Australian Government
Department of Health

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An Australian Government Initiative

Activity Work Plan 2019-2022:

Core Funding

GP Support Funding

This Core Activity Work Plan template has the following parts:

1. The Core Activity Work Plan for the financial years 2019-20, 2020-2021 and 2021-2022. Please complete the table of planned activities funded under the following:
    a) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
    b) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.
2. The Indicative Budget for the financial years 2019-20, 2020-21 and 2021-22. Please attach an excel spreadsheet using the template provided to submit indicative budgets for:
    c) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
    d) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.

Gold Coast PHN

When submitting this 2019-2022 Activity Work Plan to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Activity Work Plan has been endorsed by the CEO.

Overview

This Core Activity Work Plan covers the period from 1 July 2019 to 30 June 2022. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of up to 36 months. Regardless of the proposed duration for each activity, the Department of Health will require PHNs to submit updates to the Activity Work Plan on an annual basis.

Important documents to guide planning

The following documents will assist in the preparation of your Activity Work Plan:

- Activity Work Plan guidance material;
- PHN Needs Assessment Guide;
- PHN Program Performance and Quality Framework;
- Primary Health Networks Grant Programme Guidelines;
- Clause 3, Financial Provisions of the Standard Funding Agreement.

Formatting requirements

- Submit plans in Microsoft Word format only.
- Submit budgets in Microsoft Excel format only.
- Do not change the orientation of any page in this document.
- Do not add any columns or rows to tables, or insert tables/charts within tables – use attachments if necessary.
- Delete all instructions prior to submission.

1. (a) Planned PHN activities for 2019-20, 2020-21 and 2021-22 – Core Flexible Funding Stream

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2022.

ACTIVITY TITLE	CF 2019.1 - Integrated Care Alliance (ICA) – Pathways Non-staff expenses (license and storage costs)
Existing, Modified, or New Activity	Modified Activity CF 2017.1 Integrated Care Alliance (ICA) – Health Pathways (Healthygc) Also relates to ***HSI 2019.2 - Access to information and resources*** as the publication portal for Gold Coast health pathways information and resources and ***HSI 2019.3 Integrated Care Alliance (ICA) – Alliance Development and implementation*** (including development of health pathways and shared care for the clinical engagement and development of the specialist content for the health pathways
Program Key Priority Area	Digital Health / Area population Health
Needs Assessment Priority	**Identified health needs and service issues** • Access to Information about services and resources to support general practice in key areas is required. Page 1 of General Practice and Primary Care Needs Assessment Summary (Page 22 of 279 of full Needs Assessment Submitted) • Better systems to support care coordination required • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients Page 1 of Chronic Disease Needs Assessment Summary (page 71 of 279 full Needs Assessment submitted) • Access to clear communication and accessible information for patients, families and health care professionals • Current systems not always established for the provision of clinical care coordination of end of life care between providers Page 1 of Palliative Care Needs Assessment Summary (page 130 of 279 of full Needs Assessment submitted) • Promotion of low intensity services to General Practice to support complementary use with other primary health interventions • Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services Page 1 of Low intensity Mental Health Services Needs Assessment Summary (page 168 of 279 of full Needs Assessment submitted) • Efficient referral pathways to increase accessibility to new psychosocial services

	• Improved service coordination for individuals with severe mental illness and associated psychosocial functional impairment, while considering support available across levels of government, the community and relevant sectors Page 2 of National Psychosocial Support (NPS) Needs Assessment Summary (page 174 of 279 of full Needs Assessment submitted) • Develop clear referral pathways and supported connections to appropriate community supports Page 1 of Mental health Suicide Prevention Needs Assessment Summary (page 179 of 2779 of full Needs Assessment submitted) For children in care- • Issues with transfer of information • Limited knowledge and adherence to guidelines/frameworks by health care providers Page 1 Mental Health – Children and Youth Needs Assessment Summary (page 200 of 279 of full Needs Assessment submitted) • Develop efficient pathways to support person centred transfer of care between acute and primary care services (general practice, allied health and community services) Page 1 of Mental Health Severe and Complex Needs Assessment Summary (page 210 of 279 of full Needs Assessment submitted). • Provision of training and resources, including referral pathways, for general practice to support patients with substance use issues including ice Page 1 of Alcohol and Other Drugs Needs Assessment Summary (page 224 of 279 of full Needs Assessment submitted) • Access and awareness of appropriate services Page 1 of Aboriginal and Torres Strait Islander Mental health and Suicide Needs Assessment Summary (Page249 of 279 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** Integrated Care Alliance • Support the implementation of new integrated models of care • Preliminary work to develop models of care have been completed for a range of disease conditions implementation requirements are currently being scoped. • A major body of work for GCPHN involves the implementation of a e-library solution to enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work. Page 3 of Opportunities Priorities and Options (page 256 of 279 of full Needs Assessment) Access to information and resources • GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing web portal featuring: o Localised referral guidelines and templates for Gold Coast Health, updated to reflect the Clinical Prioritisation Criteria protocols introduced in Queensland o Review and update of existing referral templates to ensure they align to current evidence and GCH systems and protocols o Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources • A detailed local service directory

	• In addition, other software options as well as the structure of the current HealthyGC website will be reviewed and compared to ensure the service continues to function in the most effective and efficient way. Page 5 of Opportunities Priorities and Options (page 258 of 279 of full Needs Assessment)
Aim of Activity	This activity aims to provide for the license and storage costs associated with ***HSI 2019.2 - Access to information and resources*** as the publication portal for Gold Coast health pathways information and resources and ***HSI 2019.3 Integrated Care Alliance (ICA) – Alliance Development and implementation*** (including development of health pathways and shared care for the clinical engagement and development of the specialist content for the health pathways.) Together these activities increase access to appropriate timely, coordinated, high quality information and resources to support standardised care across the continuum between Primary, Community and Secondary Sectors. It aims to provide a stable, reliable, accurate digital platform that provides general practice, primary care service providers and the broader community access to the necessary curated, up-to-date information and resources that support access to service options, referral and optimal care management. In 2018/19 GCPHN and GCHHS decided not to implement the Streamliners *HealthPathways* system, based on cost, but rather agreed to revise GCPHN's HealthyGC website to better address this need and be a local solution that performed this function. This is achieved through design, delivery and maintenance of a comprehensive web-based health and wellbeing information portal that was identified as critical to integrated care within all model of care workshops. This has been identified as a keyway for general practice, primary care service providers, secondary care providers and the broader community to access locally tailored and contemporary information.
Description of Activity	This activity provides for the non-staff associated expenses of HealthyGC website (License and storage costs). Note that the staff costs associated with the maintenance and development of content are funded through the HSI stream activity ***HSI 2019.2 - Access to information and resources***. Also note that the ***HSI2019.3 Integrated Care Alliance (ICA) – Alliance Development and implementation*** covers the activity and costs for the clinical engagement and development of the specialist content for the health pathways and shared care. This activity covers the costs of licensing, hosting and other associated online publication costs to support Gold Coast health and integrated care referral and localised service pathways information. HealthyGC website is an open access, publicly available website for consumers and the community which enables access to a generated compilation of appropriate, evidenced-based quality health resources, service information and links.
Target population cohort	Whole PHN region

Indigenous specific	No
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	Extensive consultation has been undertaken as part of Integrated Care Alliance's model of care development and the development of the Deep Dive Needs Assessment and Regional Planning for Palliative Care and Aged Care RACF completed December 2018. Joint working groups and consultation activities have been undertaken with the GCH, General Practice, Primary Care Sector, Peak bodies, other State agencies and consumers. Many of these mechanisms will continue in order to provide ongoing stakeholder feedback and input to the usability and fitness for purpose of the Gold Coast's health pathways publication platform. Further detailed consultation is being undertaken during 2019 to complement the review and co-design of the HealthyGC website in collaboration with health pathways and share care component of the ***HSI 2019.1 - Access to information and resources*** activity.
Collaboration	**Gold Coast Health/Integrated Care Alliance** Joint work to support the development of this portal as the Gold Coast's knowledge platform and e-library solution to support implementation of the redesigned models of care. To provide Clinical and Executive leadership engagement in senior governance group, with a particular focus on clinical leadership engagement. **GPs, allied health and other primary care providers, public/private specialists** In the development of models of care, subsequent translation of these into mapped health pathway information and resources and to support end user requirements and testing of the publication platform for the pathways material **Consumers** Engagement with consumer advisory committee to ensure models of care, resulting health pathways materials and publication platform are fit for purpose for consumer end users; to include input into design, development, testing and continuous quality improvement
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☒ Expression of Interest (EOI)

	☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No

ACTIVITY TITLE	CF 2019.2 Chronic Disease Management
Existing, Modified, or New Activity	Modified Activity CF 2017.5 Turning Pain into Gain
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Chronic Disease management
Needs Assessment Priority	**Identified local health needs and service issues** • High rates of musculoskeletal conditions in Gold Coast North and Coolangatta • Ageing population means more musculoskeletal conditions projected • Pain management frequently focusses on medication • High levels of opioid dispensing across region, particularly Southport • Need for more awareness and support for prevention and self-management • Focus on multidisciplinary and coordinated care Page 1 of the Persistent Pain Summary Needs Assessment (page 61 of 279 of full Needs Assessment submitted) • Better systems to support care coordination required. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients • Need for greater focus on prevention, early identification and self-management Page 1 of the Chronic Disease Needs Assessment Summary (page 71 of 279 of full Needs Assessment submitted) • Comparatively high rates of potentially preventable hospitalisations (including for **cellulitis**) Page 1 and page 5 of General Practice and Primary Care Needs Assessment Summary (page 22 and 26 of 279 of Needs Assessment submitted) **Possible Options identified in Needs Assessment** Continuation of Persistent Pain Program - Turning Pain Into Gain program has the following service components • Patient self-management education program • Individual patient assessment including support to navigate service providers and recommendations to patient's GP • Access to additional allied health services where required • GP and allied health services education • Peer-to-peer support group lead by previous participants • Refresher workshops for participants at 6 months, 9 months and 12 months post program • Evaluation using validated tools Page 7 of Opportunities, Priorities and Options (page 260 of 279 of full Needs Assessment submitted) Integrated Care Alliance • Support the implementation of new integrated models of care. • Preliminary work to develop models of care have been completed for a range of disease conditions. Implementation requirements are currently being scoped. (one of which was **Chronic Wound Care**)

