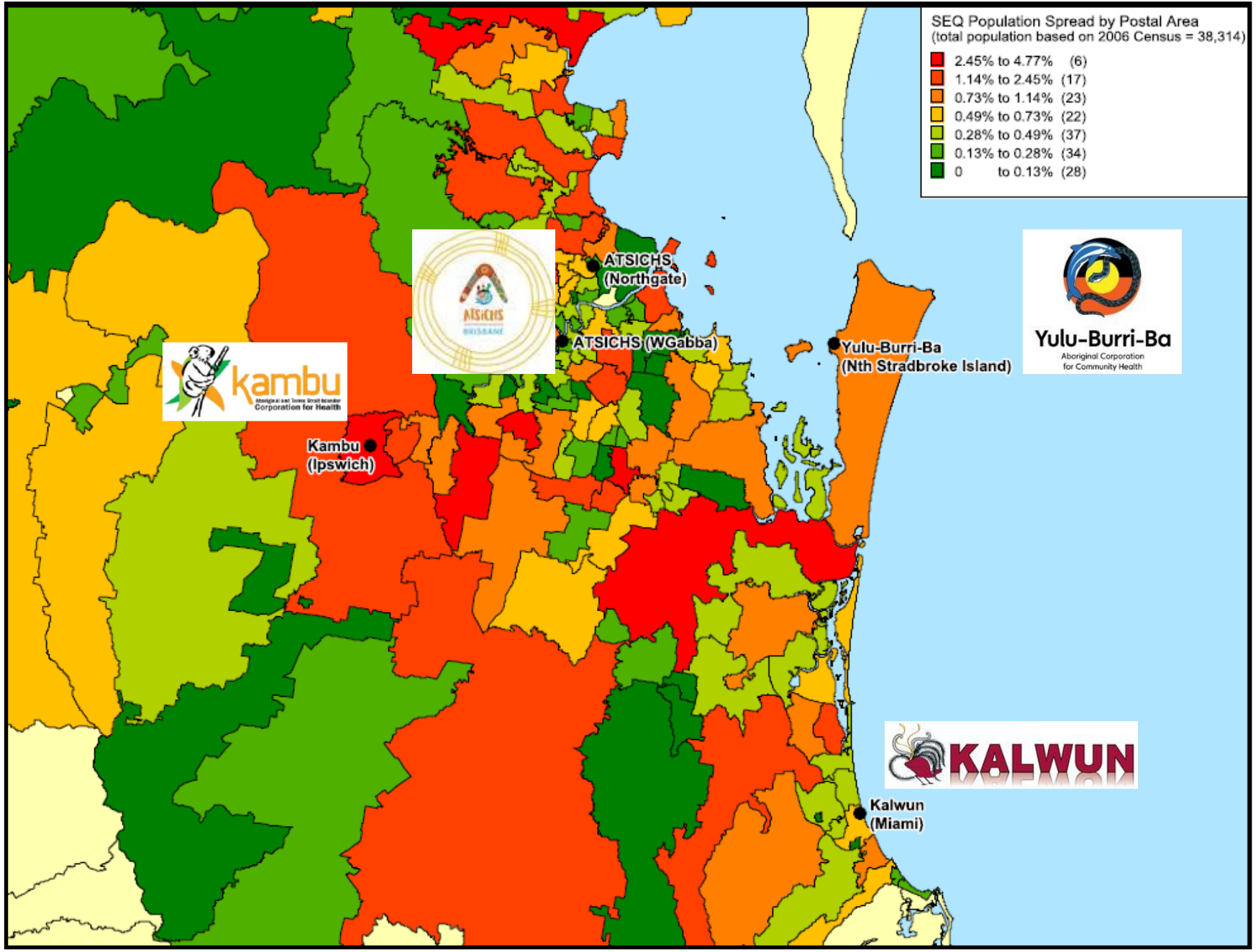


Common challenges for SEQ CCHSs

- Rapid growth of populations and movement away from the location of CCHS Clinics (5 x PHC Clinics in 2009)
- ‘Close the Gap’ funding and policy efforts in urban areas concentrated on mainstream health services – representing ‘policy by anecdote’ at best, at worse continuation of colonial constructs of Aboriginal and Torres Islander identity
- Absence of evidence on health need of urban Aboriginal and Torres Strait Islander populations – ineffective advocacy by the Sector

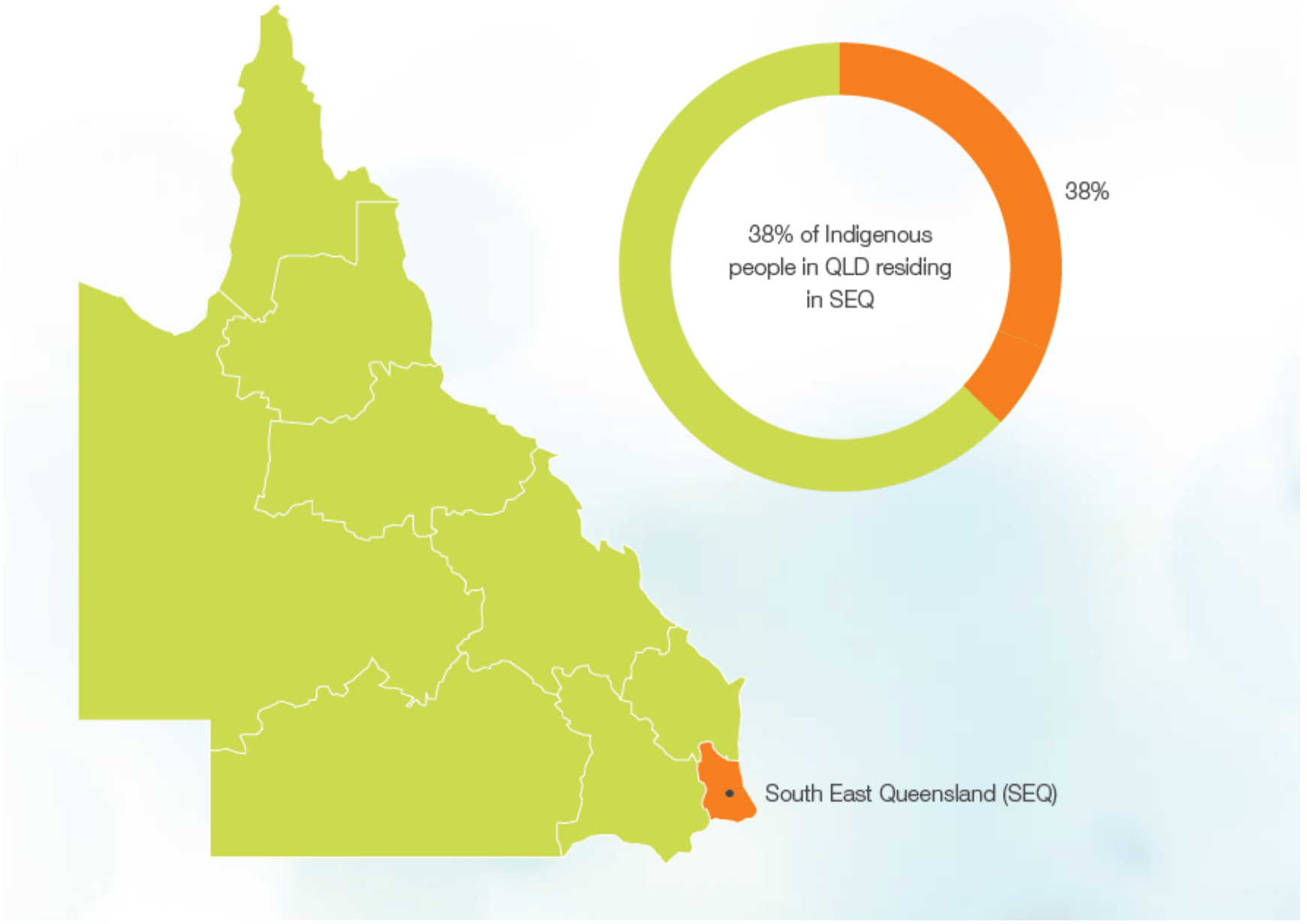
Common challenges for SEQ CCHSs

- Competition for funding and talent with other SEQ CCHSs
- Need to improve capture of Medicare income (19.2) by CCHSs as primary source of future growth funding, reducing dependency on grant funding and strengthening independence of CCHSs
- High turn-over of executives within/across SEQ CCHSs, leaving CCHSs individually vulnerable within new ‘CTG’ environment

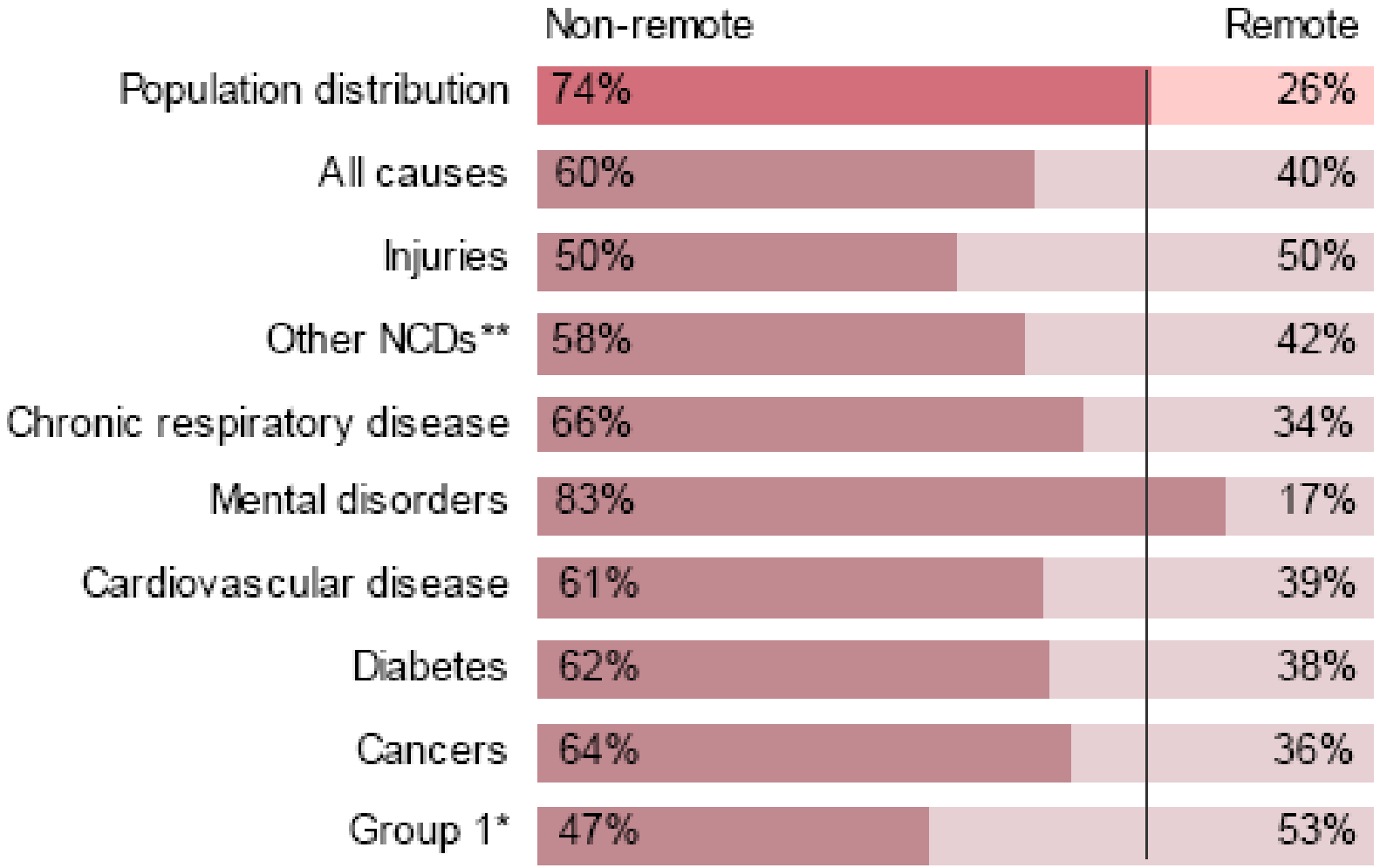

SEQ Population Spread by Postal Area
(total population based on 2006 Census = 38,314)
2.45% to 4.77% (6)
1.14% to 2.45% (17)
0.73% to 1.14% (23)
0.49% to 0.73% (22)
0.28% to 0.49% (37)
0.13% to 0.28% (34)
0 to 0.13% (28)
ATSICHS (Northgate)
ATSICHS (WGabba)
Yulu-Burri-Ba (Nth Stradbroke Island)
Yulu-Burri-Ba
Aboriginal Corporation for Community Health
kambu
Aboriginal and Torres Strait Islander Corporation for Health
Kambu (Ipswich)
KALWUN
Kalwun (Miami)

