Brisbane South PHN

Refugee Health Connect (RHC) Evaluation

Executive Summary

March 2016

RHC (Refugee Health Connect) has saved us huge costs in terms of doctor and nursing time completing the initial health assessment and immunisations….When RHQ (Refugee Health Qld) was defunded we took a large hit financially…The introduction of MIRHS (Mater Integrated Refugee Health Service) and RHC has taken some of those costs away and made the process more predictable.

[Survey of stakeholders: Tier 1 practice: February 2016]

Prepared by
Mater UQ Centre for Primary Health Care Innovation

GLOSSARY

BSPHN – Brisbane South PHN

BNPHN – Brisbane North PHN

HSS – Humanitarian Settlement Services programme- a funding programme of the Department of Social Services which facilitates humanitarian entrants to access services as needed

MDA – Multicultural Development Association – the agency responsible for settling new arrivals under the HSS programme in the Brisbane region – both Brisbane South and Brisbane North

MHS – Mater Health Services

MIRHS – Mater Integrated Refugee Health Service

MUQCPHCI – Mater UQ Centre for Primary Health Care Innovation

SEQ RH CAG – South East Queensland Refugee Health Clinical Advisory Group

SEQ RH PAG – South East Queensland Refugee Health Partnership Advisory Group

Tier 1 practice – those practices that are able to able to conduct a Refugee Health Assessment, correctly bill Medicare for a completed RHA and are able to identify issues for follow up, to refer and transfer ongoing care.

Tier 2 practice – those practices who offer ongoing care (beyond the health assessment).

EXECUTIVE SUMMARY

Introduction

In November 2015 the Brisbane South PHN commissioned Mater UQ Centre for Primary Health Care Innovation (the Centre) to undertake a comprehensive evaluation of RHC. RHC had been operating for 18 months (since June 2014) and it was seen to be timely to evaluate its effectiveness in two key areas: building refugee health capacity in primary care and connecting people from refugee background to primary health care services.

Methodology

The Centre conducted meetings with key stakeholders, audited relevant documents and minutes, reviewed data, conducted in depth case studies of two practices and surveyed partners. Data was gathered for the calendar years 2014 and 2015.

Findings

This evaluation has found that RHC has enhanced

- **Partnerships**
  - Focussed broad advocacy for system improvement within the health system
  - Enhanced inter professional and inter system communication, collaboration and innovation
- **Linkages**
  - Linked 953 people from refugee backgrounds with primary care over 2 year period. This amounts to 95% of people arriving in Brisbane and being supported by the MDA Humanitarian Settlement Support programme;
  - Facilitated the connection to a medical home in the community of 953 new arrivals to Brisbane;
  - Made a significant contribution to improving patients' safety through linkage to pharmacy and allied health.
- **Capacity building**
  - Offered one point of call to support practices and settlement agencies with clinical and administrative support;
  - Assisted practices build improvements to their business model with RHC intervention – fewer "Did Not Attend" DNA plus a significant increase in correctly undertaking and claiming the Medicare Health Assessment item number for refugees, which is only available once within the first 12 months of arrival in Australia;
  - Engaged 11 practices as Tier 1 and Tier 2 practices;
  - 94 instances of support offered through the "one point of call" number
  - Helped practices provide safe quality care to people from refugee background by increased use of interpreters and improved cross-cultural knowledge. This capacity can be extrapolated to the provision of care to CALD and other vulnerable populations;
  - Extended support to hospitals including education sessions and awareness raising of RHC in Mater ED and LCCH;
  - Through the Clinical Advisory Group coordinated 6 training opportunities on specific topics identified by clinicians (GPs and nurses) including Hepatitis, TB, mental health and paediatric health issues. All sessions attracted RACGP points, were evaluated and have had a positive impact on the before and after learning capacity of participants. (Evaluations conducted and held BSPHN.)