	Page 3 of Opportunities, Priorities and Options (page 256 of 279 of full Needs Assessment submitted) Primary Sense: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment Page 3 of Opportunities, Priorities and Options (page 256 of 279 of full Needs Assessment submitted) Access to information and resources (p9) • Localised referral guidelines and templates for Gold Coast Health, updated to reflect the Clinical Prioritisation Criteria protocols introduced in Queensland • Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources Page 5 of Opportunities, Priorities and Options (page 258 of 279 of full Needs Assessment submitted)
Aim of Activity	Describe what this activity will aim to achieve, and how it will address the identified need (300 word limit). The aim of this activity is to: • Promote improved primary care and chronic conditions management through assessment, self- management training, education, and peer support to patients, with limited access to allied health services where required. • Promote evidence - based resources including reference sites, guidelines and pathways to assist participating primary care clinicians with wound management in their own clinical setting to include direct clinical supervision and professional development of participating nurses and general practitioners at the Chronic and Complex Wound Clinic. Relevant PHN Program National Performance and Quality Framework measures: • P1 - PHN activities address prioritised needs and national priorities • P4 - Support provided to general practices and other health care providers • P7 - Rate of GP style emergency department (ED) presentations • P12 - Rate of potentially preventable hospitalisations • O14 - PHN stakeholder engagement Expected results of this activity include the following local performance measures: • Improved patient's confidence in self-management,

	• Improved patient reported clinical outcomes and overall patient satisfaction. • Improved general practitioner's confidence in managing patients with chronic disease management • Improved patient reported clinical outcomes and overall patient satisfaction. • Improved clinician reported experience of care and workforce satisfaction. • Reduction of PPH related to chronic wounds and persistent pain
Description of Activity	The Chronic Disease Management Activity promotes improved primary care and chronic conditions management through enhanced primary care services that provide assessment, self- management training, education, and peer support to patients, with limited access to allied health services where required. These include the following programs: 1. Turning Pain into Gain is an innovative primary care model of service delivery which combines a number of evidence-based interventions to deliver a patient centred self-management program with the following service components included: • Patient self-management education program • Access to digitally supported cycle of care decision support tools and resources for healthcare providers • Individual patient assessment including support to navigate to appropriate service providers and recommendations to patient's GP • Access to Additional Allied Health Services where • GP and Allied Health Education Program • Peer to peer support group lead by previous participants • Refresher workshops for participants at 6 months, 9 months and 12 months' post program. 2.General Practitioner with Special Interest (Chronic and Complex Wound Care) The Chronic Wound Service is an innovative primary care model which combines a number of evidence-based interventions to deliver a patient centred model of care with the following service components included: • To pilot a primary care-based model (GP specialist clinic) of care for patients with chronic and complex wounds whilst maintaining close relationships with the patients' usual general practitioner and tertiary services. • To increase capability of the general practice workforce to manage chronic and complex wounds • To promote access and use of evidenced-based guidelines, resources, templates and chronic wound management planning templates to all clinicians on the Gold Coast • Access to GP wound specialist via phone for support and training to support more timely access to specialist wound advice Both these activity addresses the needs by providing coordinated health services focussed on provision of evidence-based interventions, and information through a medical home model.

Target population cohort	Gold Coast (SA4) residents who comply with the following eligibility criteria: • Have suffered chronic or persistent pain which has lasted for more than 3-6 months (The youth focussed component of the program (20-35yrs) has been co-designed with patients and health care providers.) • Have a complex and chronic wound requiring ongoing service within primary care.
Indigenous specific	No
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	Consultation with contractors as part of ongoing contract monitoring and performance management processes including specific feedback from: o Referring GPs and practice nurses across the Gold Coast o Patients and families o Gold Coast Health and private specialists o Gold Coast Health & non-270, government agencies community nursing services
Collaboration	The activity involves the following collaboration: **Gold Coast Health/Integrated Care Alliance** Joint work to support the development of this activity and to support ongoing implementation and maintenance of the redesigned models of care. **GPs, allied health and other primary care providers, public/private specialists** In the development of models of care, subsequent translation of these into information and resources to support implementation of the activity in general practice and RACFs; working closely with participating practices and GPs to ensure their engagement, feedback and input into ongoing service delivery **General Practitioners** Referrers to the program and access to education sessions **Contractor** Delivers the program in collaboration with a range of specifically identified allied health providers (who have undergone an audit process to ensure suitability and alignment to program outcomes) **Gold Coast Hospital and Health Services** • GCH Pain Clinic • GCH Wound Services Collaboration with Contractor to ensure alignment of programs and effective use of referral pathways by specialists and general practitioners.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones? • Development of Wound Services model Consultation and design May – August 2019

	• Procurement of Wound Services August – September 2019 • Wound Service Delivery Commence 1 October 2019 • Pilot of the GC Wound Services (October 2019-2021) TBC • Review and evaluation of pilot GC Wound Services model (2021)
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension Turning Pain into Gain will continue to be commissioned from the same provider. ☒ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. The pilot program (GP specialist Wound) Clinic will be established with a GP with long standing recognition and respect within the Gold Coast and nationally for expertise and speciality in management of wounds with in primary care. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	***CF 2019.3*** *Health Service Access for Hard to Reach Populations*
Existing, Modified, or New Activity	New Activity NP 2017.4 Access to health services for the homeless (HealthyGC)
Program Key Priority Area	Aboriginal and Torres Strait Islander Health If Other (please provide details): and Culturally and Linguistically Diverse Populations (CALD)

Needs Assessment Priority	**Identified local health needs and service issues**
	• Access to Information about services and resources to support general practice in key areas required
	Page 1 of General Practice and Primary Care Needs Assessment Summary (page 22 of 279 full Needs Assessment submitted)
	• Effective service engagement with people who
	  o Are from culturally and linguistically diverse (CALD) backgrounds….
	  o Identify as Aboriginal and/or Torres Strait Islander
	• A local workforce comprised of peer support workers, life coaches and support workers able to provide client-centred, trauma-informed, culturally appropriate and recovery-orientated support in both outreach and centre-based settings
	Page 2 National Psychosocial Support Needs Assessment Summary (page 174 of 279 of full Needs Assessment submitted)
	
	Data, research and consultation with service users, service providers and community members identified the following groups as high risk / hard to reach on the Gold Coast including:
	• Culturally and Linguistically Diverse people (CALD)
	• Aboriginal and Torres Strait Islander people
	• Access to psychological services for the CALD population is limited
	• Interpreters used in psychological interventions would benefit from training in mental health
	Page one of Mental Health Hard to Reach Groups Needs Assessment Summary (page 188 of 279 of full Needs Assessment Submitted)
	
	• Limited services in the northern part of the region where there are large child and youth populations and significant demand for Mental Health (MH) services for this cohort, including services for Aboriginal and Torres Strait Islander Children
	Page 1 of Mental Health – Children and Youth Needs Assessment Summary (page 200 of 279 of full Needs Assessment submitted)
	
	• Barriers to accessing residential rehabilitation due to upfront financial costs, child care responsibilities and funds to cover housing costs while in rehabilitation.
	• Small Aboriginal and Torres Strait Islander workforce which limits the capacity of providers to work with clients who require treatment.
	• Cultural competency of mainstream alcohol and other drugs treatment services requires improvement to confidently, safely and effectively work with Aboriginal and Torres Strait Islander people.
	Page 1 of Alcohol and Other Drugs Needs Assessment Summary (page 224 of 279 of full Needs Assessment submitted)
	• Cultural competency, transport and cost affect access to services for Aboriginal and Torres Strait Islander people
	• Focus on chronic disease early identification and self-management
	• Large growth in Aboriginal and Torres Strait Islander population in northern Gold Coast areas.
	• Gaps remain in terms of life expectancy and many contributing factors Higher rates of Aboriginal and Torres Strait Islander people with diabetes and COPD in the region and higher rates of smoking
	Page 1 of Aboriginal and Torres Strait Islander Health Needs Assessment Summary (page 237 of 279 of full Needs Assessment submitted)

	• Access and awareness of appropriate services • Mainstream services that are culturally appropriate and safe • Limited Australian and Torres Strait Islander workforce in specialist mental health services including suicide support Page 1 of Aboriginal and Torres Strait Islander Mental Health and Suicide Needs Assessment Summary (page 249 of 279 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** NA
Aim of Activity	Aim – to utilise well established and respected service providers who specialise in engaging with hard to reach groups to provide an integrated navigation services to increase access to the following services for these populations: • Mainstream primary and secondary health care services including mental health, Alcohol and drug treatment and suicide prevention services as well as other chronic disease services. Relevant PHN Program National Performance and Quality Framework measures: • P1 - PHN activities address prioritised needs and national priorities • P4 - Support provided to general practices and other health care providers • P12 - Rate of potentially preventable hospitalisations • AC1 - Rate of MBS services provided by primary care providers • O14 - PHN stakeholder engagement
Description of Activity	This model will be co-designed with identified hard to reach communities and health and social service provider currently provide services to these targeted populations using integrated service navigation coordinators. It is anticipated that the co-design will focus on the outcome of improved health outcomes for hard to reach population through timely and increased access to mainstream services. • Increasing awareness of and maximising links between services for Aboriginal and Torres Strait Islander people and culturally and linguistically challenges communities, including those provided by Commonwealth and state/territory governments, AMSs, and other organisations • Support mainstream services in developing and implementing strategies to improve access to mainstream primary care for Aboriginal and Torres Strait Islander people and culturally and linguistically challenges communities, • Developing and implementing strategies to improve the capacity of mainstream primary care providers to deliver culturally appropriate primary care services to Aboriginal and Torres Strait Islander people and culturally and linguistically challenged communities, including: o Self-identification o Uptake of Aboriginal and Torres Strait Islander specific MBS items including item 715 - Health Assessments for Aboriginal and Torres Strait Islander People, care planning and follow up items • Collaborating with local Indigenous health services and mainstream health services in a partnership approach for the delivery of primary care services.