SEQ Aboriginal and Torres Strait Islander Population

- Minimum of 40,000 – estimated to total 50,000 with under-counts (2009)
- More than the total Indigenous population of Victoria
- More than the total Indigenous population of South Australia
- More than two thirds of the total Indigenous population of NT
- More than half of the total Indigenous population of Western Australia
- Over 10% of Australia's total Indigenous population


38%
38% of Indigenous people in QLD residing in SEQ
South East Queensland (SEQ)

The Gap by selected causes (Voss et al 2007)



Population Growth

Local Government Area	Indigenous Population 2011	Indigenous Population 2016	Growth %
Brisbane	14,629	17,070	17%
Moreton Bay	8,482	12,571	48%
Logan	7,774	9,817	26%
Gold Coast	6,196	9,293	50%
Ipswich	6,416	8,429	31%
Redlands	2,617	3,431	31%
Lockyer Valley	1,012	1,508	49%
Scenic Rim	932	1,225	31%
Total	**48,058**	**63,334**	**32%**

IUIH - Overview

- Established in 2009 as a strategic response to population growth/dispersion across SEQ by four (4) Community Controlled Health Services:
  - ATSICHS Brisbane;
  - Kambu Health Service;
  - Kalwun Development Corporation (Kalwun Health Service); and
  - Yulu-Burri-Ba Health Service
- Response also to the 'Close the Gap' policy environment – mainstreaming of health care to urban populations

ATSICHS BRISBANE

kambu Aboriginal and Torres Strait Islander Corporation for Health

KALWUN

Yulu-Burri-Ba Aboriginal Corporation for Community Health

IUIH – The Challenge

- Our existing service system/s were NOT capable of expansion to meet the needs of our growing populations – we needed significant AND quick change to realise the opportunities of ‘CTG’
- Rather than defend the traditional model and trade rhetoric with government (and others), our leaders needed to undertake the hard and unpopular work of leading the renewal and managing the transformation of our sector in SEQ
- Reforms needed to be all encompassing to strengthen corporate governance and management systems, whilst also strengthening our service delivery systems

Governance Model

- IUIH established as a company limited by guarantee under Corporations Law
- 'Mixed-Board' structure, with equal representation from Members (4) plus independent Directors/expertise (4) – IUIH Chairperson elected from amongst Nominee Directors:
  - 1 x Nominee Director from **ATSICHS Brisbane, Kambu, Yulu-Burri-Ba and Kalwun**
  - 1 x Independent Expert – Clinical/Indigenous Health
  - 1 x Independent Expert – Business & Not-for-Profit
  - 1 x Independent Expert – Financial Management
  - 1 x Independent Expert – Clinical/Specialist
- IUIH Board model inspired by Apunipima Cape York Health Council

Governance Model (cont.)

- Constitutional reforms driven within Member Organisations to strengthen community governance, including:
  - Rules to prevent family domination of Boards AND avoidance of conflicts of interest by CEO or Senior Management Team being related to Board Members;
  - Rules preventing staff dominating membership AND former staff being elected to the Board within a specified timeframe;
  - Setting minimum qualifications for Board Members and requirements for those not meeting requirement to acquire qualification within timeframe;
  - Appointment of independent/professional Company Secretaries; and
  - Use of independent expert Directors

Our Board

Yulu-Burri-Ba
Aboriginal Corporation for Community Health

Chairperson

Vacant

kambu
Aboriginal and Torres Strait Islander Corporation for Health

KALWUN

ATSICHS BRISBANE

Independent

Influencing our approach…

Urban Indian Health Institute
A Division of the Seattle Indian Health Board

KIMBERLEY ABORIGINAL MEDICAL SERVICES LTD

apunipima
CAPE YORK HEALTH COUNCIL

Southcentral Foundation

Inspiring our approach…

- Our shared history and strength of collective action
- Developing our Cultural Integrity Framework – ‘The Ways’, as foundation for our operation and direction