- Developed and distributed print, on line and multi-media resources, including bound clinical and administrative folders which are given to all practices visited not just Tier 1 practices;
- Produced and distributed Clinical guidelines;
- Enabled further academic research and has enabled the primary care community to learn about innovations in the model of refuge health care.

It is evident that the success of RHC relies on a strong collaborative approach and it is difficult to extricate all the specific financial and in-kind contributions of all the key stakeholders. The investment in BSPHN has enabled other contributions from other key stakeholders.

Enablers

- The RHC partnership has been able to draw on the skills, attitudes and knowledge of a group of individuals who have the capacity to act as "boundary spanners" across systems. [1] The Program Support Office of BSPHN has both clinical and program experience and these skills are complemented by the experience of other key stakeholders that enable all partners to appreciate the constraints of the other and to contribute productively to a shared vision. It is critical that the model spans the settlement system, housing availability, practice capacity and clinical priorities in order to achieve an integrated care model.
- The partnership has been able to draw on the expertise of the refugee communities through the Mater UQ Centre for Primary Health Care Innovation (the Centre's) Greater Brisbane Refugee Health Advisory Group (G8), a four year partnership with communities. Through the G8 the lived experience and identified needs of refugee communities are directly incorporated in the model of care.
- Practices have displayed a considerable flexibility and good will to respond to emergent needs as was the case when the increase to the Syrian intake was announced by the Prime Minister, practices were ready to open on a Sunday if needed.
- Practices have exhibited considerable responsiveness to patient need and drawing on RHC support have readily developed innovative strategies to care for a complex and vulnerable group.

Barriers

- RHC operates across complex systems including the settlement and social care system (Centrelink, TAFE, housing) and the primary/tertiary care systems. The former is dependent on government policy about arrival rates of humanitarian entrants and the geographic location of that settlement. As evident from the data the numbers of humanitarian entrants vary a great deal from quarter to quarter making service planning challenging. The primary care system is dependent on remaining financially sustainable and up-skilled in refugee health with every new arrival population. Each practice is a small business with the business needs and capacity varying between each.
- RHC has no control or direct input to these complex systems but has to work across all of them to achieve an integrated, patient centred model of care..

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[1] Hilaricus notes that "boundary spanners" in the healthcare sector to encourage agents from different organizational settings to join a new joint field. *Boundary Spanning Between Organizations In The Healthcare Sector* Janis Hilaricus
CEREGMIA, Université des Antilles et de la Guyane. Janis.hilaricus@martinique.univ-ag.fr

– The settlement service has an accommodation model which includes Short Term (up to 4 weeks) and Long Term accommodation. RHC needs to work with the settlement service to ensure referrals to a general practice are timely and patients are linked to a Tier 1 practice. However it is often the case that patients may need to transfer from a Tier 1 to a new practice closer to their long term accommodation. This involves transfer of clinical care and extra work for all key stakeholders and for the patient, the rebuilding of trust with a new practice.

Recommendations for BSPHN

The BSPHN has the necessary leadership and expertise in refugee health to lead in system development in primary care for health care for this community. It is recommended that the BSPHN

1. Increase the level of resources allocated to the RHC Refugee Health Care Facilitator/Program Support Officer and the Clinical lead to meet the ongoing demands and increase usage of RHC as it gains profile;
2. Consider a future further increase in the resources allocated to the RHC Refugee Health Care Facilitator/Program Support and to the Clinical lead to accommodate the expansion of the Refugee intake to Queensland. This is specifically in line with Queensland Premier's expressed commitment to take 3500 Syrians on top of the existing case load. This will require all stakeholder to increase their resource commitment to RHC.
3. Increase the capacity of primary care system to provide long term sustainable care in the medical home in the community through
    a. Investing time, training and resources to strategically increase the number of Tier 2 practices in areas of need
    b. Allocating time for regular visits, resource updates and training with Tier 1 practices in areas of need, keeping in mind staff turnover and changes to the refugee intake;
4. Continue to build and support the partnership, the capacity of practices and the knowledge base in the health system through delivering inter-disciplinary education sessions, resource development, clinical support, community engagement and research initiatives.