	Expected results for the project include increased health outcomes for the targeted population as a result of increase access to mainstream services for the target hard to reach groups. Improving Access • Maintain or Increase number of 715 Health Checks • Deliver one Feedback session with participants of the program each year to collect patient feedback and adjust model.
Target population cohort	Aboriginal and Torres Strait Islander people and Culturally and linguistically Diverse people
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector, The model will be co-designed with the indigenous community and the services provided by an indigenous provider
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	Co-design and consultations with community, providers (health and social Service), clients with lived experience and other funders/Commissioners Ongoing feedback mechanisms once service is established to ensure effective implementations.
Collaboration	GCPHN works in collaboration with the following stakeholders to complete and inform the needs assessment and determine locally appropriate and integrated service solution: • The Karulbo Partnership (a local regular meeting with representation from organisations working in relation to A&TSI health and wellbeing with around 30 attendees at meetings) • The Aboriginal & Torres Strait Islander community • Kalwun (AMS), • Krurungal (ATSI Providers) • CURA – CALD providers • Institute of Urban Indigenous Health (IUIH) • Gold Coast Health – Aboriginal & Torres Strait Islander Services • other health and social service providers.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/06/2019 Activity end date: 30/06/2021

	If applicable, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: October 2019 Service delivery end date: June 2021 Any other relevant milestones • Consultation and Co-design May – August 2019 • Procurement of Services August – September 2019 • Service Delivery Commence 1 October 2019
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☒ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. GCPHN has long standing relationships with key identified providers targeting services for the Aboriginal and Torres Strait Islander and Culturally and Linguistically diverse communities and will work with them and the community to determine the model of service and procurement approach that will possibly be a direct approach given the strength of these providers with their communities. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned?

	No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	CF 2019.4 - Enhanced Primary Care
Existing, Modified, or New Activity	Modified Activity CF 2017.6 Enhanced Primary Care in RACFs.
Program Key Priority Area	Aged Care If Other (please provide details): Palliative Care
Needs Assessment Priority	**Local health needs and service issues – GCPHN Needs Assessment 2018 Older Adults Summary** • The issue of 'reluctant consumers' of conventional services and support, particularly in relation to entering RACFs, is a hidden need which potentially impacts all levels of the community and service sectors. • Interstate migration to the Gold Coast for people in their older adult years potentially impacts the availability and strength of formal and informal support systems • The increased complexity of care and support needs of RACF residents requires an appropriately skilled workforce. • Home Care Package waitlists are substantial (HCP 3 and 4 in particular), delaying the delivery of care to older people to support them to remain at home, which can lead to acute hospitalisations and premature placement in an RACF • Improved understanding of business processes for GPs and other providers could support more frequent and effective delivery of integrated services into RACFs • High numbers of preventable hospital admissions for older adults are recorded for chronic obstructive pulmonary disorder, urinary tract infections, angina and heart failure • The prevalence of dementia in the Gold Coast region is projected to almost double by 2030, and the rate of hospitalisations for dementia has increased rapidly in recent years. In permanent residential aged care, over half of residents have a diagnosis of dementia. • The Gold Coast has high rates of medicine dispensing for anxiety disorders and Alzheimer's compared to national rates, and pockets of high dispensing for antidepressants and antipsychotics such as Southport. • Low uptake, awareness and confidence in relation to advance care planning, including documentation, legal requirements and how to

	approach conversations, for both service providers and community members. • Over 80% of residents in residential aged care facilities (RACFs) have medium-to-high care needs in the domains of daily living activities, cognition/behaviour and complex health care. • High rates of dementia, particularly for residents of aged care facilities • High number of hospital admissions for UTIs, COPD and cardiovascular disease • High rates of anxiolytic (medication or other intervention that inhibits anxiety) medicine dispensing, particularly in Southport • Low uptake and awareness of advance care planning (documents and legal requirements) and end of life care • Capacity to deliver coordinated community palliative care services is limited • Currently limited options to inform community of advanced care options Mental health needs of older people are not currently always being met, and additional support may be required for general practice and community to do this
Aim of Activity	The aim of this activity is to support GPs managing patients in Residential Care Facilities to optimise comprehensive multidisciplinary care planning. This includes promoting patient choice and decision making about end of life care through Advanced Care Plans. The activity is designed to address identified needs by supporting and implementation of comprehensive care planning for residents including end of life planning. Relevant PHN Program National Performance and Quality Framework measures: • P1 - PHN activities address prioritised needs and national priorities • P4 - Support provided to general practices and other health care providers • P9 - Rate of GP Team Care Arrangements / Case Conferences • P12 - Rate of potentially preventable hospitalisations • AC1 - Rate of MBS services provided by primary care providers in residential aged care facilities • O14 - PHN stakeholder engagement Expected results of this activity include the following local performance measures: • increased uptake of advanced care planning
Description of Activity	The program supports enrolled RACFs to engage a designated Clinical Nurse (Educator) to “Champion” and support General Practitioners and their wider practice team to drive comprehensive multidisciplinary care planning including advanced care planning utilising evidenced based pathways and resources. The service components will be underpinned by a coordinated approach to educating the aged care nurses with three projects running simultaneously including the: • Advance Care Planning project: support RACFs to embed an evidence-based ACP program, adapted for individual facilities, in their routine clinical care to support high quality end-of-life care for residents and their families. • Palliative Approach Nurse Education Project, support RACFs to embed within their routine clinical practice a comprehensive evidence-based palliative approach to care, thereby improving resident and family outcomes.

	• Resources and Events Project conduct educational events and develop promote online educational resources for RACFs as a sustainable strategy to support ACP Champions and InterAct Palliative Nurse Approach in RACFs to provide quality end-of-life care to residents and their families. • Provide educational support and resources within RACFs to assist in raising the confidence of staff and GP caring for specialist palliative patients • Work in collaboration and partnership with InterAct team who provide clinical nursing care and intervention to patients residing in RACFs • Educate facilities to promote and Support an ED bypass model for specialist palliative care patients in RACFs • Facilitate the provision of appropriate pathways for on specialist palliative care. • Support quality, timely and responsive care services to RACF residents delivered through a GP led multi-disciplinary primary health care team; • Provision of onsite education on clinical/care coordination services with an emphasis on clinical handover and EOL care; • Education, training, information and resources to support RACF staff, visiting health professionals, family of residents in the delivery of the Project; • Development of a robust clinical governance framework to support the delivery of high quality, safe, evidence-based generalist palliative care in RACF. To facilitate quality improvement and change management process within the RACF • Liaise with local/regional health services – primary, specialist, allied health and acute to ensure integrated and coordinated care. • To promote the utilisation of evidenced based pathways and resources to assist patient inclusive clinical decision making and support advance care planning with General Practices • Develop RACF specific coordinated care protocols and site operational process for the aged care recipients with complex needs utilizing best practice and evidence- based Model of Care in collaboration with the treating GPs within the Facility through piloting an incentivisation scheme. • Co-designing a quality incentive program with GP's and RACF to embed sustainable change in the implementation of multidisciplinary care planning and advanced care plans for residents of RACF's This component links closely with • "HSI 2019.1 Access to information and resources" activity • Greater Choices for At Home Palliative Care (GCFAHPC) Project • Advanced Project
Target population cohort	Residents of a selected group Gold Coast RACFs, who are at risk of poor health outcomes due to geriatric syndromes, complex comorbid chronic disease sets, palliative care, frailty and barriers to access to timely appropriate health care.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No
Coverage	Targeted Residential Aged Care Facilities and their regular GPs within the Gold Coast region.

Consultation	Extensive engagement and consultation was completed in development of the Palliative and Out of Hours Aged Care Regional Needs Assessment and Regional Planning completed December 2018. Joint working groups and consultation activities have been undertaken with the GCPHN Clinical and Community Advisory Group, GCH, General Practice, Primary Care Sector, Peak bodies, other State agencies and consumers. Many of these mechanisms will continue in order to provide ongoing feedback and input to ensure ongoing engagement and continuous improvement: **General Practice, RACFs and Multidisciplinary Service Providers** To support design, development, implementation of the activity **Gold Coast Health/Integrated Care Alliance** Supporting collaboration and RACF/GP through the QLD State Wide End of Life Strategy and advanced care planning training offered locally. **RACGP** To provide advice and direction towards ensuring optimal alignment with and utilisation of the RACGP Silver book guidelines - Medical care of older persons in residential aged care facilities
Collaboration	**Gold Coast Health/Integrated Care Alliance** Joint work to support the development of this activity and to support ongoing implementation and maintenance of the redesigned models of care. To provide Clinical and Executive leadership engagement in senior governance group, with a particular focus on ongoing clinical outreach support and education for general practice and RACFs. **GPs, allied health and other primary care providers, public/private specialists** In the development of models of care, subsequent translation of these into information and resources to support implementation of the activity in general practice and RACFs; working closely with participating practices and GPs to ensure their engagement, feedback and input into ongoing service delivery **Metro South Brisbane Hospital and Health Service** Link to ensure administration of advance care planning documentation
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones • Clinical Nurse Educator Service Agreement in Place 1 May 2019 • Preparation and onboarding of RACF & GP 1 July 2019 • Clinical Nurse Educator commence Service Delivery 1 July 2019 • Co-design of incentive program for GP & RACF 30 September 2019 • Implementation of Incentive Program 1 October 2019
Commissioning method and	1. Please identify your intended procurement approach for commissioning services under this activity:

approach to market	☐ Not yet known ☐ Continuing service provider / contract extension ☒ Direct engagement. The GCH service are the only secondary public hospital and community health palliative and aged care service provider locally. As part of the Integrated Care Alliance redesigned models of care, agreement has been reached between the PHN and the GCH about the commitment of the GCH to providing extended services as outreach into RACFs and to support optimal primary care in RACFs. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