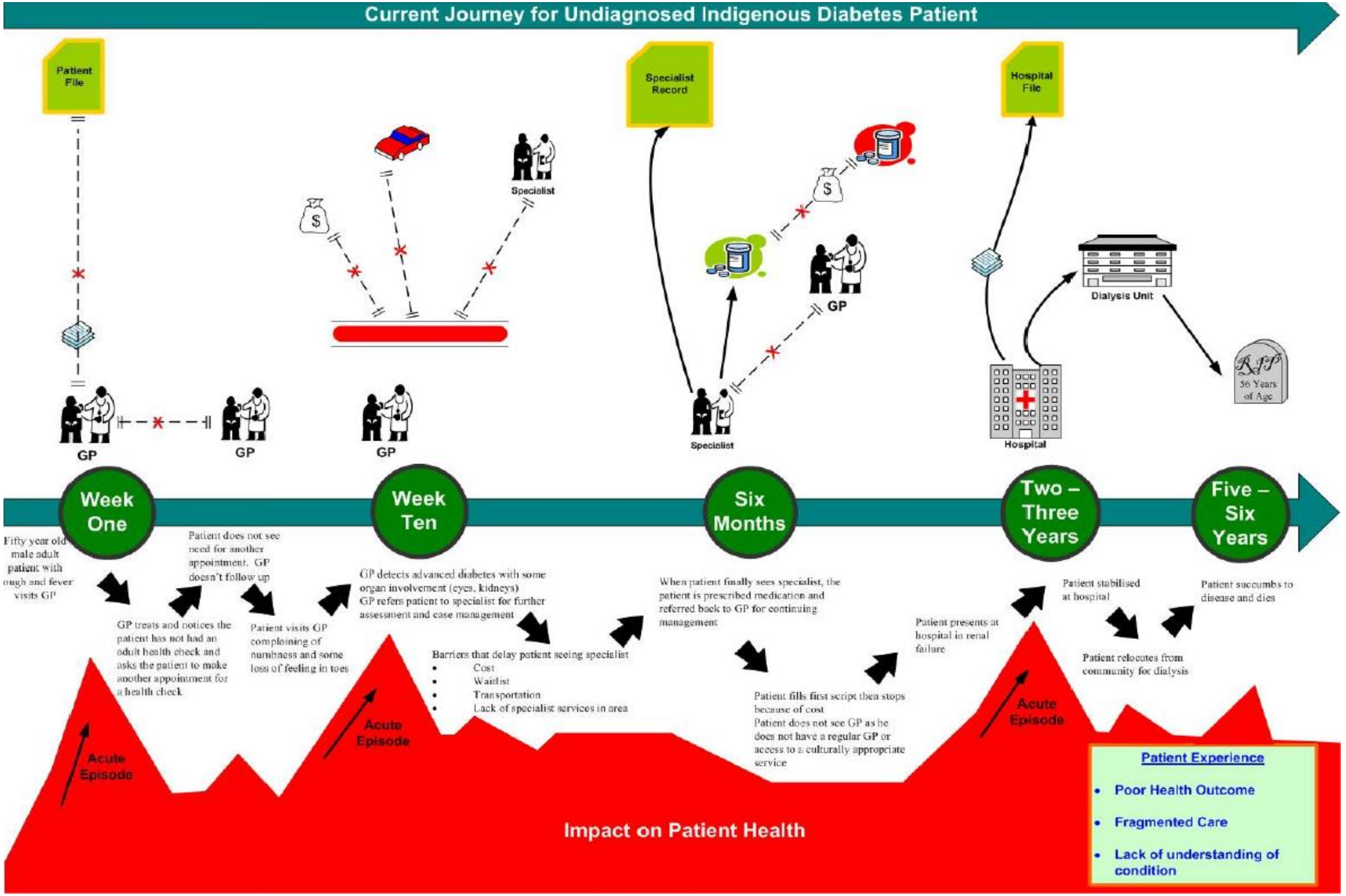
Cultural Integrity
Investment Framework

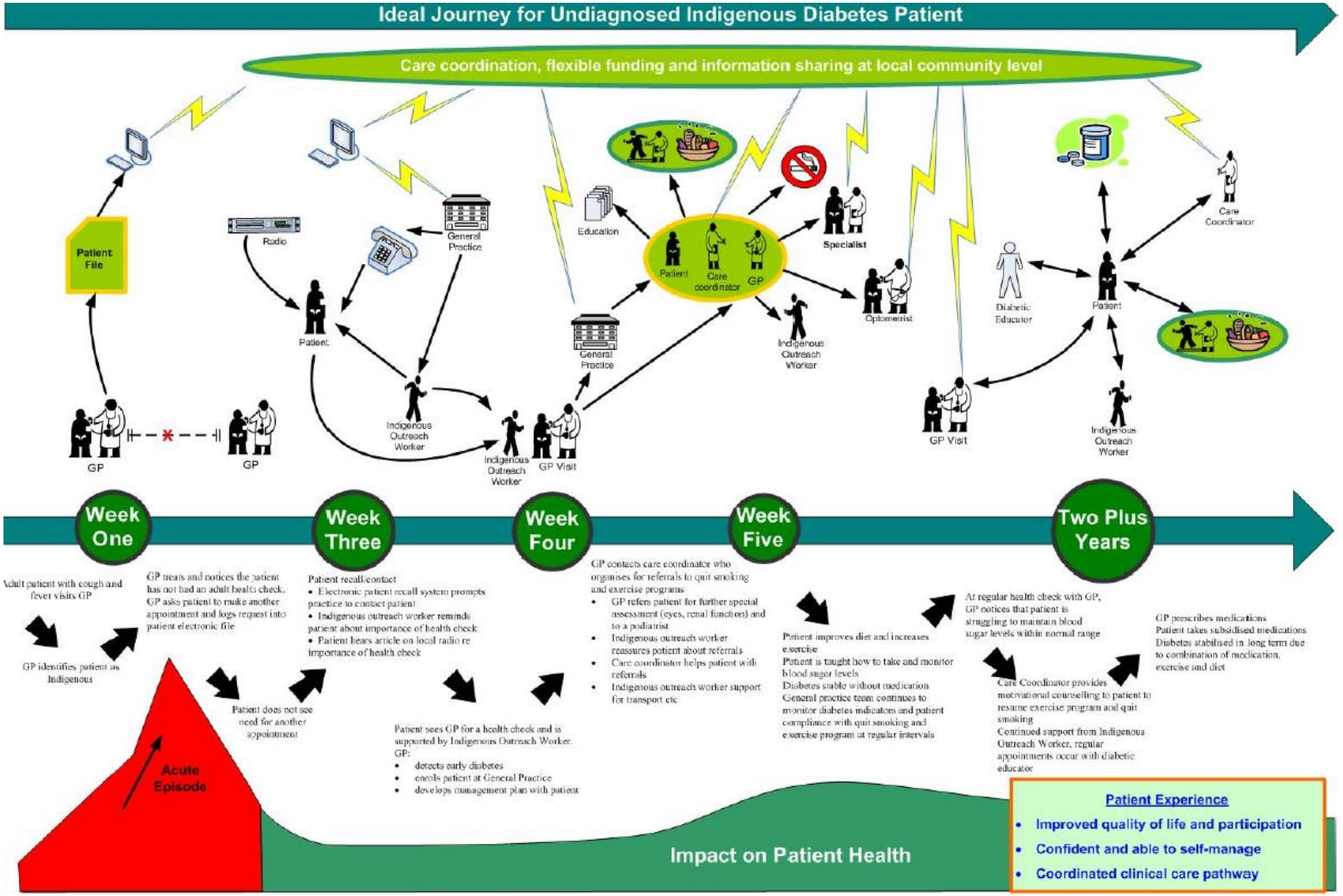
THE WAYS STATEMENT

Role of the IUIH

- Complexity and fragmented nature of the health system, compounded by fragmented CTG investment by government, meant the solution for increasing access to comprehensive primary health care at the local level lay first at integration of the system AND investment at a regional level
- The IUIH to undertake the role of ‘regional integrator’ and ‘system enabler’, enabling SEQ CCHSs to focus on critical role of service delivery and supporting CCHSs to expand PHC Clinics in accordance with regionally identified/agreed need

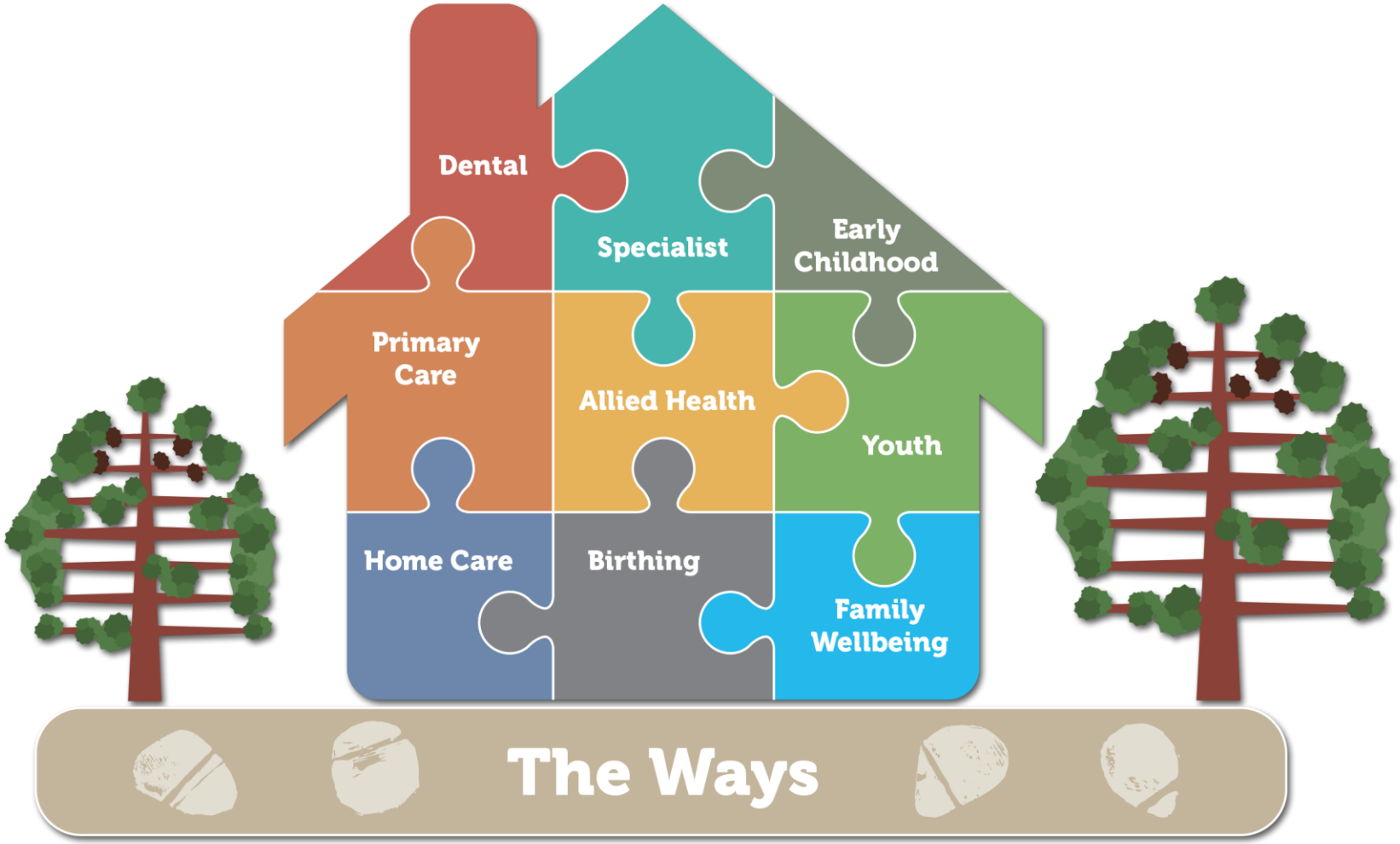

Australian Government
Queensland Government
Closing the Gap.


Current Journey for Undiagnosed Indigenous Diabetes Patient
Patient File
Specialist Record
Hospital File
Specialist
$
GP
Dialysis Unit
RIP
56 Years of Age
Specialist
Hospital
Week One
Week Ten
Six Months
Two – Three Years
Five – Six Years
Fifty year old male adult patient with cough and fever visits GP
GP treats and notices the patient has not had an adult health check and asks the patient to make another appointment for a health check
Patient does not see need for another appointment. GP doesn't follow up
Patient visits GP complaining of numbness and some loss of feeling in toes
GP detects advanced diabetes with some organ involvement (eyes, kidneys)
GP refers patient to specialist for further assessment and case management
Barriers that delay patient seeing specialist
Cost
Waitlist
Transportation
Lack of specialist services in area
When patient finally sees specialist, the patient is prescribed medication and referred back to GP for continuing management
Patient fills first script then stops because of cost
Patient does not see GP as he does not have a regular GP or access to a culturally appropriate service
Patient presents at hospital in renal failure
Patient stabilised at hospital
Patient relocates from community for dialysis
Patient succumbs to disease and dies
Acute Episode
Acute Episode
Acute Episode
Impact on Patient Health
Patient Experience
Poor Health Outcome
Fragmented Care
Lack of understanding of condition

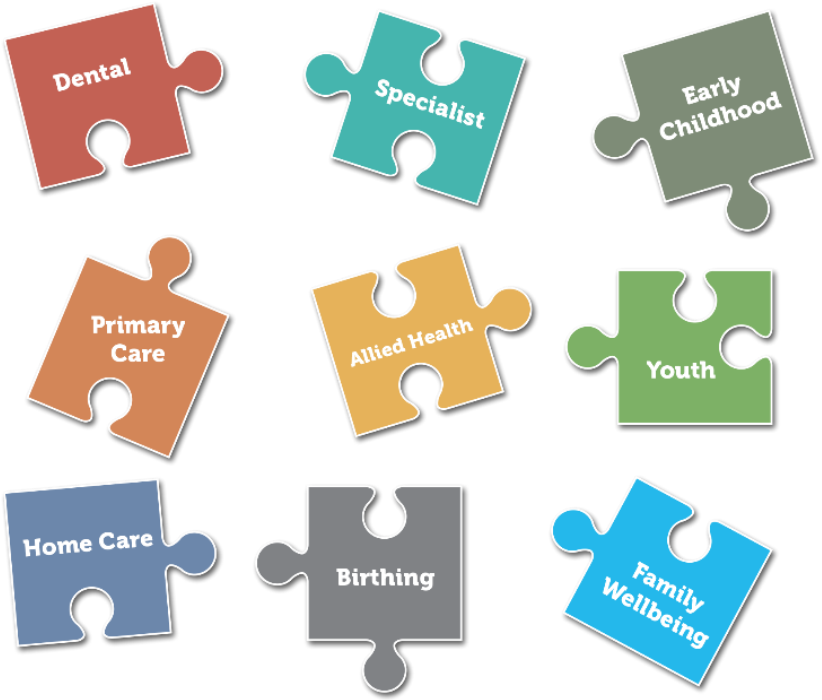

Ideal Journey for Undiagnosed Indigenous Diabetes Patient
Care coordination, flexible funding and information sharing at local community level
Patient File
Radio
General Practice
Education
Patient
Care coordinator
GP
Specialist
Optometrist
Indigenous Outreach Worker
Diabetic Educator
Care Coordinator
GP
GP
Indigenous Outreach Worker
GP Visit
Week One
Week Three
Week Four
Week Five
Two Plus Years
Adult patient with cough and fever visits GP
GP identifies patient as Indigenous
GP treats and notices the patient has not had an adult health check. GP asks patient to make another appointment and logs request into patient electronic file
Patient does not see need for another appointment
Patient recall/contact
• Electronic patient recall system prompts practice to contact patient
• Indigenous outreach worker reminds patient about importance of health check
• Patient hears article on local radio re importance of health check
Patient sees GP for a health check and is supported by Indigenous Outreach Worker. GP:
• detects early diabetes
• enrols patient at General Practice
• develops management plan with patient
GP contacts care coordinator who organises for referrals to quit smoking and exercise programs
• GP refers patient for further special assessment (eyes, renal function) and to a podiatrist
• Indigenous outreach worker reassures patient about referrals
• Care coordinator helps patient with referrals
• Indigenous outreach worker support for transport etc
Patient improves diet and increases exercise
Patient is taught how to take and monitor blood sugar levels
Diabetes stable without medication
General practice team continues to monitor diabetes indicators and patient compliance with quit smoking and exercise program at regular intervals
At regular health check with GP, GP notices that patient is struggling to maintain blood sugar levels within normal range
Care Coordinator provides motivational counselling to patient to resume exercise program and quit smoking
Continued support from Indigenous Outreach Worker, regular appointments occur with diabetic educator
GP prescribes medications
Patient takes subsidised medications
Diabetes stabilised in long term due to combination of medication, exercise and diet
Acute Episode
Impact on Patient Health
Patient Experience
• Improved quality of life and participation
• Confident and able to self-manage
• Coordinated clinical care pathway