Mater
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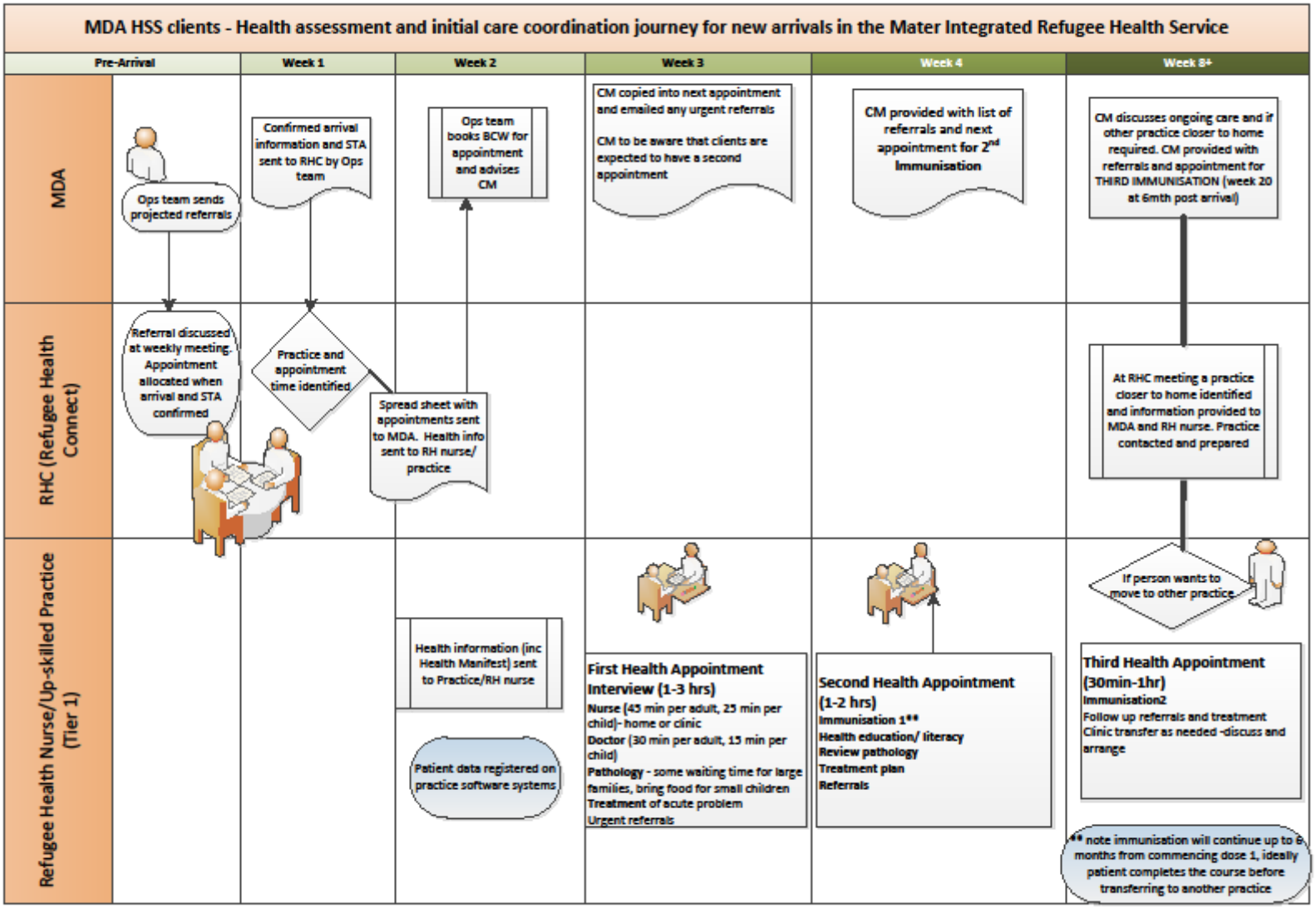
MDA HSS clients - Health assessment and initial care coordination journey for new arrivals in the Mater Integrated Refugee Health Service