1. (b) Planned PHN activities for 2019-20 to 2021-22 – Core Health Systems Improvement Funding Stream – General Practice Support funding

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	HSI 2019.1 - Commissioning Systems and Stakeholder Engagement
Existing, Modified, or New Activity	Existing Activity HSI 2018.2 Commissioning Systems and Stakeholder Engagement
Needs Assessment Priority	NA
Aim of Activity	To provide commissioning excellence support to the PHN and partner activities towards supporting one world class health system for the Gold Coast and supporting high performing primary care. Relevant PHN Program National Performance and Quality Framework measures: • P1 - PHN activities address prioritised needs and national priorities • P2 – Health System Improvement and Innovation • P4 - Support provided to general practices and other health care providers • W3 - PHN Commissioning Framework • IH6 - PHN provides support for Aboriginal and Torres Strait Islander identified health workforce • O2 - PHN Clinical Council and Community Advisory Committee membership • O3 - PHN Board considers input from committees • O5 - PHN Board has a regular review of its performance • O6 - PHN Board approves strategic plan • O8 - Quality Management System • O10 - Performance management process • O11 - Cultural awareness training • O12 - Rate of contracts that include both outputs and outcomes performance indicators • O14 - PHN stakeholder engagement
Description of Activity	This activity provides the commissioning systems support for the PHN's activities including Health System Improvement, General Practice Support, After Hours and Other Funding programs including ITC, MH, AOD, Palliative Care. The activity provides the following functions and resourcing: • Needs assessment and annual planning • Market assessment and Service co-design • Procurement and contracting • Performance monitoring, Quality, Risk and Evaluation • Stakeholder Engagement, communications and marketing

	These activities enable the primary health care sector to be inform, be engaged in and shape the evaluation of current primary and intermediate care services as well as shape future services through: • Ensuring primary care inform the annual and specific needs assessment activities • Involving primary care sector in market assessment and Service co-design • Supporting primary care sector to engage in and inform commissioning through procurement and contracting activities • Providing data and information to the primary care sector that assists in their decision support and driving quality improvement of services and improved patient outcomes To inform, be engaged and contribute through an extensive set of communications and engagement channels and programs
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity. NA
Target population cohort	Healthcare system, providers and consumers in the whole PHN region i.e. Gold Coast PHN Region (Gold Coast SA4)
Indigenous specific	No
Coverage	Whole PHN region i.e. Gold Coast PHN Region (Gold Coast SA4)
Consultation	**General Practice Gold Coast** Provide ongoing engagement opportunities, communication channels and advice about general practice in the Gold Coast; input into service review, development and evaluation; partner in delivering education and other quality improvement activities **Primary Care Partnership Council** Provide ongoing engagement opportunities, communication channels and advice about broader primary care sector and key state agencies in the Gold Coast; input into service review, development and evaluation **Karulbo Partnership** Provide ongoing engagement opportunities, communication channels and advice about engagement of Aboriginal and Torres Strait Islander People in PHN and partner activities and about culturally appropriate practices and service models in the Gold Coast; input into service review, development and evaluation **Gold Coast Health/Integrated Care Alliance with Gold Coast Health** Provide ongoing engagement opportunities, communication channels and advice and a formalised partnership through which the PHN consults with GCH board, executive, administrative and clinical leads about referral, care coordination, service integration and clinical handover in the Gold Coast; input into service review, development and evaluation; partner in delivering education, models of care development and other integration activities **Gold Coast Health specialists, academics and local providers** Engage with a variety of local, national and international health service specialist and researchers to access expert advice and input to Co-design, service development, evaluation and procurement activities **National Health Service Directory, 13 Health**

	Ongoing engagement to ensure a collaborative approach to each other's service directory
Collaboration	**General Practice Gold Coast** Provide advice and input into the service review, development and engagement of Gold Coast General practice in PHN and partner activities **Primary Care Partnership Council** Provide advice and input into the service review, development and engagement of Gold Coast Primary Care Sector in PHN and partner activities **Karulbo Partnership** Provide advice and input into the service review, development and engagement of Aboriginal and Torres Strait Islander People in PHN and partner activities and about culturally appropriate practices and service models **Gold Coast Health General Practice Liaison Unit** Provide advice and liaison between general practice and Gold Coast Health **Gold Coast Health/Integrated Care Alliance with Gold Coast Health** Provide advice and input into referral, care coordination, service integration and clinical handover **Gold Coast Health specialists, academics and local providers** Provide advice and engagement of Health Service Providers and researchers in Co-design and procurement **National Health Service Directory, 13 Health** Link to each other's service directory and ensure sharing and refining service directory information across these services
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process?

	No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	HSI 2019.2 - Access to information and resources (HealthyGC)
Existing, Modified, or New Activity	Existing Activity HSI 2018.1 Access to information and resources If activity is existing or modified, provide the relevant reference/s from previous Activity Work Plan/s where possible. Also relates to ***CF 2019.1 Integrated Care Alliance (ICA) – health pathways Non-staff expenses (license and storage costs)*** which provides for this component of publication platform costs and ***HSI 2019.3 Integrated Care Alliance (ICA) – Alliance Development and implementation*** (including development of health pathways and shared care) which provides for the clinical engagement and development of the specialist content for the health pathways
Needs Assessment Priority	**Identified health needs and service issues** • Access to Information about services and resources to support general practice in key areas is required. Page 1 of General Practice and Primary Care Needs Assessment Summary (Page 22 of 279 of full Needs Assessment Submitted) • Better systems to support care coordination required • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients Page 1 of Chronic Disease Needs Assessment Summary (page 71 of 279 full Needs Assessment submitted) • Access to clear communication and accessible information for patients, families and health care professionals • Current systems not always established for the provision of clinical care coordination of end of life care between providers Page 1 of Palliative Care Needs Assessment Summary (page 130 of 279 of full Needs Assessment submitted) • Promotion of low intensity services to General Practice to support complementary use with other primary health interventions • Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services Page 1 of Low intensity Mental Health Services Needs Assessment Summary (page 168 of 279 of full Needs Assessment submitted) • Efficient referral pathways to increase accessibility to new psychosocial services • Improved service coordination for individuals with severe mental illness and associated psychosocial functional impairment, while considering support available across levels of government, the community and relevant sectors Page 2 of National Psychosocial Support (NPS) Needs Assessment Summary (page 174 of 279 of full Needs Assessment submitted) • Develop clear referral pathways and supported connections to appropriate community supports Page 1 of Mental health Suicide Prevention Needs Assessment Summary (page 179 of 2779 of full Needs Assessment submitted) For children in care- • Issues with transfer of information

	• Limited knowledge and adherence to guidelines/frameworks by health care providers Page 1 Mental Health – Children and Youth Needs Assessment Summary (page 200 of 279 of full Needs Assessment submitted) • Develop efficient pathways to support person centred transfer of care between acute and primary care services (general practice, allied health and community services) Page 1 of Mental Health Severe and Complex Needs Assessment Summary (page 210 of 279 of full Needs Assessment submitted). • Provision of training and resources, including referral pathways, for general practice to support patients with substance use issues including ice Page 1 of Alcohol and Other Drugs Needs Assessment Summary (page 224 of 279 of full Needs Assessment submitted) • Access and awareness of appropriate services Page 1 of Aboriginal and Torres Strait Islander Mental health and Suicide Needs Assessment Summary (Page249 of 279 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** Integrated Care Alliance • Support the implementation of new integrated models of care • Preliminary work to develop models of care have been completed for a range of disease conditions. Implementation requirements are currently being scoped. • A major body of work for GCPHN involves the implementation of a e-library solution to enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work. Page 3 of Opportunities Priorities and Options (page 256 of 279 of full Needs Assessment) Access to information and resources • GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing web portal featuring: o Localised referral guidelines and templates for Gold Coast Health, updated to reflect the Clinical Prioritisation Criteria protocols introduced in Queensland o Review and update of existing referral templates to ensure they align to current evidence and GCH systems and protocols o Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources • A detailed local service directory • In addition, other software options as well as the structure of the current HealthyGC website will be reviewed and compared to ensure the service continues to function in the most effective and efficient way. Page 5 of Opportunities Priorities and Options (page 258 of 279 of full Needs Assessment)
Aim of Activity	This activity aims to provide general practice, consumers, primary care sector and community providers with access to readily available, evidence based information, resources, service and referral options, tailored specifically to the

	Gold Coast region through an extensive set of communications and engagement channels and programs particularly including HealthyGC online publication platform. Information is provided about GCPHN, our programs, services, service directory as well as health pathways information and resources through a stable, reliable, accurate, localised digital platform for general practice, primary care service providers and the broader community to access the necessary curated, up-to-date information and resources that support access to service options, referral and optimal care management. The activity aims to achieve the following National PHN Performance Framework targets: • P1 - PHN activities address prioritised needs and national priorities • P4 - Support provided to general practices and other health care providers • P7 - Rate of GP style emergency department (ED) presentations • O14 - PHN stakeholder engagement The activities ensure that the primary health care sector are kept informed, about service access, referral pathways, needs assessment, planning and co-design of current primary and intermediate care services as well as promote opportunities to shape future services through: • Providing health service access and referral information about available services, pathways and e-referral templates for the Gold Coast region • Ensuring primary care inform the annual and specific needs assessment activities • Communicating opportunities for primary care sector in market assessment and Service co-design • Supporting primary care sector to engage in and inform commissioning through procurement and contracting activities • Providing data and information to the primary care sector that assists in their decision support and driving quality improvement of services and improved patient outcomes
Description of Activity	The activity addresses the needs through delivery of a patient centred, coordinated, curated online platform of information and resources including but not limited to local service options, GCPHN and our programs and services, referral options, health pathways. GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing HealthyGC web portal featuring: • Localised referral guidelines and templates for Gold Coast Health, updated to reflect the new Clinical Prioritisation Criteria protocols being introduced in Queensland • Review and update of existing referral templates to ensure they align to current evidence and GCHHS systems and protocols • An e-library of professional resources and educational material • Patient facing resources • Publication of health pathways information across a number of prioritised service areas/health issues • Links to local service directory/ies.