Mainstream system - fragmentation

Our system – integration

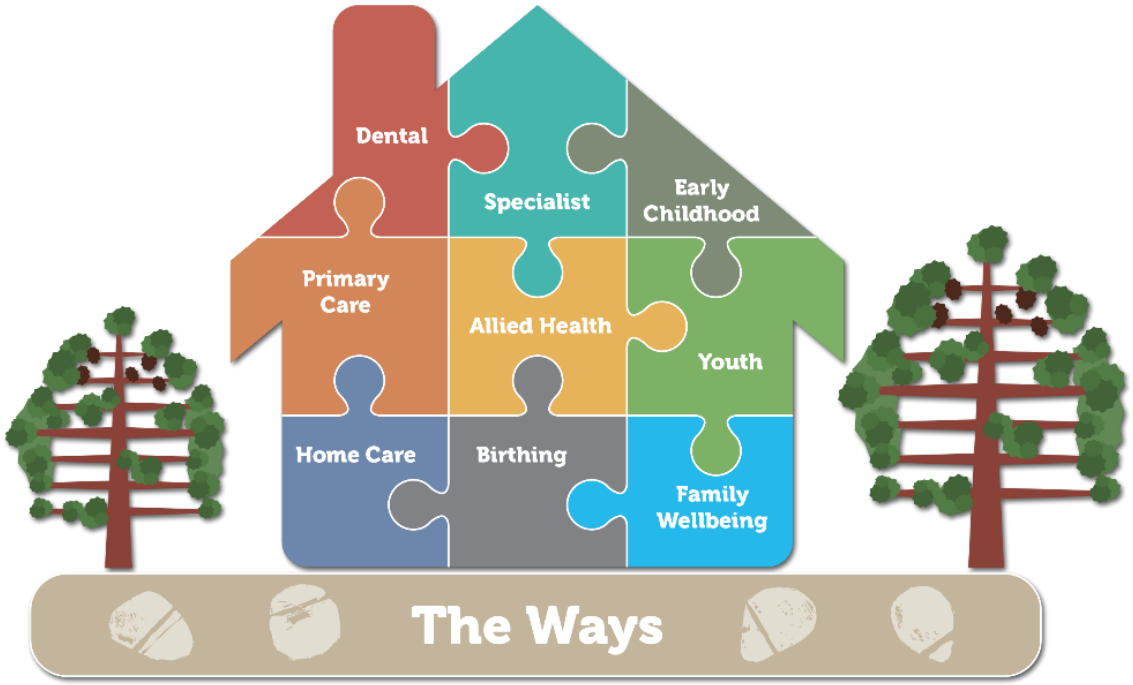


Mainstream



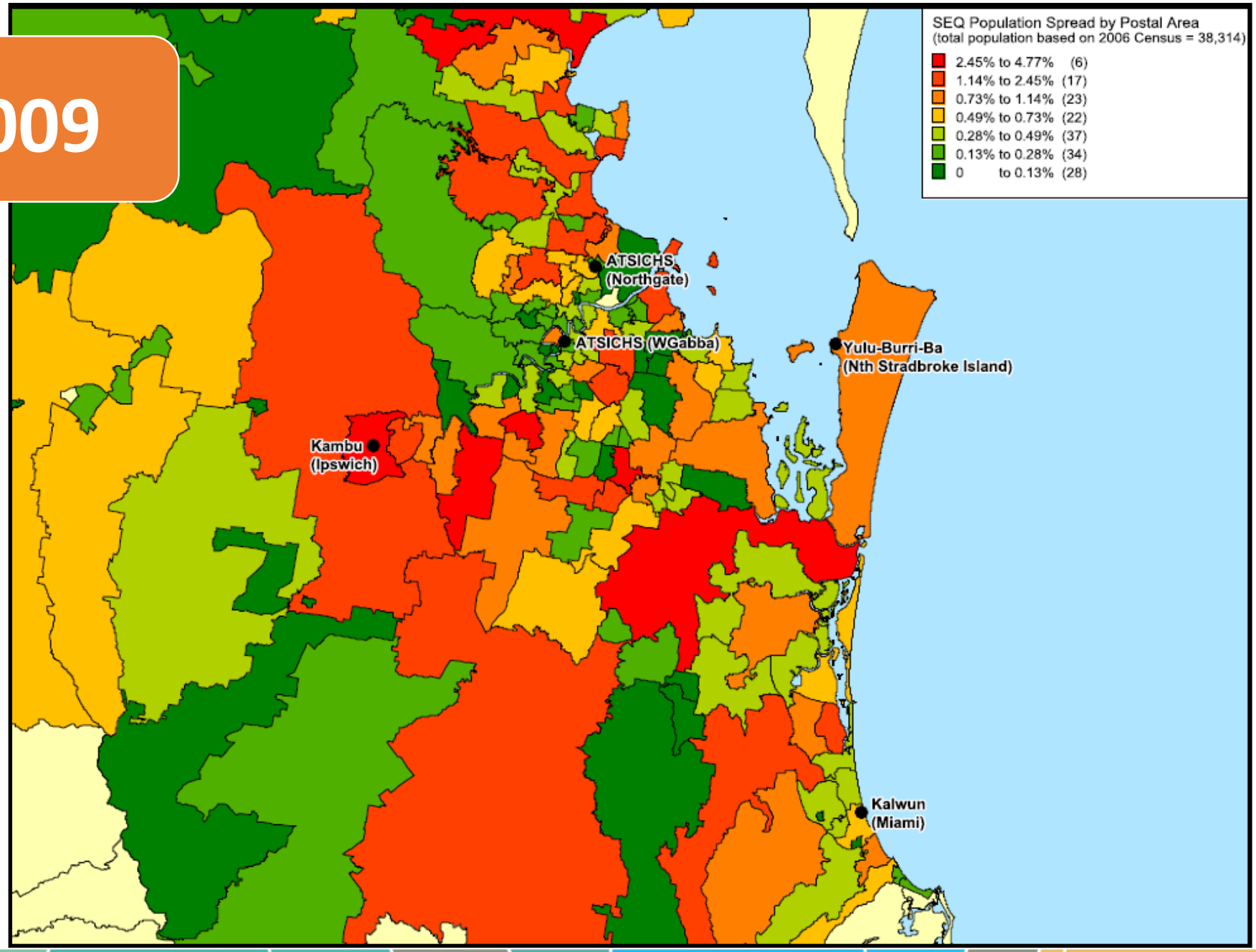
VS

IUIH

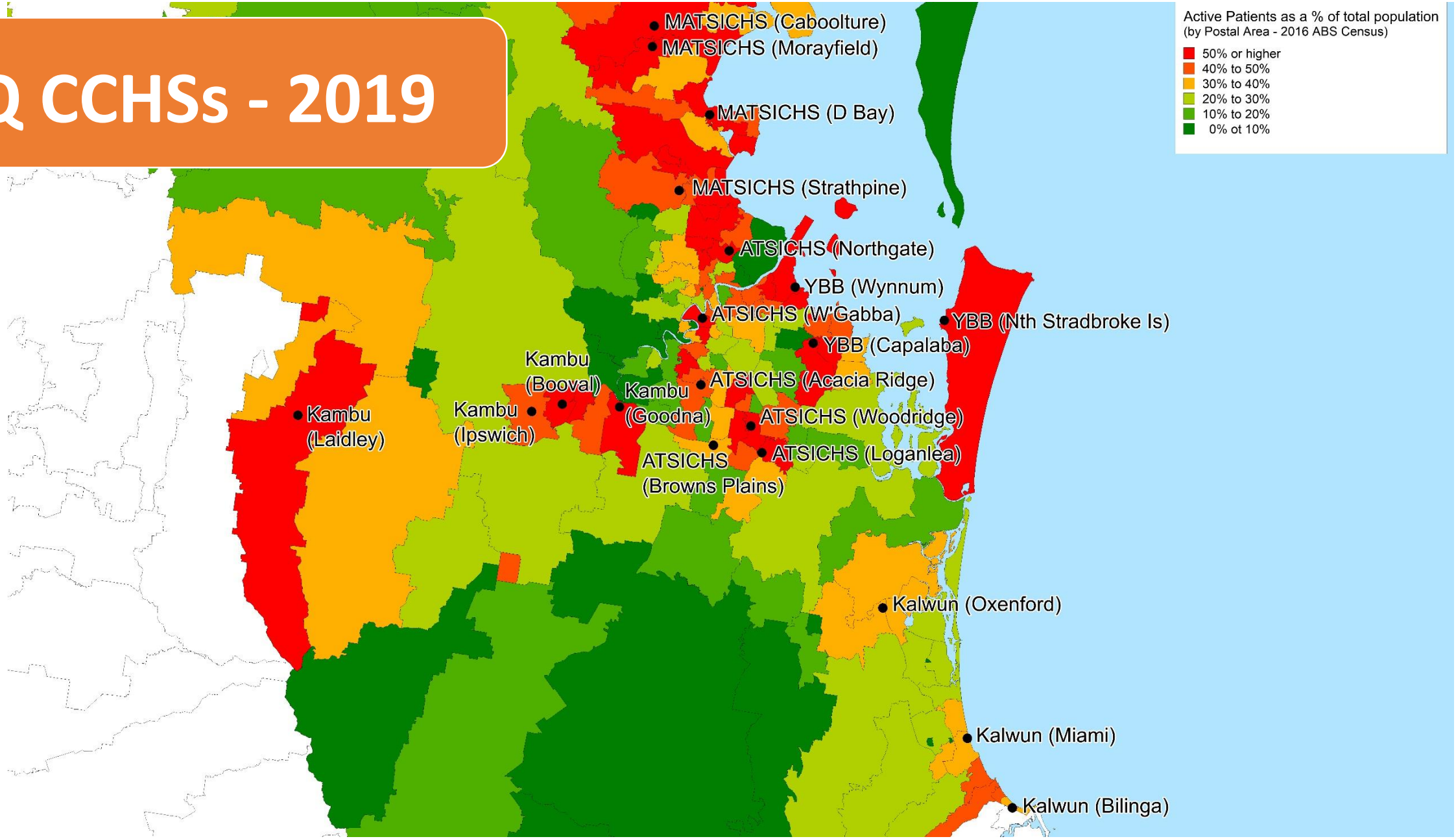


- Originally commencing as ‘IUIH Model of Care’, focussed on consistent approach to operation of PHC Clinics
- Expanded to ‘IUIH System of Care’ with growth and integration of regional allied health, specialist AND social support services