Refugee Health Connect is a one point of call regarding all aspects of refugee health Ph. 3864 7580

28 July 2015

SUMMARY OF OUTCOMES

The Evaluation identified that the RHC Model has been successful in meeting its objectives. Immediate term outcomes are listed below along with aspirational outcomes for the medium and long term.

Immediate outcomes* 1.1.2014 – 31.12.2015	Medium term from 2016 - 2018	Long term from 2018
Referrals 953 people linked to general practice over 2 year period. This represents approximately 98% of people being settled under HSS.	Increased capacity to make referrals to "ready" practices Health assessments are completed	Refugees and asylum seekers experience fewer difficulties in accessing health services
Service improvement Health Assessment billing increased Rates of DNA decreased.	Practices experience fewer barriers to offering services to patients of refugee backgrounds	Primary care business model is sustainable is able to access necessary support and services
Capacity Building • 30 Practices supported • 11 Tier 1 and Tier 2 practices identified (8 signed Working Together agreements) • 2 practices are Tier 2 practices. • 6 training events offered • Print, web based and multimedia resources developed and well received.	Existing practices maintain their commitment Additional Tier 2 practices engaged	
Partnerships • SEQ RH-PAG in place and effective. • SEQ RH-CAG in place – Attended by all PHN's in South East Queensland	RH-PAG continues to monitor need, settlement patterns RH-PAG to become a Qld wide advisory group for the Qld Refugee Health and Wellbeing Network CAG continues to monitor and respond to need Clinical knowledge is shared.	
Advocacy and research • RHC informed the Policy Working Group	Data available is able inform health service planning and evaluation.	A growing body of research evidence to inform further developments of refugee health services.
Transferability	The RHC model is replicated in other jurisdictions and adapted to local contexts.	The primary care system demonstrates its responsiveness in a rapidly changing context

TABLES

TABLE 1: Refugee and Humanitarian Arrivals to Queensland 2014 and 2015 (Source Settlement Data base: DSS)

Country of Birth	Arrived 2014	Arrived 2015
Afghanistan	204	91
Eritrea	163	131
Burma	158	133
Somalia	124	146
Congo	81	177
Other	161	95
Sudan	102	67
Iran	105	46
Ethiopia	55	75
Kenya	21	96
Pakistan	85	18
Bhutan	53	27
Iraq	45	27
Nepal	33	21
Burundi	32	11
Malaysia	22	20
Syria	21	19
PNG	21	5
Rwanda	7	18
Uganda	16	7
Liberia	9	
TOTAL	1518	1230

TABLE 2: People seeking asylum and living in the community in Queensland on Bridging Visas - (Source DIBP)

Country of Citizenship	At June 2014	At June 2015
Sri Lanka	993	900
Iran	743	827
Stateless	396	397
Afghanistan	431	365
Iraq	123	144
Pakistan	12	138
Bangladesh	161	137
Vietnam	<10	115
Sudan	118	111
Somalia	41	50
Burma	29	38
Indonesia	10	18
India	<10	15
Eritrea	12	11
Other	116	
Ethiopia	<10	<10
Palestinian authority	21	<10
Syria	<10	<10
TOTAL	3246	3296

TABLE 3: 2014 Humanitarian entrants to Queensland, HSS entrants settled in Brisbane by MDA.