	During 2019, other software options and a review of the information architecture and content management system will be completed to ensure the service continues to function in the most effective and efficient way and meet the needs of its users. Priority will be given to increasing pathways information to support improved navigation and access to local service provider information in PHN priority areas and other locally identified health topic areas, to ensure information and resources published online are kept current and appropriately curated to support appropriate, timely referrals and agreed service pathways. This links with the activity ***HSI 2019.3 Integrated Care Alliance (ICA) – Alliance Development and implementation (including development of health pathways and shared care)*** for the clinical engagement and development of the specialist content for the health pathways that will be published on the HealthyGC web portal. The review will engage stakeholders to explore options for most effective ways to increase communication, awareness and referral and service pathways between service providers and improve user experience in line with contemporary e-solutions. The activity includes linking and liaison with the National Health Service Directory and other related directories to ensure most effective information sharing. This activity links closely with practice support activities and other program activities including the hosting of referral templates, resources and information to support local health decision assist tools including: • Referral templates • Resources, clinicians and consumers • Professional development • Resource directory Expected results include achieving increased access to contemporary evidence-based resources and localised service and referral information.
Associated Flexible Activity/ies:	CF 2019.1 Integrated Care Alliance (ICA) – health pathways non-staff expenses (license and storage costs) in relation to publication platform costs
Target population cohort	Primary Care Sector (in particular general practice), local health system stakeholders and the community of the Gold Coast PHN Region (Gold Coast SA4)
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	whole PHN region i.e. Gold Coast PHN Region (Gold Coast SA4)
Consultation	**General Practice Gold Coast** Provide ongoing engagement opportunities, communication channels and advice about general practice in the Gold Coast; input into development and evaluation; partner in delivering educational information and resources for general practice **Primary Care Partnership Council**

	Provide ongoing engagement opportunities, communication channels and advice about broader primary care sector and key State agencies input **Karulbo Partnership** Provide ongoing engagement opportunities, communication channels and advice about engagement of Aboriginal and Torres Strait Islander People in PHN services and activities and about culturally appropriate practices **Gold Coast Health/Integrated Care Alliance with Gold Coast Health** Provide ongoing engagement opportunities, communication channels and advice and a formalised partnership through which the PHN consults with GCH board, executive, administrative and clinical leads about referral templates, service options, service integration and clinical handover information and resources for the Gold Coast; partner in delivering education information and resources, health pathways publication e-library and other integration activities **National Health Service Directory, 13 Health** Ongoing engagement to ensure a collaborative approach to each other's service directory
Collaboration	**GCPHN staff**. Management of the review, implementation and Ongoing support **General Practice Staff** Provide input and feedback as key users of the activity; co-design of enhancements to the activity as part of the review, implementation and Ongoing user support **Gold Coast Health and Hospital Service/Integrated Care Alliance** Provide input and feedback as key users of the activity; co-design of enhancements to the activity as part of the review, implementation and Ongoing maintenance of the content **Peak bodies including RACGP, AGPAL and GPA** Consultation to ensure activity aligns to the standards **GCPHN Primary Health Care Improvement Committee** Comprises local general practice staff who provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities **General Practice Gold Coast (GPGC)** Linkage to ensure collaboration and partnership with general practice in the Gold Coast **Primary Care Training Providers** Including Pharmacy Guild, Pharmaceutical Society of Australia, General Practice Gold Coast, National Prescribing Service, Australian Primary Health Care Nurses Association, Gold Coast Medical Association, Royal Australian College of General Practitioners, Local Universities. To ensure linkage, coordination and a collaborative approach to avoid duplication of training events and address gaps
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?

	- Review and refresh of main website architecture and tranche 1 of content migration/health pathways information for key priorities published by 31 October 2019 - tranche 2 and 3 of content migration/health pathways information for key priorities published by 31 October 2021
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Request for Proposal process undertaken in January – March 2019 with expected commencement of review consultancy by End March 2019. Completion of review consultancy expected end October 2019. 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	HSI 2019.3 Integrated Care Alliance (ICA) – Development and Implementation (including development of health pathways and shared care)
Existing, Modified, or New Activity	Modified Activity Modified activity (2016-18 Activity Work Plan – Reference NP 2017.1 Integrated Care Alliance (ICA)). Also relates to ***CF 2019.1 Integrated Care Alliance (ICA) – health pathways Non-staff expenses (license costs)*** in relation to publication platform costs and ***HSI 2019.2 Access to information and resources*** as the publication portal for Gold Coast health pathways information and resources***.*** The work also relates to the Greater Choices for at home palliative care program activities.
Needs Assessment Priority	**Identified health needs and service issues** • Access to Information about services and resources to support general practice in key areas is required. Page 1 of General Practice and Primary Care Needs Assessment Summary (Page 22 of 279 of full Needs Assessment Submitted) • Better systems to support care coordination required • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients Page 1 of Chronic Disease Needs Assessment Summary (page 71 of 279 full Needs Assessment submitted) • Access to clear communication and accessible information for patients, families and health care professionals • Current systems not always established for the provision of clinical care coordination of end of life care between providers Page 1 of Palliative Care Needs Assessment Summary (page 130 of 279 of full Needs Assessment submitted) • Promotion of low intensity services to General Practice to support complementary use with other primary health interventions • Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services Page 1 of Low intensity Mental Health Services Needs Assessment Summary (page 168 of 279 of full Needs Assessment submitted) • Efficient referral pathways to increase accessibility to new psychosocial services • Improved service coordination for individuals with severe mental illness and associated psychosocial functional impairment, while considering support available across levels of government, the community and relevant sectors Page 2 of National Psychosocial Support (NPS) Needs Assessment Summary (page 174 of 279 of full Needs Assessment submitted) • Develop clear referral pathways and supported connections to appropriate community supports Page 1 of Mental health Suicide Prevention Needs Assessment Summary (page 179 of 2779 of full Needs Assessment submitted) For children in care- • Issues with transfer of information

	• Limited knowledge and adherence to guidelines/frameworks by health care providers Page 1 Mental Health – Children and Youth Needs Assessment Summary (page 200 of 279 of full Needs Assessment submitted) • Develop efficient pathways to support person centred transfer of care between acute and primary care services (general practice, allied health and community services) Page 1 of Mental Health Severe and Complex Needs Assessment Summary (page 210 of 279 of full Needs Assessment submitted). • Provision of training and resources, including referral pathways, for general practice to support patients with substance use issues including ice Page 1 of Alcohol and Other Drugs Needs Assessment Summary (page 224 of 279 of full Needs Assessment submitted) • Access and awareness of appropriate services Page 1 of Aboriginal and Torres Strait Islander Mental health and Suicide Needs Assessment Summary (Page249 of 279 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** Integrated Care Alliance • Support the implementation of new integrated models of care • Preliminary work to develop models of care have been completed for a range of disease conditions. I implementation requirements are currently being scoped. • A major body of work for GCPHN involves the implementation of a e-library solution to enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work. Page 3 of Opportunities Priorities and Options (page 256 of 279 of full Needs Assessment) Access to information and resources • GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing web portal featuring: o Localised referral guidelines and templates for Gold Coast Health, updated to reflect the Clinical Prioritisation Criteria protocols introduced in Queensland o Review and update of existing referral templates to ensure they align to current evidence and GCH systems and protocols o Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources • A detailed local service directory • In addition, other software options as well as the structure of the current HealthyGC website will be reviewed and compared to ensure the service continues to function in the most effective and efficient way. Page 5 of Opportunities Priorities and Options (page 258 of 279 of full Needs Assessment)
Aim of Activity	**Overall Program Objectives:** Create a single integrated healthcare system for the Gold Coast by:

	• Improving the coordination of care to ensure consumers receive the right care at the right place at the right time by the right person. • Increasing the effectiveness and efficiency of health services for consumers. • Engaging and supporting clinicians to facilitate improvements in our health system. The aim of GCPHN's contribution to this program is to develop and redesign models of care that facilitate improved experience and outcomes for patients and the workforce across the continuum of care, and to enable these through the development and implementation of ICT/Analytics solutions to support that (equivalent local solution for Health pathways and shared care) (refer activity ***CF 2019.1*** and ***HSI 2019.2)***. This activity includes development of a model for localised Gold Coast health pathways and shared care frameworks, which will provide general practice, consumers, primary care sector, community and secondary providers with access to readily available, evidence based information, resources, service and referral options, tailored locally to the Gold Coast region. To ensure Primary Care and General Practice are informed, engaged in and contribute through an extensive program of engagement to develop, implement and review the health pathways and shared care in line with locally agreed models of care developed by the Integrated Care Alliance and other joint programs. Also to support adoption and ongoing maintenance of health pathways, including localisation of integrated care service pathways for the Gold Coast region
Description of Activity	Continue to develop and implement new integrated models of care for the prioritised diseases/conditions, commencing with broad based community and MDT workshops. GCPHN will fund GP and primary care practitioners to attend and participate in models of care development and implementation. These workshops will continue to refine models of care throughout 2019-2022. From 1 July 2019 completed models of care will pass through a series of assurance gateways providing validation against the criteria of: consumer acceptability, financial sustainability, quality and safety, workforce implications and ICT compatibility with implementation commencing for Palliative Care in the first instance. The development and redesigned models of care will facilitate improved experience and outcomes for patients and the workforce across the continuum of care. Implement health pathways and shared care to support the implementation of new models of care. The activity addresses the needs through delivery of a patient centred, coordinated program to develop health pathways and shared care (as required) information and resources that include local service options for nationally and locally identified priority areas (including but not limited to: palliative care, aged care RACF, mental health, AODs treatment services). During 2019/20, the focus will be on developing local exemplars for two of the above priority areas commencing with Palliative care as detailed in the **Greater Choices for at home palliative care program activities.** This activity will develop • Localised referral guidelines and templates for Gold Coast Health, updated to reflect the new Clinical Prioritisation Criteria protocols being introduced in Queensland