SEQ CCHSs - 2009



SEQ CCHSs - 2019

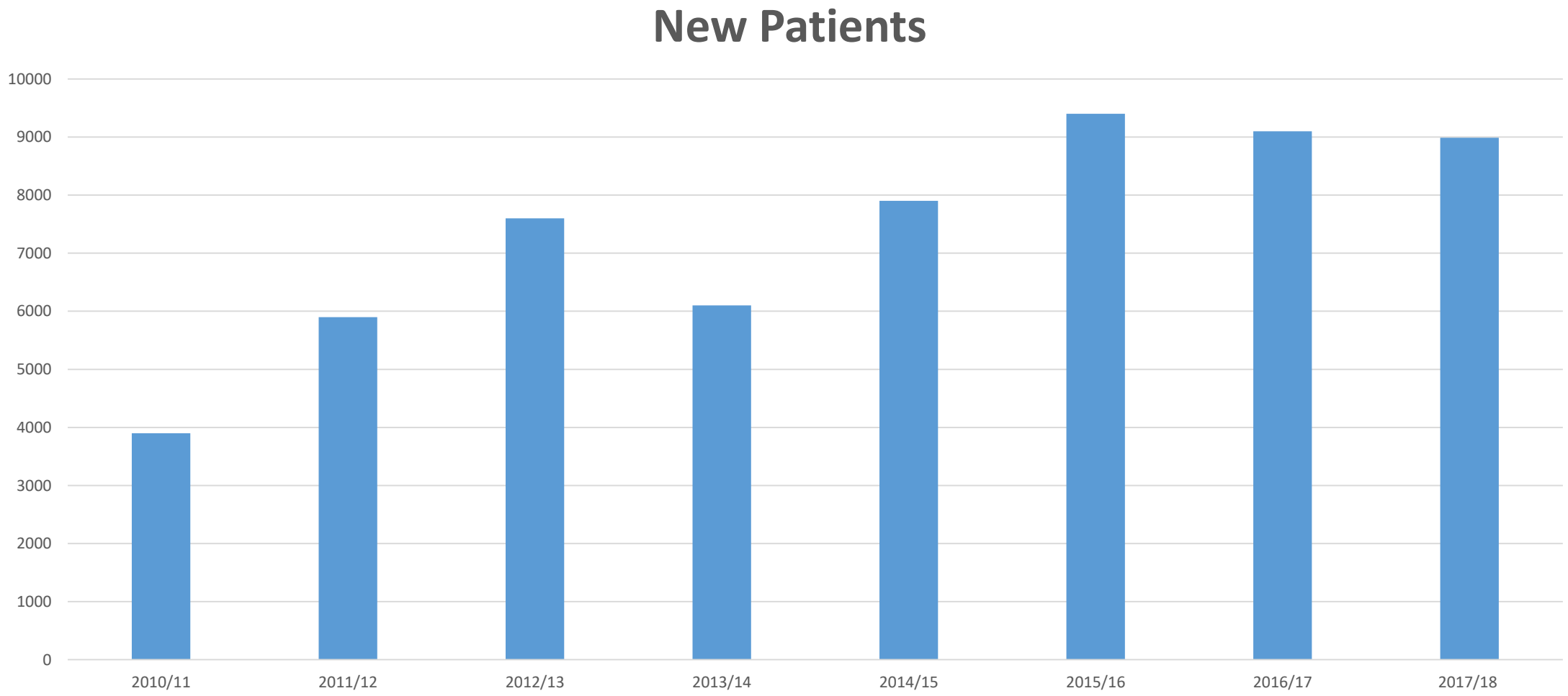


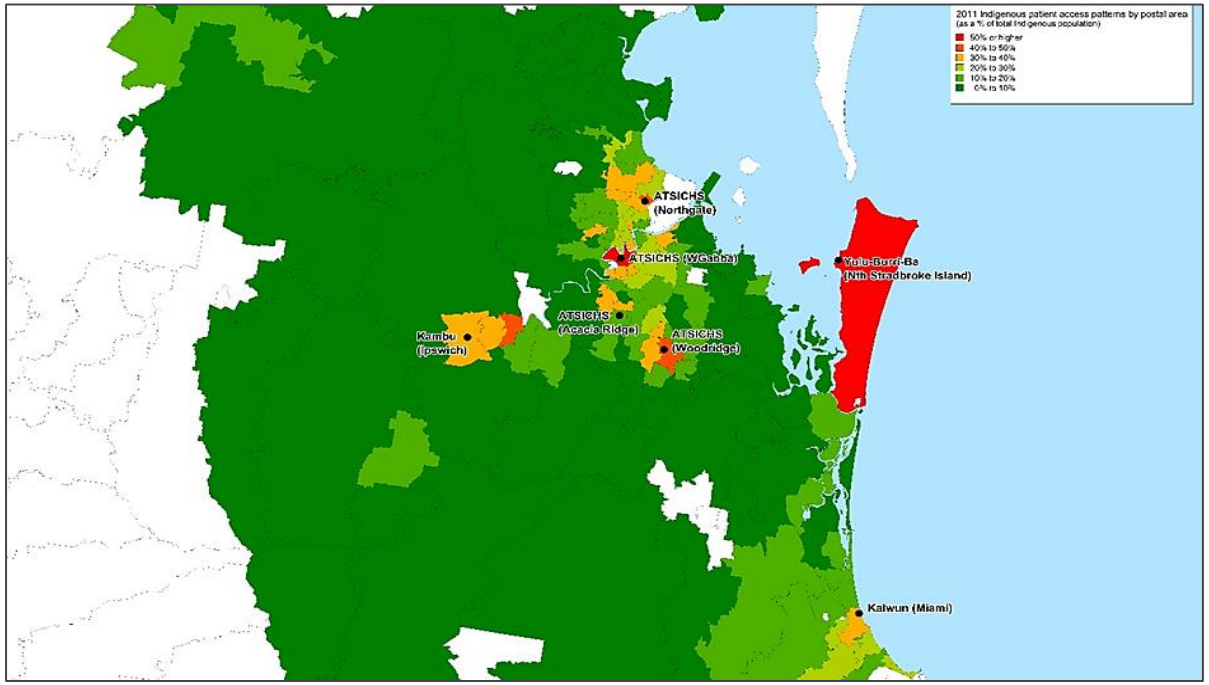
Measures of Success

PROVIDING THE MEASURES OF SUCCESS

"That's all the evidence we need, to know people are responding, taking control of their health and voting with their feet".