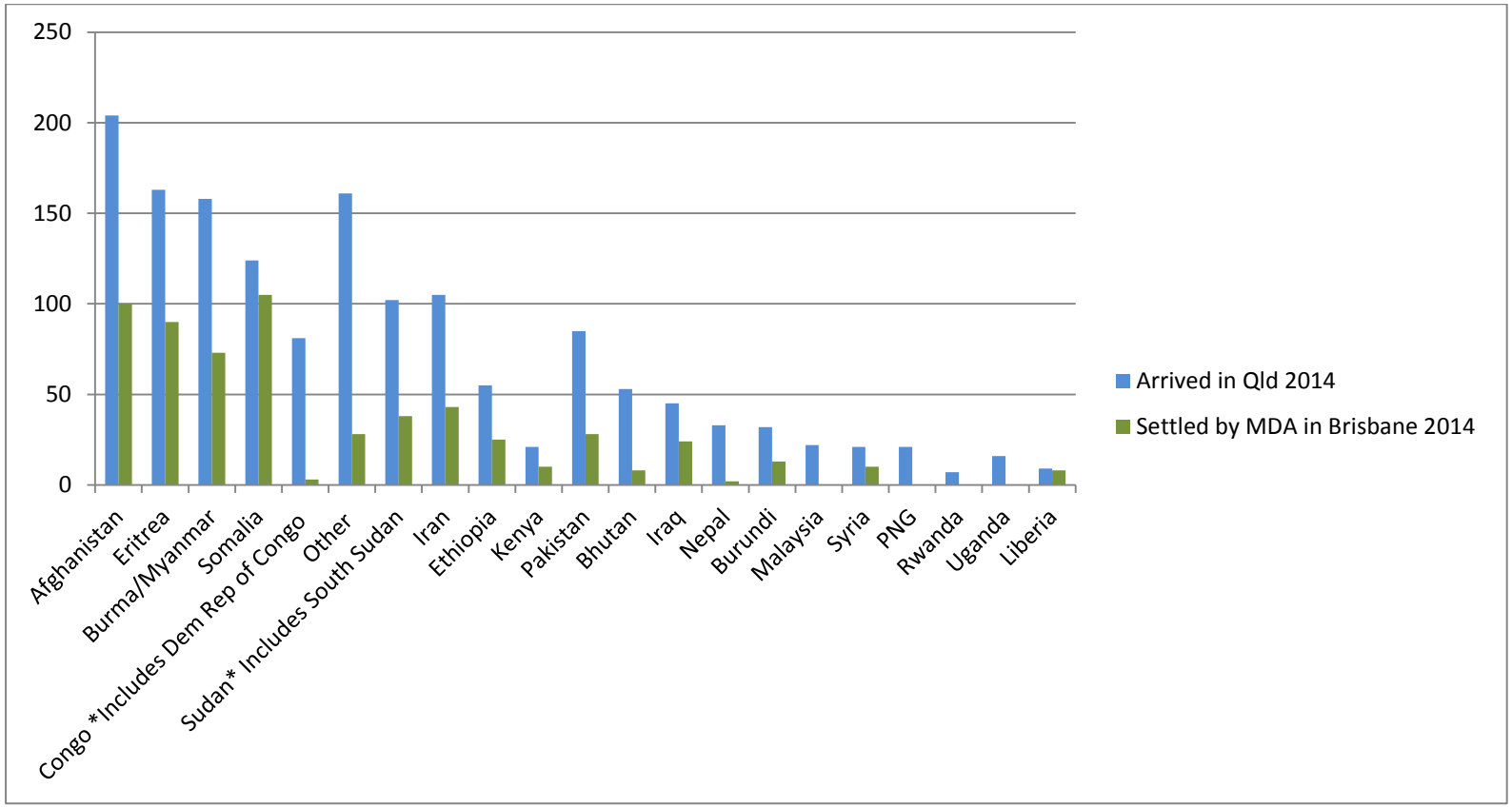


TABLE 4: 2015 Humanitarian entrants to Queensland, HSS entrants settled in Brisbane by MDA.