	• Review and update of existing referral templates to ensure they align to current evidence and GCHHS systems and protocols • Develop, curate and maintain the locally agreed content and provide that to the publication platform to support maintenance of an e-library of professional resources and educational material as well as patient facing resources as determined appropriate • Agreed health pathways and shared care across a number of prioritised service areas/health issues commencing with the identified priority areas (listed above). Priority will be given to engaging local clinicians towards increasing agreed pathways information that support improved navigation and access to local service providers. This will focus on PHN priority areas and other locally identified health topic areas, to ensure information and resources published online are kept current and appropriately curated to support appropriate, timely referrals and agreed service pathways. The activity will engage stakeholders and particularly clinicians to explore options for most effective ways to increase communication, awareness and referral and service pathways between service providers and improve user experience in line with contemporary digitally optimised solutions. During 2019, the agreed format and framework will be developed along with a localised how to guide to support the development and roll out of a program of health pathway and shared care development throughout 2020-2022. Another key body of work for GCPHN in 19/20 will involve the implementation of an updated e-library solution to host and enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work. The e-library solutions is addressed through activities ***CF 2019.1 Integrated Care Alliance (ICA) – health pathways Non-staff expenses*** in relation to publication platform costs ((equivalent to the Streamliners® licensing costs) and ***HSI 2019.2 Access to information and resources*** in relation to the broader staffing costs associated with the broader website, stakeholder engagement and commissioning systems supporting activities ***.*** Expected results include achieving increased access to contemporary evidence-based resources and localised service and referral information. An evaluation framework is being developed to support this work. ICA performance indicators are in development and will include measures against the triple aim of population health, patient and practitioner experience and value for money. Measures of system performance will be included.
Associated Flexible Activity/ies:	***CF 2019.1 Integrated Care Alliance (ICA) – health literacy / pathways Non-staff expenses*** (license and storage costs) in relation to publication platform costs ***HSI 2019.2 Access to information and resources*** in relation to the broader staffing costs associated with the broader communications channels, website administration, content management system, stakeholder management and commissioning systems supporting activities
Target population cohort	ICA target population is whole of Gold Coast population, primarily accessing public health services initially. Work has commenced to explore how the private hospital and specialists can adopt these models as care and systems.
Indigenous specific	No

	If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Primary Care Sector (in particular general practice), local health system stakeholders and the community of the Gold Coast PHN Region (Gold Coast SA4)
Consultation	**General practices, GPs and General Practice Gold Coast** Provide ongoing engagement opportunities, communication channels and advice about general practice in the Gold Coast; input into design, development, implementation, maintenance and evaluation; partner in delivering educational information and resources for general practice **Primary Care Partnership Council** Provide ongoing engagement opportunities, communication channels and advice about broader primary care sector and key State agencies input into health pathways and shared care development and maintenance **Karulbo Partnership** Provide ongoing engagement opportunities, communication channels and advice about engagement of Aboriginal and Torres Strait Islander People in PHN services and activities and about culturally appropriate practices **Gold Coast Health/Integrated Care Alliance with Gold Coast Health** Provide ongoing engagement opportunities, communication channels and advice and a formalised partnership through which the PHN consults with GCH board, executive, administrative and clinical leads about health pathways, shared care, referral templates, service options, service integration and clinical handover information and resources for the Gold Coast; partner in delivering education information and resources, health pathways and shared care publication e-library and other integration activities
Collaboration	**Gold Coast Health and Hospital Service/Integrated Care Alliance:** Role is to provide input and feedback as key users of the activity; co-design of enhancements to the activity as part of the review, implementation and ongoing maintenance of the content – ICA – Alliance Group member – Model of care development input from specialists – Executive leadership engagement in senior governance group. – Clinical engagement in every level of governance, with a particular focus on clinical governance. **GCPHN Primary Health Care Improvement Committee** Comprises local general practice staff who provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities **GPs and allied health and private specialists:** Input to the development of models of care and the subsequent translation of these onto health pathways solution and e-library **Consumers (representative groups and individuals):** Input to the development of models of care to ensure they are developed with appropriate consideration of consumers input and needs. **General Practice Gold Coast (GPGC)** Linkage to ensure collaboration and partnership to ensure health pathways and shared care support and actively engage with general practice in the Gold Coast **Primary Care Training Providers** Including Pharmacy Guild, Pharmaceutical Society of Australia, General Practice Gold Coast, National Prescribing Service, Australian Primary Health Care Nurses Association, Gold Coast Medical Association, Royal Australian College of General Practitioners, Local Universities. To support coordination and a

	collaborative approach to training and ongoing continuous professional development events that support the health pathways implementation
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones? - Tranche 1 of health pathways information for key priorities published by 31 October 2019 - Tranche 2 and 3 of health pathways information for key priorities published by 31 October 2021
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☒ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*HSI 2019.4 Regional mental health and suicide prevention plan*
Existing, Modified, or New Activity	Modified Activity Primary Mental Health Care 2016-2019 8.1 Development of regional mental health and suicide prevention plan
Needs Assessment Priority	Department of Health requirement in Deed and in COAG Agreement
Aim of Activity	This activity aims to develop a Foundational Regional Mental Health and Suicide Prevention Plan (the Plan) to focus on working together to identify service gaps, shared priorities and make better use available resources to meet regional needs in the short term Primarily the Plan will embed integration of mental health and suicide prevention pathways and services for people with or at risk of mental illness or suicide through a whole of system approach. The Plan will also commence the work to drive and inform evidence-based service development to address identified gaps and deliver on regional priorities which have been developed and delivered in partnership with local communities.
Description of Activity	Having already laid the initial groundwork including joint GCPHN and Gold Coast Health board understanding and commitment to the development of the Plan, GCPHN has recruited a dedicated project position to coordinate and progress the development of the Plan. A consultation plan will be developed to ensure appropriate and meaningful engagement of key stakeholders including consumers and carers, NGO service providers, general practice and other mental health service providers in all stages of the development of the Plan Building on work already undertaken including the GCPHN 2018 Needs Assessment and the NMHSPF to compile evidence. Undertake mapping of services and pathways using common language in the NMHSPF. Identify: • potential gaps in and duplications impacting optimal service • service fragmentation issues and • priorities for change Agree with Gold Coast Health: • roles and responsibilities for priorities for change • ongoing governance requirements • appropriate KPIs and reporting requirements Finalise documentation and secure joint endorsement from GCPHN and Gold Coast Health. By 2020, it is expected that GCPHN and Gold Coast Health will be signatories to an integrated Gold Coast plan that will support the integrated delivery of

	mental health and suicide prevention services. While being a Foundational plan it is expected that the National Mental Health Planning Framework Tool will be used to support the development of the plan and initial service planning considerations.
Associated Flexible Activity/ies:	MH1, MH2, MH3, MH4, MH5, MH7; AOD1.1, AOD1.2, AOD1.3
Target population cohort	GCPHN population with mental health needs, with a particular focus on a number of population cohorts including Aboriginal and Torres Strait Islander people, children and young people, people with drug and alcohol issues and people at risk of suicide.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No While not predominantly supporting the Aboriginal and Torres Strait Islander community, the Gold Coast AMS and more broadly the Aboriginal and Torres Strait Islander Partnership group Karulbo will be actively engaged the development of the plan.
Coverage	Whole of Gold Coast PHN Region (Gold Coast SA4)
Consultation	In addition to the governance arrangements, a number of specific working groups will be established to inform and guide the development of the plan. Existing groups will be actively engaged including mental health consumer and carer groups and panels, the local Aboriginal and Torres Strait Islander Partnership Group, local Mental Health and Drug and Alcohol sector at multiple times during the process. In addition it is envisaged that documentation will be made publicly available for consultation in an online format to assist in prioritisation. A large workshop is also planned to assist with a broad representation of stakeholders across the sector, including consumers and carers to assist in prioritisation
Collaboration	Gold Coast Primary Health Network – Project partner delivering coordination, engagement, data and planning expertise Gold Coast Health – project partner contributing clinical, data and planning expertise
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 13/03/2019 Activity end date: 30/06/2020 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and approach to market	This project will be delivered by GCPHN and Gold Coast Health staff 1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension

	☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Click to choose 2b. Is this activity this result of a previous co-design process? Click to choose 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Click to choose 3b. Has this activity previously been co-commissioned or joint-commissioned? Click to choose

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	GPS 2019.1 Primary Care Improvement Program
Existing, Modified, or New Activity	Modified Activity Modified (inclusion of innovation activity from 2018/2019 sustaining support of quality improvement activity within a population health management model) incorporating recommendations from the Innovation activity evaluation. (2018-19 Activity Work Plan relevant Activity reference/s HIS 2018.5 Primary Care Improvement Program
Needs Assessment Priority	**Identified local health needs and service issues** • Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza) • My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers • Potential to increase use of data in general practice software to proactively plan care • Frequently current systems (including MBS payments and data) do not support population health approach and care-coordination Page 1 of General Practice and Primary Care Needs Assessment Summary (page 22 of 279 of full Needs Assessment submitted) • Better systems to support care coordination required. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients • Need for greater focus on prevention, early identification and self-management • High rates of smoking and harmful alcohol intake across the region identification and self-management. Page 1 of Chronic Disease Needs Assessment Summary (page 71 of 279 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** Continuous quality Improvement Tier 3 Practice Support • Supported implementation of continuous quality improvement methodologies using practice data to drive improvements and other building blocks of high performing primary care • Collection and use of clinical data to improve the population's health • The General Practice determines priority areas for improvement through review of their clinical data • Development of an action plan utilising a CQI methodology through peer to peer conversations • Develop tailored clinical audit reports to determine baselines measures and monitor improvement over time • Review and monitor progress towards achievements/improvements • Access to decision support tools including cycles of care through GCPHN website. (page 2 of Opportunities, priorities and options, page 255 of 279 of full Needs Assessment submitted) Population health management Tier 4 Practice Support