New Patients, 2010 - 2018





2011

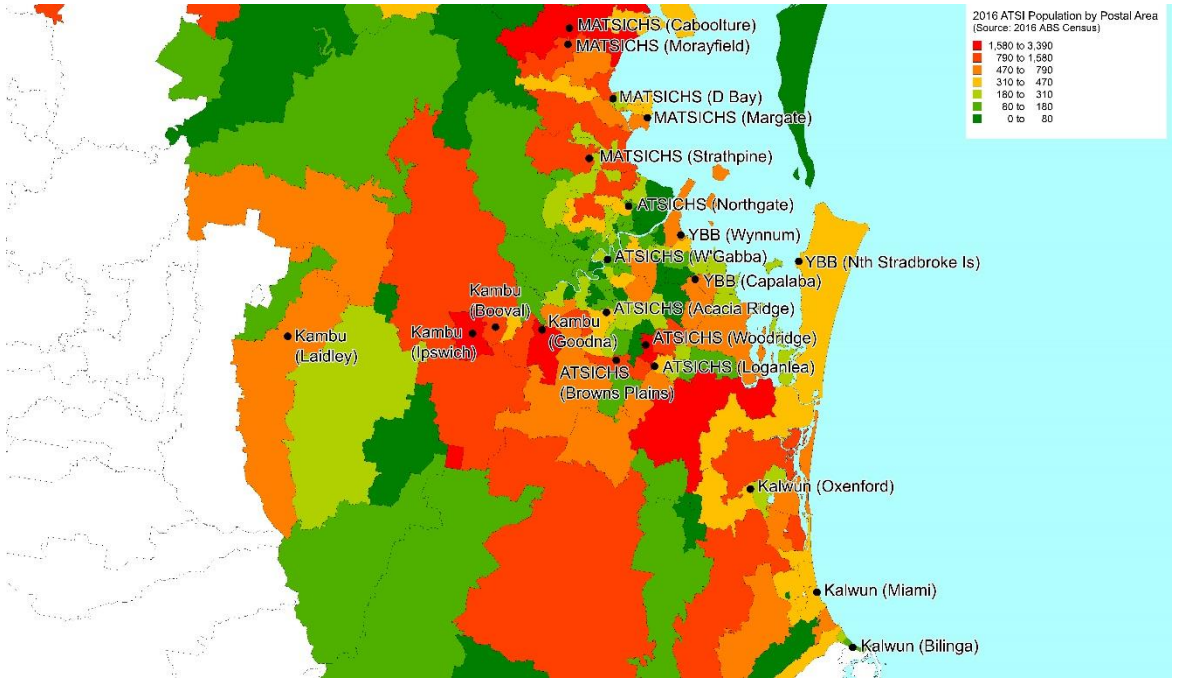
Just under

8000 active Aboriginal and Torres Strait Islander clients

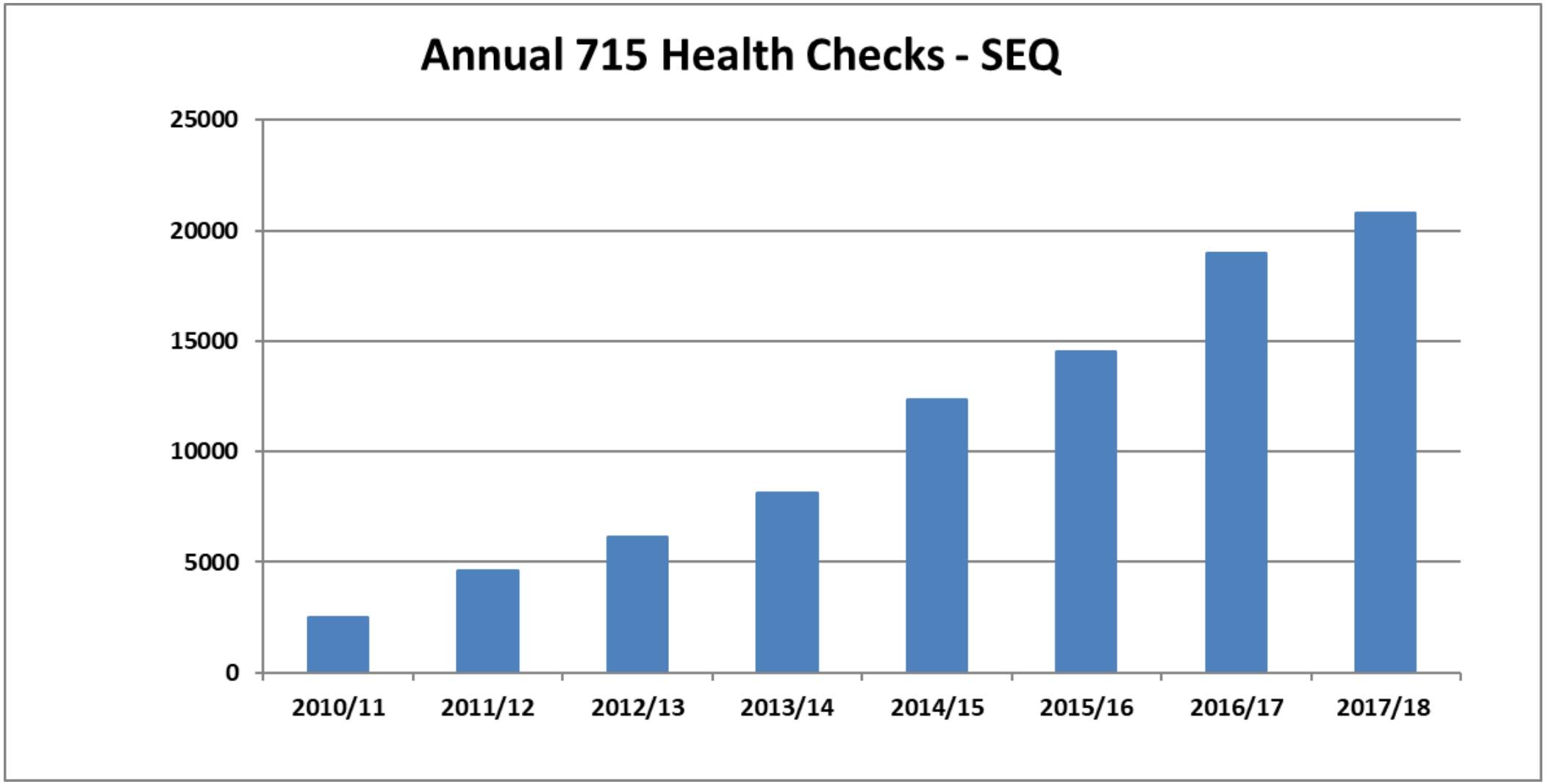
2019

>35,000

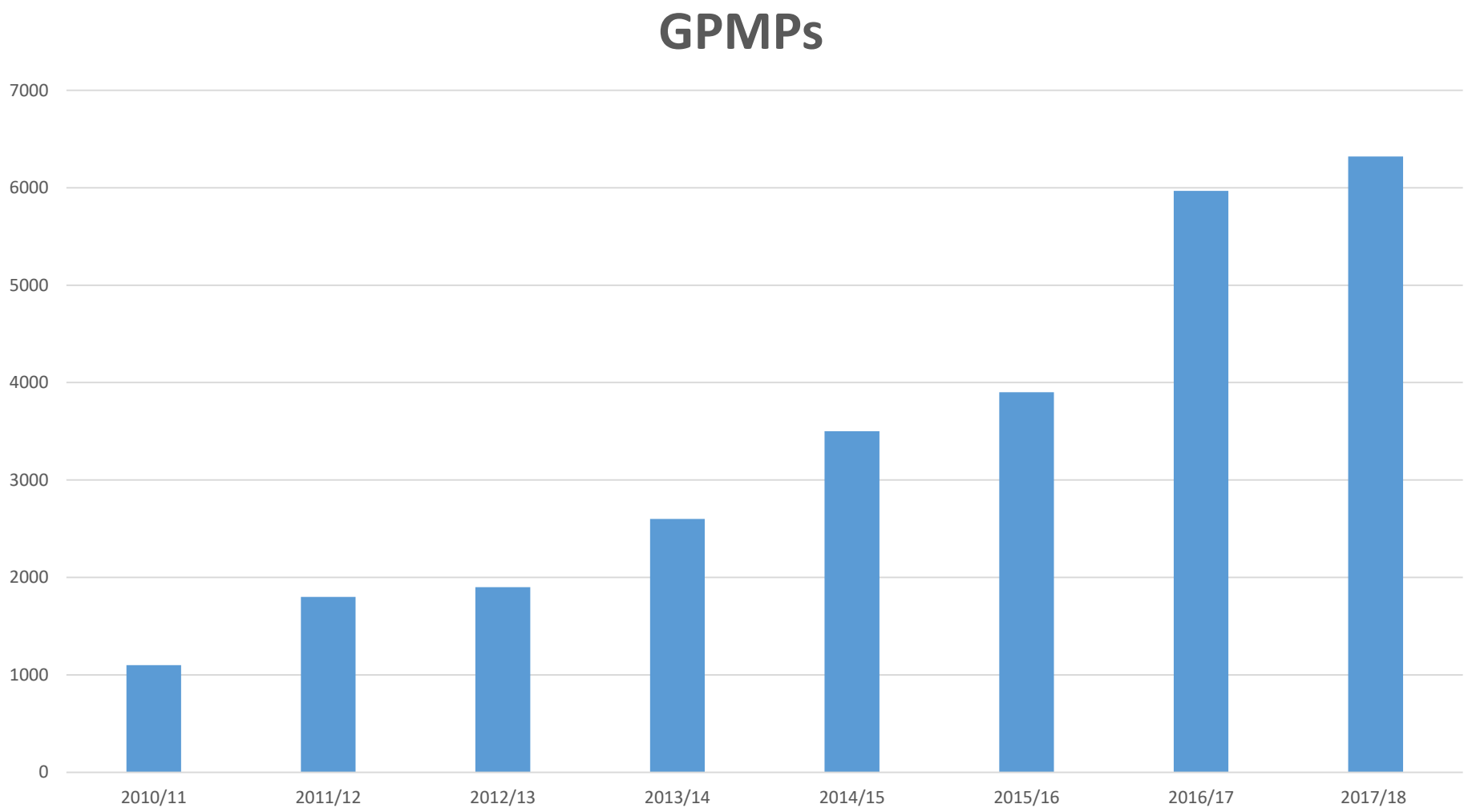
Active Indigenous patients (Total 49,000)