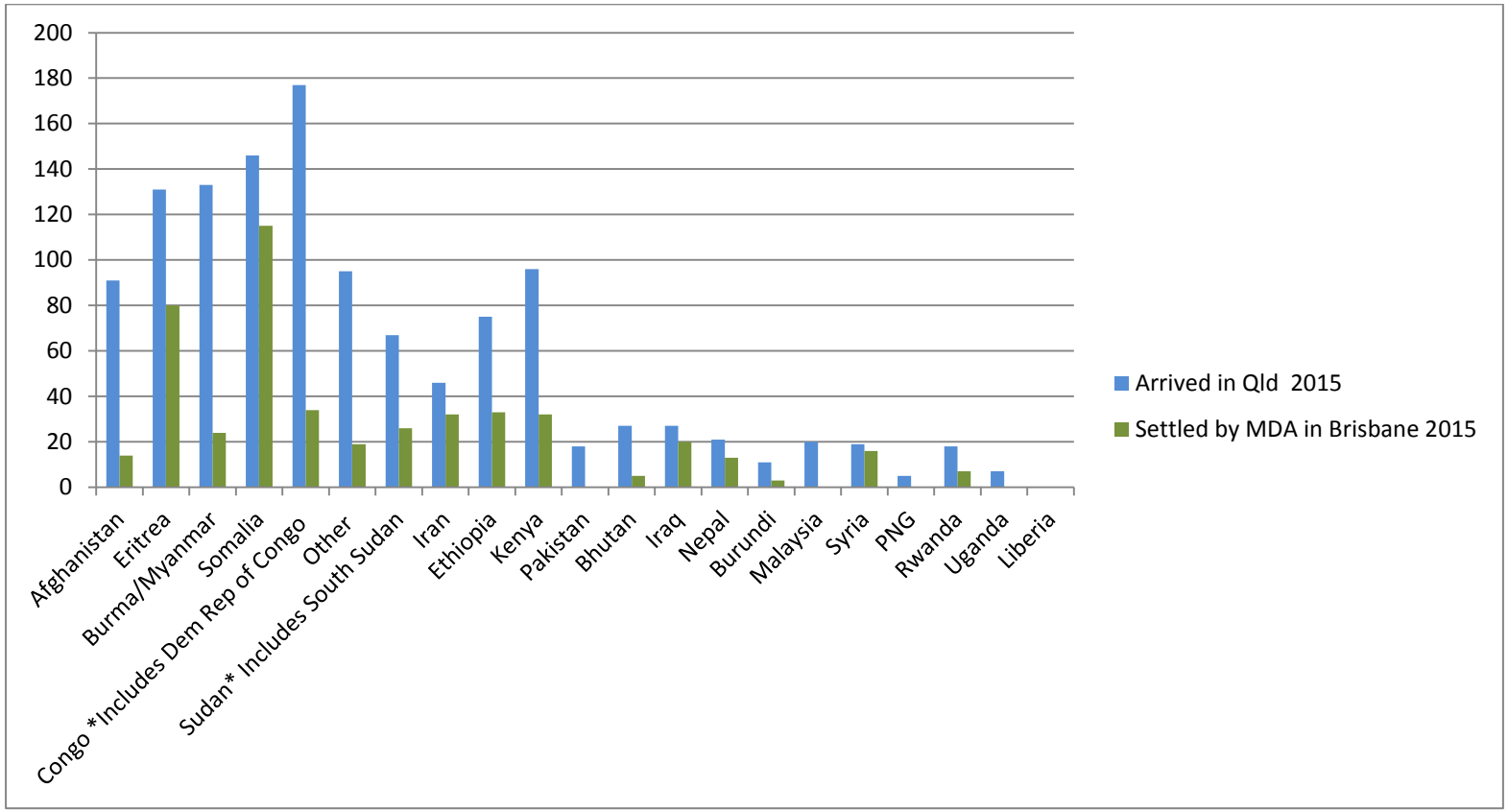


TABLE 5: HSS ARRIVALS (MDA – Brisbane South and North) 2014 and 2015