	• Improved management of patient health care in general practice • Reducing unnecessary referrals and admissions to hospital. GCPHN 3 Opportunities, priorities and options Priority Possible Options Expected Outcome Potential Lead • Allocated Practice Support Officer to facilitate improved comprehensive and patient centred care planning • Develop person centred, goal orientated care plans that align with MBS requirements. • Provide education and training in the use of the care plans template which support utilisation of systematic cycles of care requiring recall and reminder where necessary to support improved patient management. • Provide regular data reports to monitor improvement in care management of patients. (page 2 of Opportunities, priorities and options, page 255 of 279 of full Needs Assessment submitted) Primary Sense Continue refinement and implementation in trial practices of automated pseudonymised data extraction and analysis of the health profile of the entire practice population. This includes generating actionable optimal care reports and create a single integrated healthcare system for the Gold Coast by: • Improving the coordination of care to ensure consumers receive the right care at the right place at the right time by the right person. • Increasing the effectiveness and efficiency of health services for consumers. • Engaging and supporting clinicians to facilitate improvements in our health system. Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management systems and applying evidenced based algorithms. GCPHN with Gold Coast Health (GCH) GCPHN with key stakeholders 4 Opportunities, priorities and options Priority Possible Options Expected Outcome Potential Lead medication safety alerts for general practices, analysed population health data for the practice to inform the service response and for GCPHN needs assessment and other commissioning purposes. Primary Sense: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts of patients at immediate risk from medication prescribing safety issues

	Page 3 of Opportunities, priorities and options, page 255 of 279 of full Needs Assessment submitted
Aim of Activity	The aim is to • Support health practitioners and their teams to deliver data informed, high quality and safe health care to their communities on the Gold Coast. • Support the integration of Quality Improvement including Clinical Audits • To progress quality improvement from GCPHN led to practice led • Support practices to meet the requirements of the Quality Improvement Practice Incentive Payment • Integrate Digital Health requirements into all activities to support sustainable business processes
Description of Activity	This program of work moves beyond HSI 2019.4 Practice Support A. Tier 1 & 2 activities and encompasses GCPHN's Tier 3 and 4 practice support activities as well as a wider program based on evidence based best practice methods to achieve high performing primary care. It includes activities to achieve better quality of care through continuous quality improvement methodologies, clinical audits and using health information to drive improvements. It also utilises other building blocks of high performing primary care to inform continuous improvement in primary health care, including but not limited to the collection and use of clinical data to improve the population's health. **Tier 3 Quality Improvement Program** Each practice that enrols in this program has an allocated GCPHN General Practitioner (GP) Clinical Lead and Practice Support Officer (PSO) who support practice staff to identify their quality improvement (QI) goals and activities. The GCPHN GP and PSO provide peer to peer support to increase the practice team's confidence and abilities to independently lead QI initiatives. • The General Practice determine their priority areas for improvement through review of their clinical data (data report provided by GCPHN) • GCPHN facilitates a practice engagement meeting, introducing resources and processes to allow practices to: o Develop a QI action plan through peer to peer discussion, utilising QI methodology. o Develop tailored clinical audit reports to determine baselines measures and monitor improvement over time. (at specified intervals) o Participate in regular touch point meetings with practices to review and monitor improvements and progress towards goals. o Provides access to decision making support tools including easily accessible cycles of care through GCPHN website. o Monitor practices ability to maintain future independent QI activities. o Support the increased use of digital health including My Health Record to enhance QI activities **Tier 4 - Population Health Quality Improvement program** Each practice that enrols in this program has an allocated GCPHN General Practitioner (Advisor) and practice support officer who assist in driving and supporting the initiative through peer to peer support. This program promotes

	quality improvement from a population health perspective (rather than the disease register focus of Tier 3) Focus area will be defined by first analysing the practice population profile by utilising clinical audit data extraction tools The program promotes a whole of practice team approach to deliver care to selected population groups which could include: • Patients at high risk of poor health outcomes (e.g. multimorbidity, aged and frail – 75 years and older) • Vulnerable groups (Out of home care children, Aboriginal and Torres Strait Islander people, patients with Mental health conditions) • Preventative care to attempt to minimize the development of chronic diseases (proactive health assessment to identify risk factors and implement appropriate interventions to support patient self-care) • Support increased use of My Health Record systems and processes; i.e. uploading and viewing to ensure this becomes BAU in clinical processes • Maximizing digital health processes, including My Health Record; secure messaging and data quality activities and integrating this into quality improvement activities for any focus area selected. Practices will be offered Primary Sense™ clinical audit tool who have compatible software, to support risk stratification and a more detailed level of practice population profile.
Associated Flexible Activity/ies:	HIS 2019.4 Practice Support A. Tier 1 & 2 HSI 2019.3 Primary Sense™ Population Health Management clinical audit tool
Target population cohort	Practice defined cohorts of patients dependent on focus area General Practitioners, Practice Managers, Practice Nurses, practice support staff
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? The activity aims to include Aboriginal and Torres Strait Islander people as an optional focus Yes
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	**GCPHN Staff**- implementation and engagement **General Practice Staff**- implementation and engagement **Peak bodies including RACGP and all relevant accreditation organisations**- Consultation to ensure activity aligns to the standards. **The Australian Digital Health Agency** **GCPHN Primary Health Care Improvement Committee comprising local general practice staff** - provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities. **Practice staff participating in the trial phase of the implementation of Primary Sense™ clinical audit tool** -- implementation and engagement **General Practice Gold Coast (GPGC)** - linkage to ensure consultation and partnership **Queensland Health and Hospital Service, General Practice Liaison Unit (GPGC)**– linkage to ensure consultation and partnership **Quality Improvement Committee –** clinical advisory group **State and National Universities**- exploring potential research collaboration opportunities relating to quality improvement

	ACG Johns Hopkins ACG Risk Stratification tool support team: supporting evidence-based practice and data quality
Collaboration	**GCPHN Staff**- implementation and engagement **General Practice Staff-** implementation and engagement **Peak bodies including RACGP and all relevant accreditation organisations**- Collaboration to ensure activity aligns to the standards. **The Australian Digital Health Agency** **GCPHN Primary Health Care Improvement Committee comprising local general practice staff** - provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities. **Practice staff participating in the implementation of Primary Sense™ clinical audit tool** – informing enhancements and user experience **General Practice Gold Coast (GPGC)** - linkage to ensure collaboration and partnership **Queensland Health and Hospital Service, General Practice Liaison Unit (GPGC)**– linkage to ensure collaboration and partnership **Bond University and Griffith University** – supporting evidence-based practice **ACG Johns Hopkins ACG Risk Stratification tool support team:** supporting evidence-based practice and data quality *List and describe the role of each stakeholder that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services.*
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones? NA
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No

	3b. Has this activity previously been co-commissioned or joint-commissioned? No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	GPS 2019.2 Primary Sense™ Population Health Management and audit tool
Existing, Modified, or New Activity	Modified Activity HSI 2018.3 Practice based population health management using Primary Sense™
Needs Assessment Priority	**Identified local health needs and service issues** • Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza) • My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers • Potential to increase use of data in general practice software to proactively plan care • Frequently current systems (including MBS payments and data) do not support population health approach and care-coordination Page 1 of General Practice and Primary Care Needs Assessment Summary (page 22 of 279 of full Needs Assessment submitted) • Better systems to support care coordination required. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients • Need for greater focus on prevention, early identification and self-management • High rates of smoking and harmful alcohol intake across the region identification and self-management. Page 1 of Chronic Disease Needs Assessment Summary (page 71 of 279 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** Continuous quality Improvement Tier 3 Practice Support • Supported implementation of continuous quality improvement methodologies using practice data to drive improvements and other building blocks of high performing primary care • Collection and use of clinical data to improve the population's health • The General Practice determines priority areas for improvement through review of their clinical data • Development of an action plan utilising a CQI methodology through peer to peer conversations • Develop tailored clinical audit reports to determine baselines measures and monitor improvement over time • Review and monitor progress towards achievements/improvements • Access to decision support tools including cycles of care through GCPHN website. (page 2 of Opportunities, priorities and options, page 255 of 279 of full Needs Assessment submitted) Population health management Tier 4 Practice Support • Improved management of patient health care in general practice

	• Reducing unnecessary referrals and admissions to hospital. GCPHN 3 Opportunities, priorities and options Priority Possible Options Expected Outcome Potential Lead • Allocated Practice Support Officer to facilitate improved comprehensive and patient centred care planning • Develop person centred, goal orientated care plans that align with MBS requirements. • Provide education and training in the use of the care plans template which support utilisation of systematic cycles of care requiring recall and reminder where necessary to support improved patient management. • Provide regular data reports to monitor improvement in care management of patients. (page 2 of Opportunities, priorities and options, page 255 of 279 of full Needs Assessment submitted) Primary Sense Continue refinement and implementation in trial practices of automated pseudonymised data extraction and analysis of the health profile of the entire practice population. This includes generating actionable optimal care reports and create a single integrated healthcare system for the Gold Coast by: • Improving the coordination of care to ensure consumers receive the right care at the right place at the right time by the right person. • Increasing the effectiveness and efficiency of health services for consumers. • Engaging and supporting clinicians to facilitate improvements in our health system. Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management systems and applying evidenced based algorithms. GCPHN with Gold Coast Health (GCH) GCPHN with key stakeholders 4 Opportunities, priorities and options Priority Possible Options Expected Outcome Potential Lead medication safety alerts for general practices, analysed population health data for the practice to inform the service response and for GCPHN needs assessment and other commissioning purposes. Primary Sense: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts of patients at immediate risk from medication prescribing safety issues for consideration by GP

	Page 3 of Opportunities, priorities and options, page 255 of 279 of full Needs Assessment submitted
Aim of Activity	Primary Sense supports general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms • Identifying high risk groups for proactive care • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time. Primary Sense will enable a practice- based population health management approach to reduce unnecessary hospital use by: • Correctly identify which patient groups are suitable for appropriate evidence - based interventions at a local (GP) and regional (PHN) level • Correctly identify patients at risk of poor outcomes on the Gold Coast • Enabling patients to be more effectively managed in primary care Relevant PHN Program National Performance and Quality Framework measures: • P1 - PHN activities address prioritised needs and national priorities • P2 – Health System Improvement and Innovation • P4 - Support provided to general practices and other health care providers • DH3 – Rate of accredited general practice sharing data with PHN O14 - PHN stakeholder engagement
Description of Activity	Automated de-identified data extraction and analysis of the health profile of the entire practice population - generating actionable reports and medication safety alerts for general practices, analysed population health data for the practice to inform the service response, and for GCPHN commissioning purposes: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts to patients at immediate risk from medication prescribing safety issues for consideration by GP