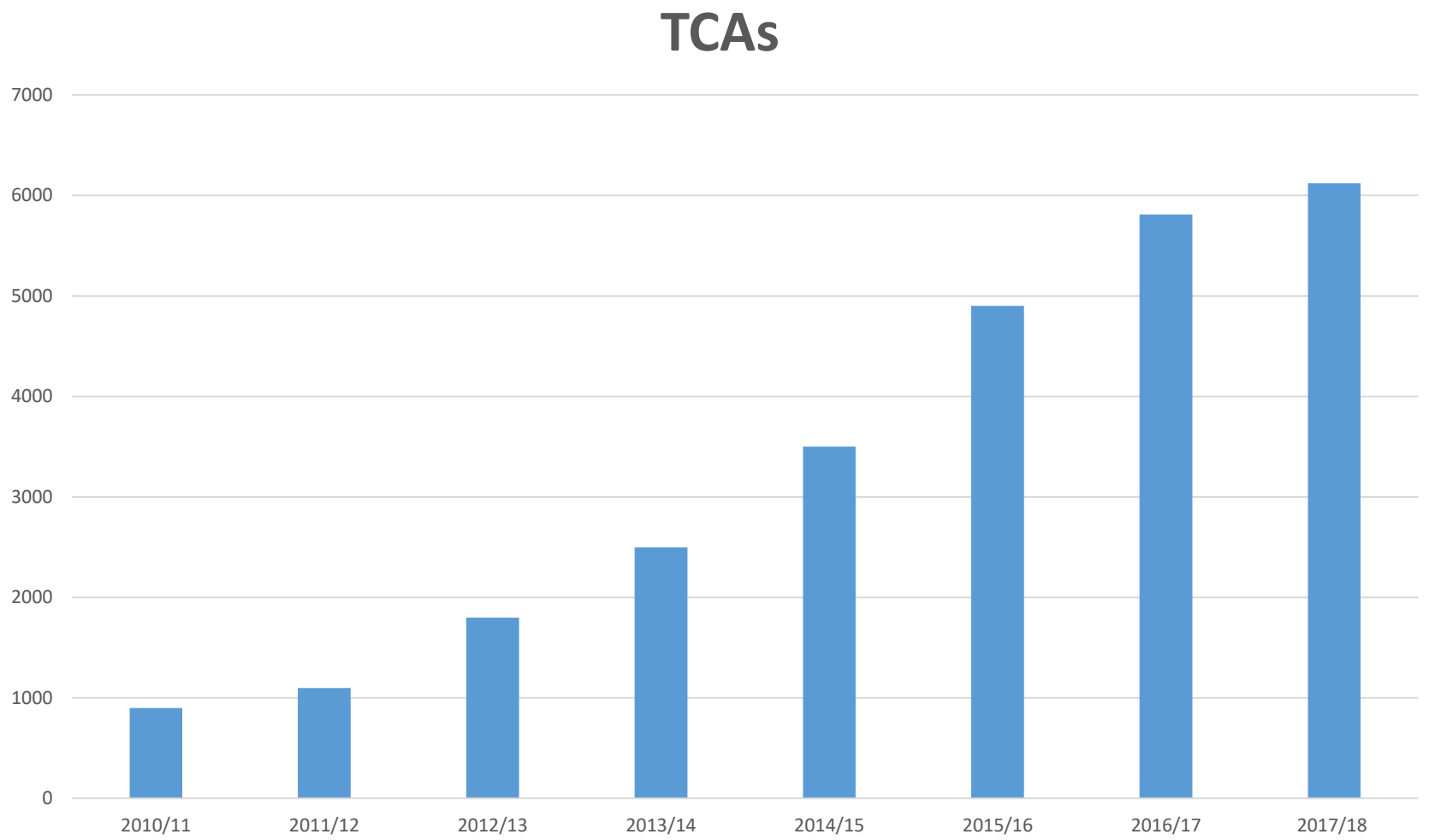
Health Checks, 2010 - 2018



GPMPs, 2010 - 2018

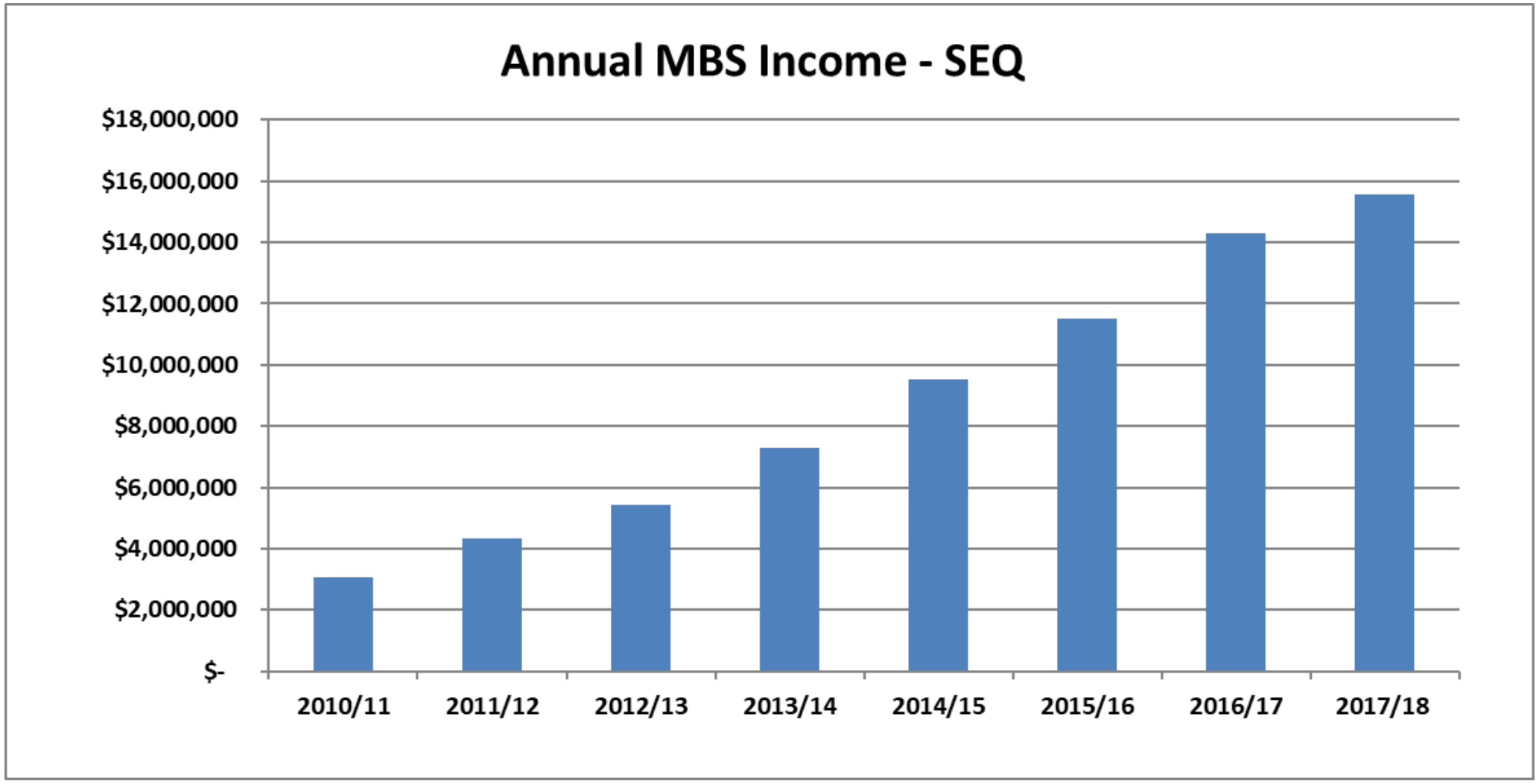


Team Care Arrangements, 2010 - 2018

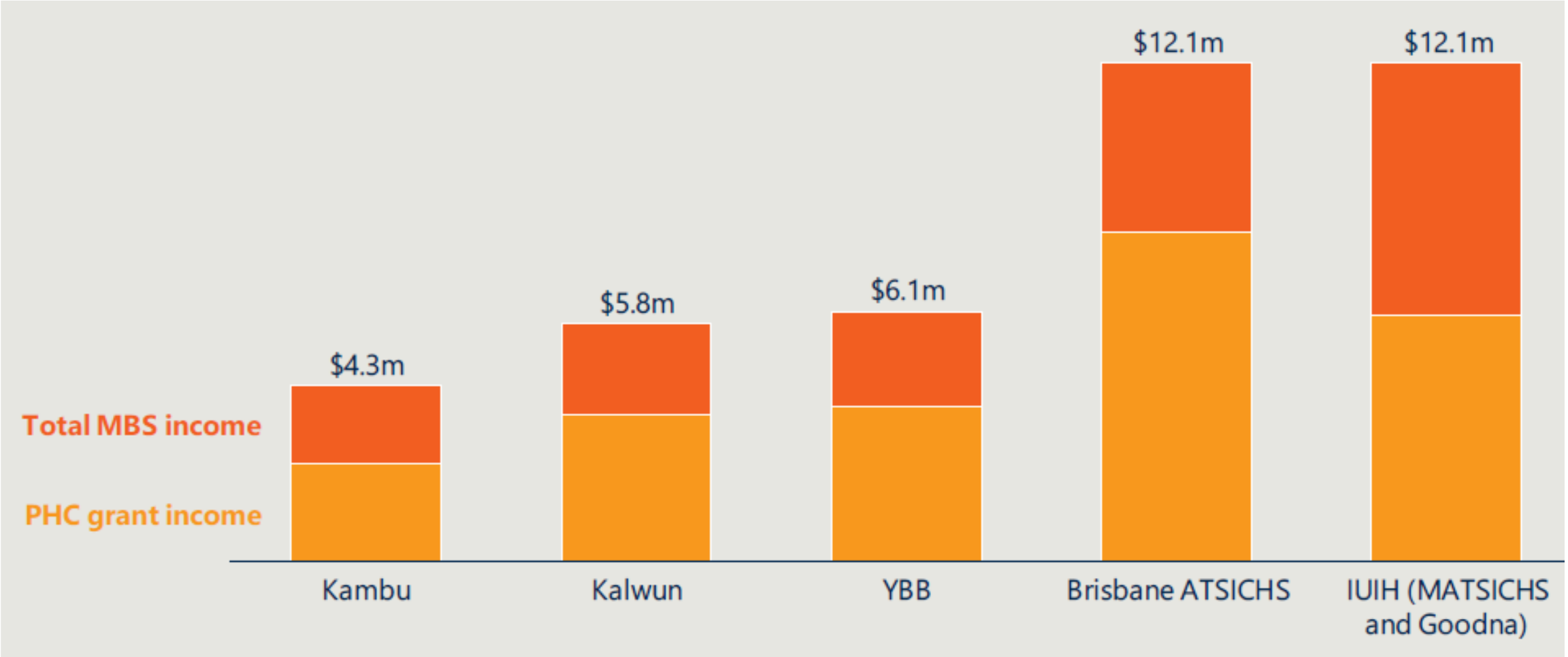


Reviews, 2010 - 2018

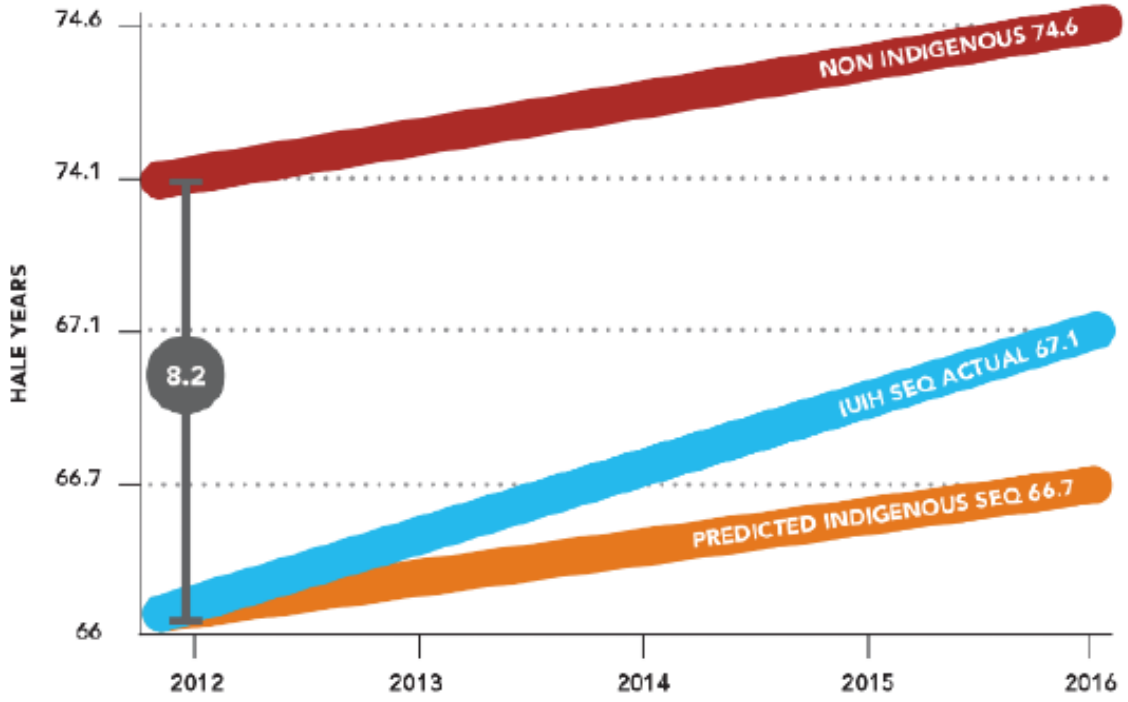
MBS Income, 2010 - 2018

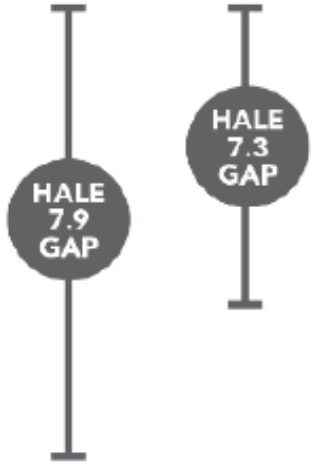


Revenue source for PHC, 2018



Closing the HALE Gap in SEQ

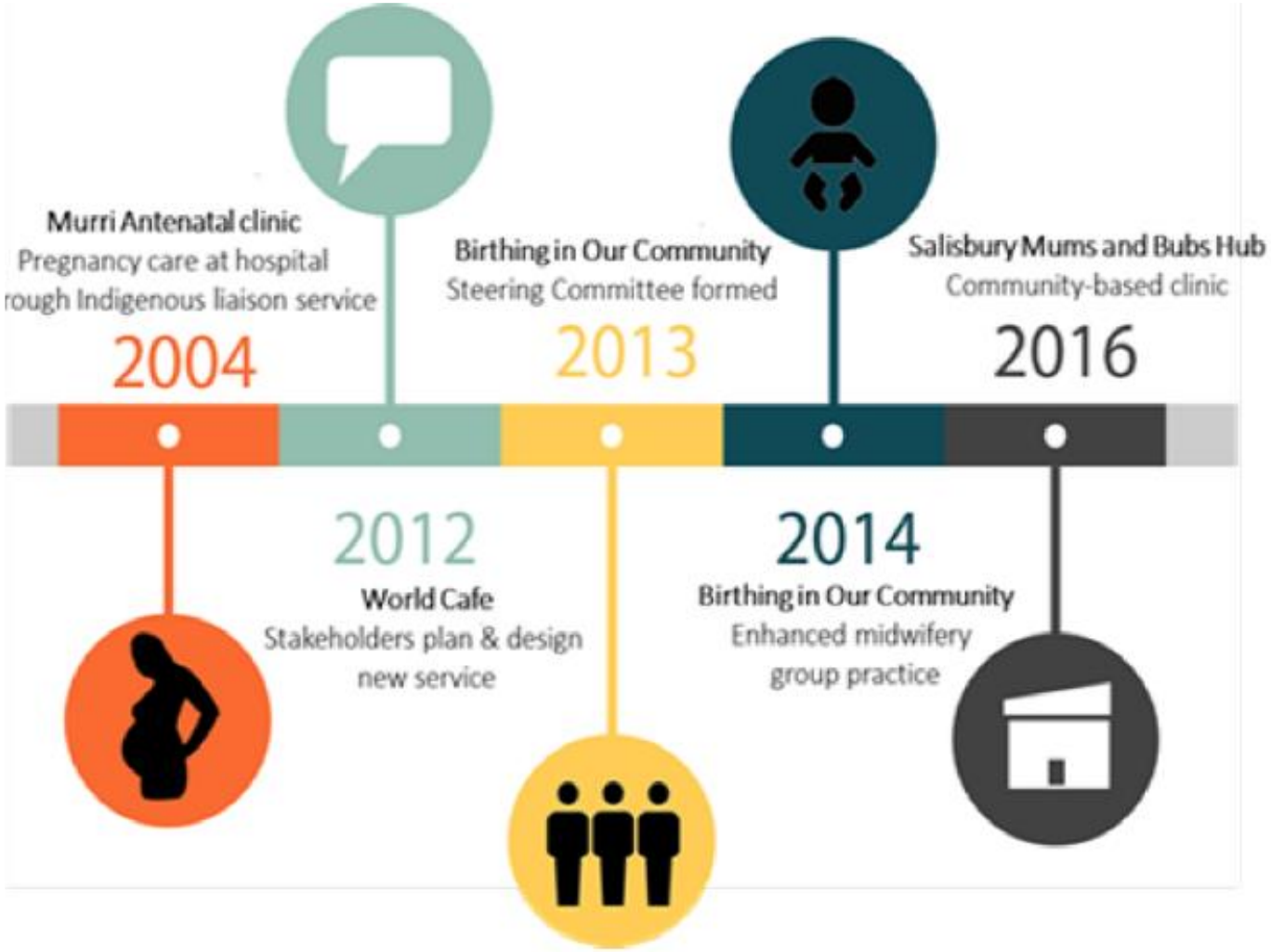




0.7

THE SURVEY INDICATES THAT OVER THE FOUR YEAR PERIOD IUIH HAS REDUCED THE HALE GAP FOR PEOPLE ATTENDING OUR CLINICS BY 0.7 YEARS.