	Primary Sense has been developed as an evidenced based decision assist tool to help inform timely decisions for better primary healthcare. Primary Sense is compatible with Medical Director and Best Practice software (comprising approximately 90% of the general practice software market in the Gold Coast) Further programming of medication safety alerts and reports will continue based on user feedback, and advice from the Quality Improvement Committee. System and process enhancements may include: • Optimising care/service navigation for selected populations based on demographics or diagnoses • Automated access to the Australian Immunisation Register from in the practice • Automation and time stamping of patient consent collection at the practice • Targeted patient selection and alerts for research project recruitment • Outcome monitoring for health activities – such as antimicrobial stewardship • Computerised decision support mechanism for better guideline implementation • Audit and feedback for GP trainee education • Automated chart review for GP training and professional development • Linked databases to better understand potentially preventable hospital admissions • Quality Improvement Clusters – peer review process • Public Health – automated post-market surveillance. Post immunisation adverse event tracking • Public Health early warning of emerging outbreaks/symptom clusters
Associated Flexible Activity/ies:	HSI 2019.5 Primary Care Improvement Program GPS 2019.4 Practice Support A. Tier 1 & 2
Target population cohort	Total practice population where Primary Sense™ is installed
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No
Coverage	The test practices have been drawn from various areas within the Gold Coast. This activity plan seeks to support the roll out of Primary Sense to provide geographical coverage for the whole PHN region, but will be dependant of the practice software and willingness to participate
Consultation	**GCPHN staff**. Staff who provide management of the program that supports general practice to use Primary Sense and other clinical audit and QI tools **General Practice Staff** To provide input and feedback as key users of the activity; co-design of enhancements to the activity as part of the review, implementation and Ongoing user support requirements **Gold Coast Health and Hospital Service/Integrated Care Alliance** Provide input and feedback as key users of the activity; co-design of enhancements to the activity as part of the review, implementation and Ongoing data analytics to support integrated care and Clinical QI activities **Peak bodies including RACGP**

	Consultation with RACGP CEO and Quality Committee members to ensure activity aligns to the standards and best practice guidelines/evidence-based practice **GCPHN Primary Health Care Improvement Committee** With local clinical and non- clinical general practice staff who provide input and advice into the current issues facing general practice, and design and implementation feedback on behalf of General Practice related to Primary Sense and other GCPHN practice support activities **General Practice Gold Coast** Provide ongoing engagement opportunities, communication channels and advice about general practice in the Gold Coast; input into service review, development and evaluation; partner in delivering education and other quality improvement activities **Kalwun Medical Corporation (Gold Coast AMS provider)** Provide ongoing engagement and advice about Aboriginal and Torres Strait Islander People in Primary Sense development activities in the Gold Coast; input into Primary Sense design and development, testing and implementation **Gold Coast Health, national and international specialists, academics** Engage with a variety of local, national and international population health service specialist and researchers to access expert advice and input to Co-design, development, evaluation and implementation activities **Quality Improvement Committee –** clinical advisory group
Collaboration	**General Practice Gold Coast** Test practices provide advice and input into the design, development, testing and implementation change management for Primary Sense **Gold Coast Health General Practice Liaison Unit** Engagement of GPLO to provide advice and guidance about integrated care and population health issues between general practice and Gold Coast Health **Gold Coast Health/Integrated Care Alliance with Gold Coast Health** Provide advice and input into referral, care coordination, service integration and clinical handover **John Hopkins University** Linking with the John Hopkins School of Public Health for use of ACG tool and to customise tool for Australian general practice data **Bond University** Linking with the Medical School and Centre for Research Excellence in Evidence Based Primary Care **Sydney University** Linking with Uni to ensure learnings from BEACH study and licence arrangements for use of ICPC2+ International Coding for Primary Care data
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known

approach to market	☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No

Proposed Activities -	
ACTIVITY TITLE	GPS 2019.3 Practice Support Tier 1 & 2
Existing, Modified, or New Activity	Modified Activity (2016-18 Activity Work Plan)
Needs Assessment Priority	**Identified local health needs and service issues** • Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza) • My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers • Potential to increase use of data in general practice software to proactively plan care • Frequently current systems (including MBS payments and data) do not support population health approach and care-coordination Page 1 of General Practice and Primary Care Needs Assessment Summary (page 22 of 279 of full Needs Assessment submitted) • Better systems to support care coordination required. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients • Need for greater focus on prevention, early identification and self-management • High rates of smoking and harmful alcohol intake across the region identification and self-management. Page 1 of Chronic Disease Needs Assessment Summary (page 71 of 279 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** General practice support Tier 1: • Support the adoption of a Clinical Audit tool with practice data being submitted to GCPHN. • Information, resources and education (delivery of clinician and patient resources) provided though face-to-face, telephone, electronic bulletins, email networks and mail out for areas including: • Public health (immunisation and cancer screening) • E-referrals from primary to secondary/tertiary and nongovernment agencies • Transition to 5th Edition Standards of Accreditation • Compliance with ePIP and QPIP Entry Level Quality Improvement Tier 2 • Practices enrolled are provided with quarterly reports which includes O a practice profile and O analysis of clinical data identifying key trends and areas for improvements • Support for effective data entry, data cleaning and quality assurance processes Page 1 of Opportunities, priorities and options (page 254 of 279 of full Needs Assessment submitted)
Aim of Activity	The aim is to support general practice in the adoption of evidence based, best practice methodology and meaningful use of digital systems. To also promote quality improvement, the uptake of practice accreditation and to ensure timely provision of information, resources and education to support changes in

	programs and policy that impact on general practice. This activity will also provide support to practices with Quality PIP requirements.
Description of Activity	Supporting general practices to deliver safe, high quality, data informed, evidence-based care to their communities. **Tier 1:** Engagement • Support to adopt a Clinical Audit tool and submission of deidentified practice data to GCPHN. • Provide support to meet requirements of Practice Incentive Program Quality Improvement • Introduction of an enhanced data extraction tool into general practice that incorporates a risk stratification tool to Practices with Medical Director and Best Practice to trial and test. • Increase engagement with the practice team by providing an annual face to face visit by a dedicated PSO to increase awareness of GCPHN support initiatives, including clinical audit initiatives aligned with PIP QI requirements. • Provide information, resources and education (delivery of clinician and patient resources) through face to face, telephone, electronic bulletins, email networks and the post for areas including: o Preparation for and to meet requirements of PIP QI o Public health i.e. immunisation and cancer screening o E-referrals from primary to secondary/tertiary and non-government agencies o Transition to 5th Edition Standards of Accreditation o Digital health systems and processes – including My Health Record **Tier 2:** Data quality • GCPHN provides enrolled practices with quarterly data reports which includes a practice profile and analysis of their clinical data. This can support the identification of key trends and potential areas for improvements to clinical outcomes or practice processes. • Increase engagement with practice team by providing an annual face to face visit by a dedicated PSO to increase awareness of GCPHN support initiatives, including clinical audit initiatives aligned with PIP QI requirements. • Promote a whole team approach to QI activities. • Promote digital health – My Health Record processes and systems with support for the practical applications. • Provide support to meet requirements of PIP QI for participating practices • Improving data quality through ensuring effective data entry, data cleaning and quality assurance processes, using markers such as increasing the recording of allergy status recorded in active patient records to >90% as measures of quality. • Building a data repository (increasing those submitting data) and accuracy (through data cleaning and data entry activities) to inform current and future GCPHN activities such as needs assessment and service development.

Associated Flexible Activity/ies	HSI 2019.5 Primary Care Improvement Program HSI 2019.6 Primary Sense™ Population Health Management and audit tool
Target population cohort	Practice defined cohorts of patient's dependant on focus area General Practitioners, Practice Managers, Practice Nurses and Practice Support staff
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	**GCPHN Staff**- implementation and engagement **General Practice Staff-** implementation and engagement The Australian Digital Health Agency **Peak bodies including RACGP and all relevant accreditation organisations**- Consultation to ensure activity aligns to the standards. **GCPHN Primary Health Care Improvement Committee comprising local general practice staff** - provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities. **Practice staff participating in the implementation of Primary Sense™ clinical audit tool** – implementation and engagement **General Practice Gold Coast (GPGC)** - linkage to ensure consultation and partnership **Queensland Health and Hospital Service, General Practice Liaison Unit (GPGC)**– linkage to ensure consultation and partnership **Bond University and Griffith University** – supporting evidence-based practice **Public Health Unit-** consultation and partnership **My Health for Life-** consultation and partnership **Pen CS-** consultation and partnership
Collaboration	**GCPHN Staff**- implementation and engagement **General Practice Staff-** implementation and engagement The Australian Digital Health Agency **Peak bodies including RACGP and all relevant accreditation organisations**- Collaboration to ensure activity aligns to the standards. **GCPHN Primary Health Care Improvement Committee comprising local general practice staff** - provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities. **Practice staff participating in the implementation of Primary Sense™ clinical audit tool** – informing enhancements and user experience **General Practice Gold Coast (GPGC)** - linkage to ensure collaboration and partnership **Queensland Health and Hospital Service, General Practice Liaison Unit (GPGC)**– linkage to ensure collaboration and partnership **Bond University and Griffith University** – supporting evidence-based practice **Primary Care Training Providers I.e. Pharmacy Guild, Pharmaceutical Society of Australia, General Practice Gold Coast, National Prescribing Service, Australian Primary Health Care Nurses Association, Gold Coast Medical Association, Royal Australian College of General Practitioners, Local**

	Universities - Linkage to ensure collaboration and avoid duplication of training events.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Ongoing business as usual activity Any other relevant milestones? NA
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No