Closing the Birth Gap in SEQ, BiOC



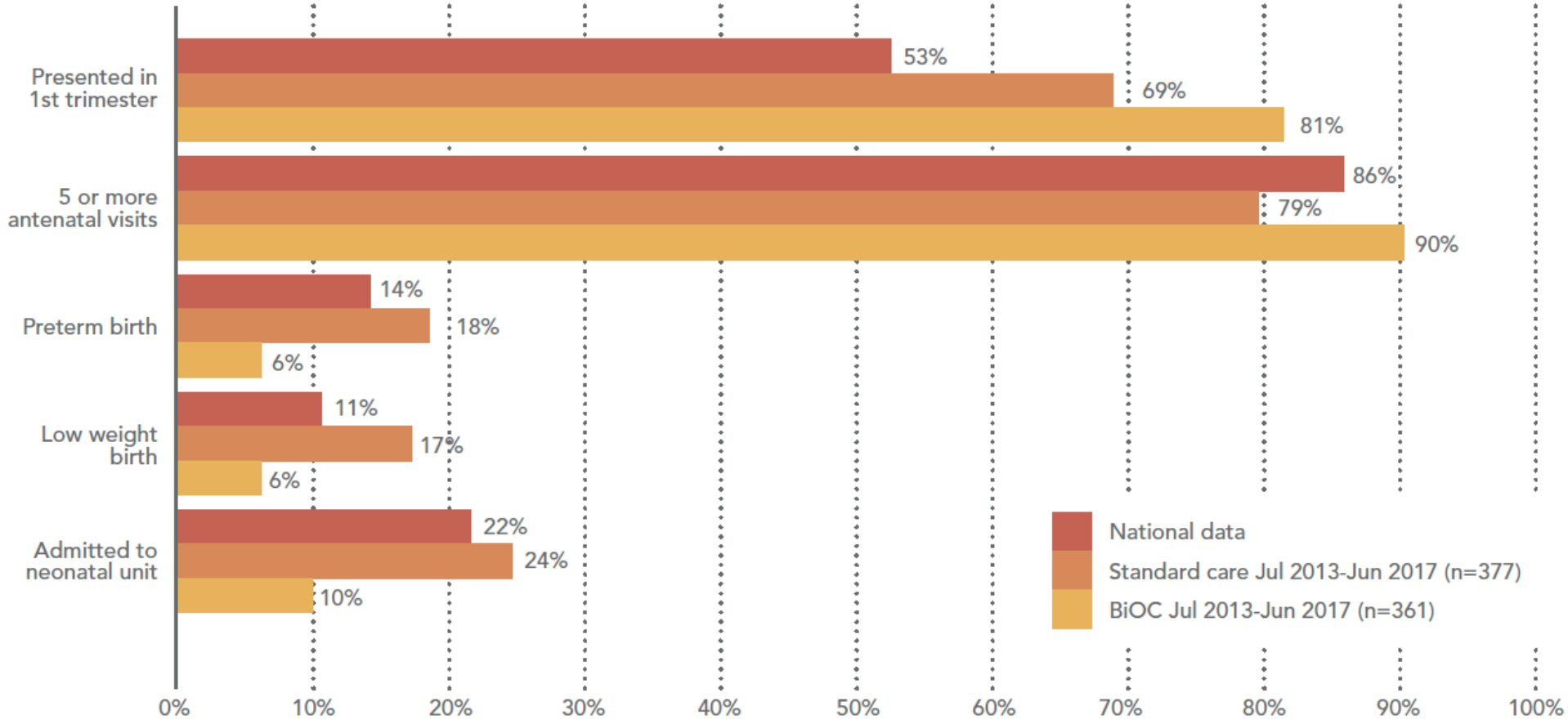
ATSICHS BRISBANE

IUIH institute for urban indigenous health

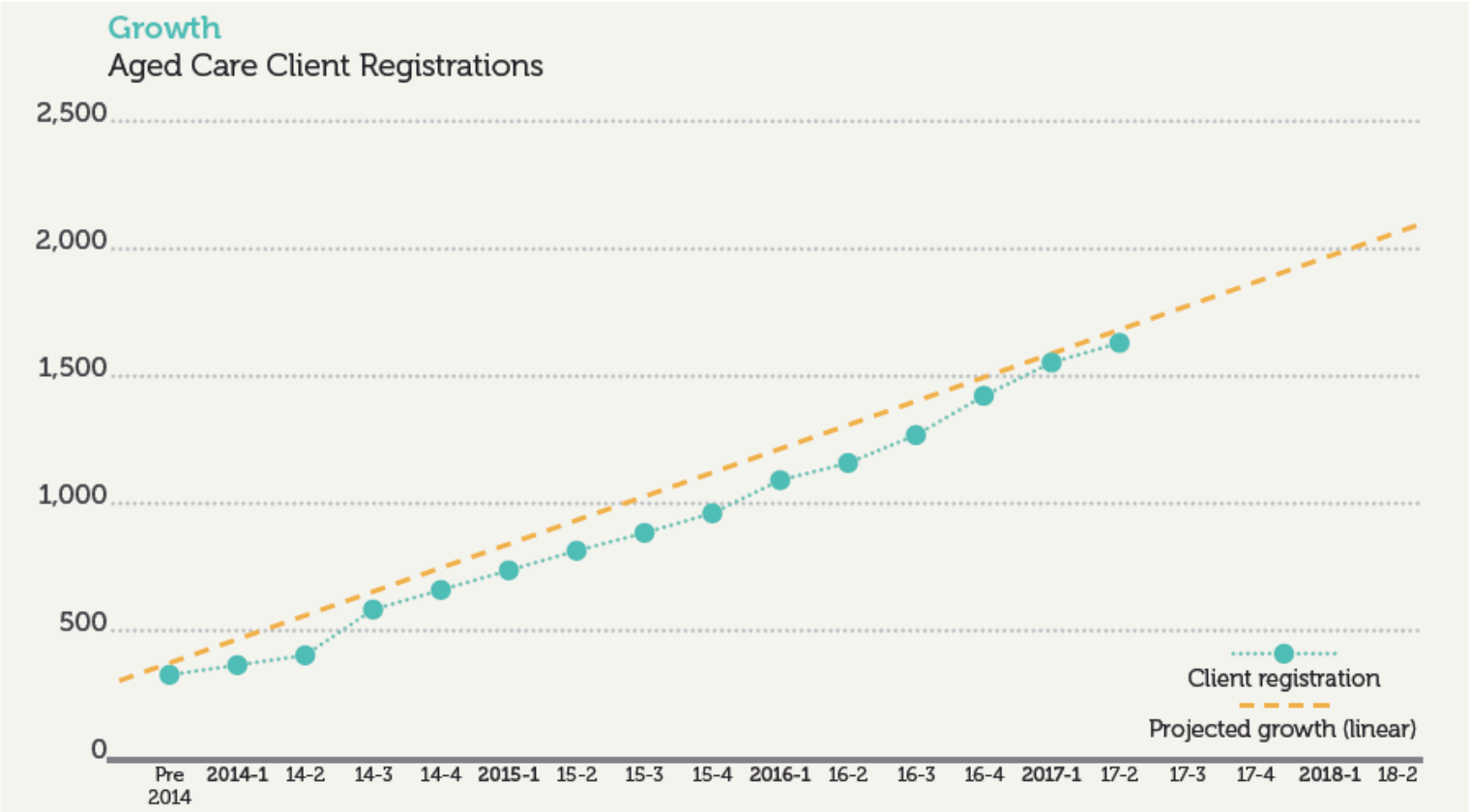
Mater
Exceptional People. Exceptional Care.

Closing the Birth Gap in SEQ, BiOC

Antenatal and Neonatal Health Outcomes— National, Standard Care and BiOC 2013-17

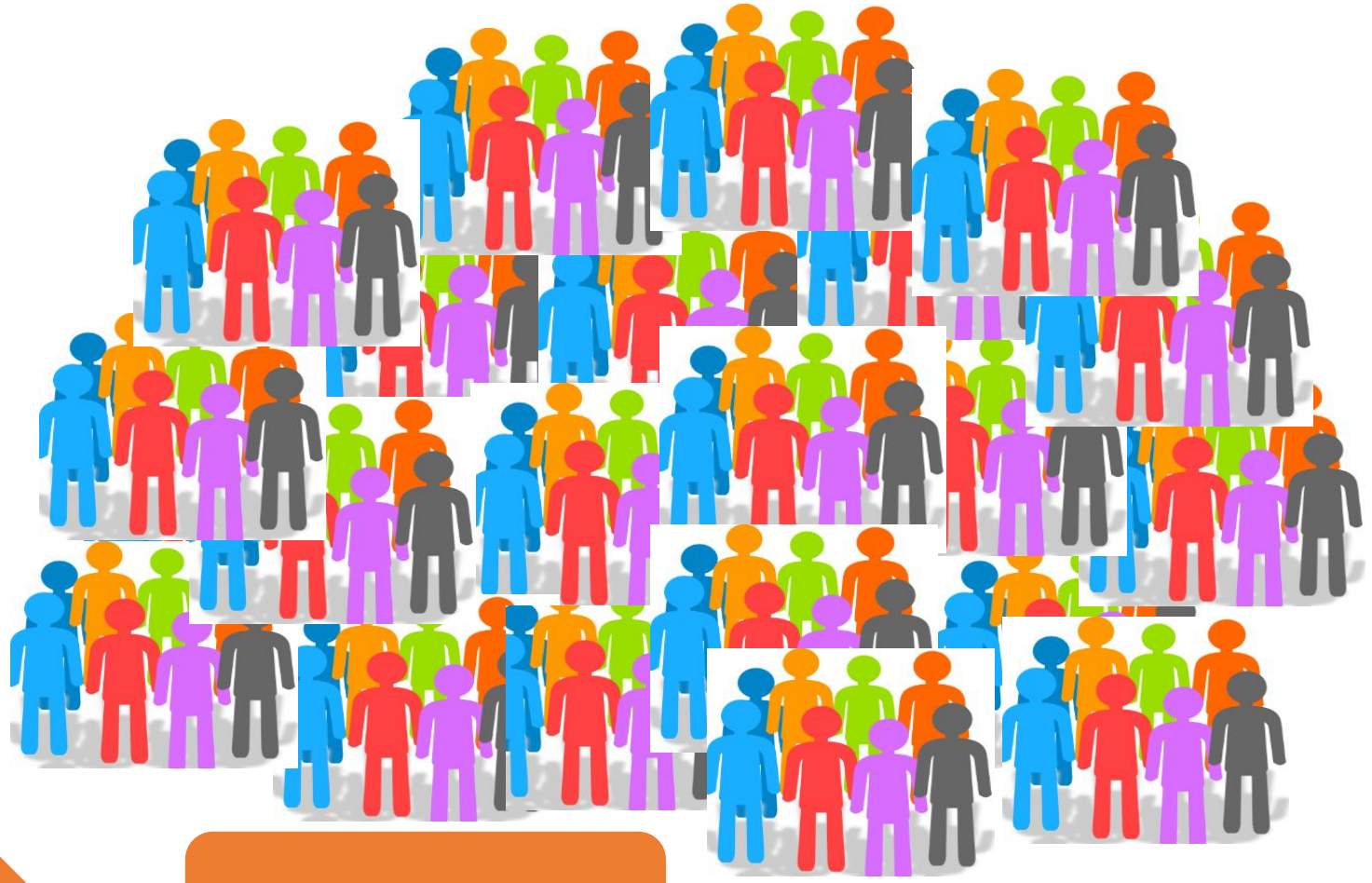


Respecting our Elders…



- No Indigenous provider within Brisbane North/Moreton Bay Region, with few Elders accessing mainstream providers
- Largest Indigenous provider of Home Care Services nationally, with over 1500 Elders
- Integration of Home Care Service with Primary Health Care enables seamless and more comprehensive care at NO cost to Elders

Closing the Employment Gap



200

1300