Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2018-2019:

Core Funding

General Practice Support Funding

After Hours Funding

Gold Coast Primary Health Network

Please follow the below steps (and the instruction sheet) for completing your Activity Work Plan (AWP) template for 2018-19:

1. **Core Operational and Flexible Funding** 2018-2019 has three parts:
    a) Provide a link to the strategic vision published on your website.
    b) Complete the table of planned activities funded by the *Core Flexible Funding Stream* under the Schedule – Primary Health Networks Core Funding (including description of any Health Systems Improvement (HSI) activity to support delivery of commissioned activity).
    c) Complete the table of planned activities funded by the C*ore Operational Funding Stream: HSI*[1] under the Schedule – Primary Health Networks Core Funding and planned activities under the Schedule – **General Practice Support Funding**[2].

2. **After Hours Primary Health Care Funding** 2018-2019 has two parts:
    a) Provide strategic vision for how your PHN aims to achieve the After Hours key objectives.
    b) Complete the table of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Health Care Funding.

[1] HSI Funding is provided to enable PHNs to undertake a broad range of activities to assist the integration and coordination of health services in their regions, including through population health planning, system integration, stakeholder engagement and support to general practice. HSI activities will also support the PHN in commissioning of health services in its region.

[2] Planned activities under the Schedule - General Practice Support Funding have been combined with the HSI activities to lessen the reporting burden on PHNs.

When submitting this Activity Work Plan 2018-2019 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and that it has been endorsed by the CEO.

The Activity Work Plan must be lodged to your Program Officer via email on or before four (4) weeks after the execution of the Core Schedule Deed of Variation.

Overview

The key objectives of Primary Health Networks (PHN) are:

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care in the right place at the right time.

Each PHN must make informed choices about how best to use its resources to achieve these objectives.

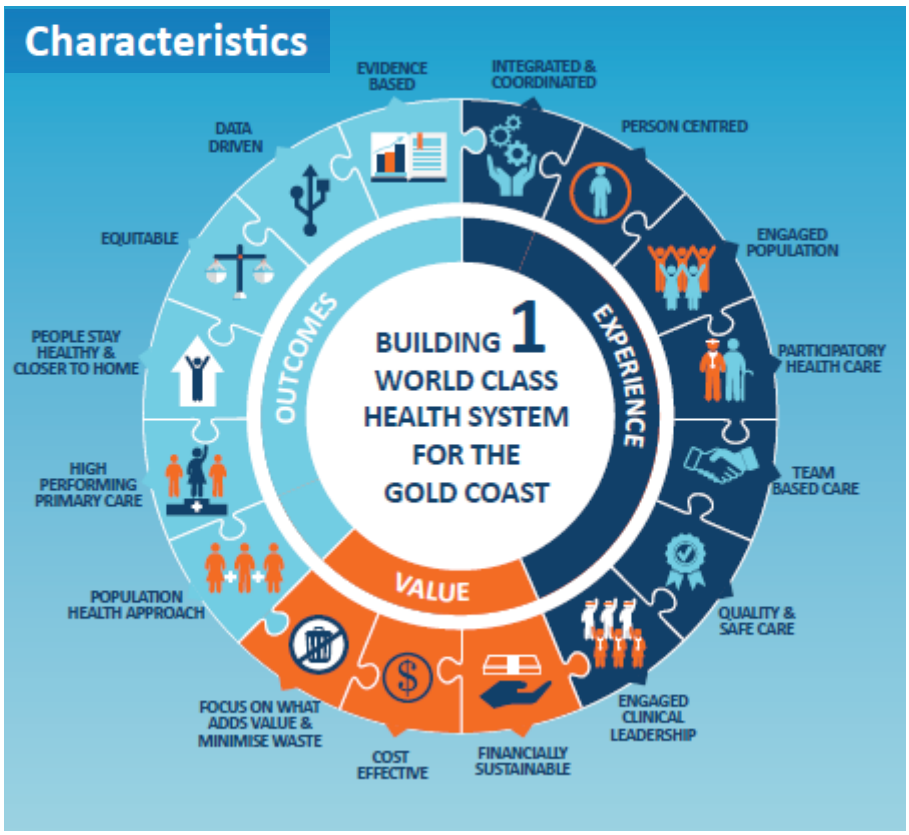
This Activity Work Plan covers the period from 1 July 2018 to 30 June 2019.

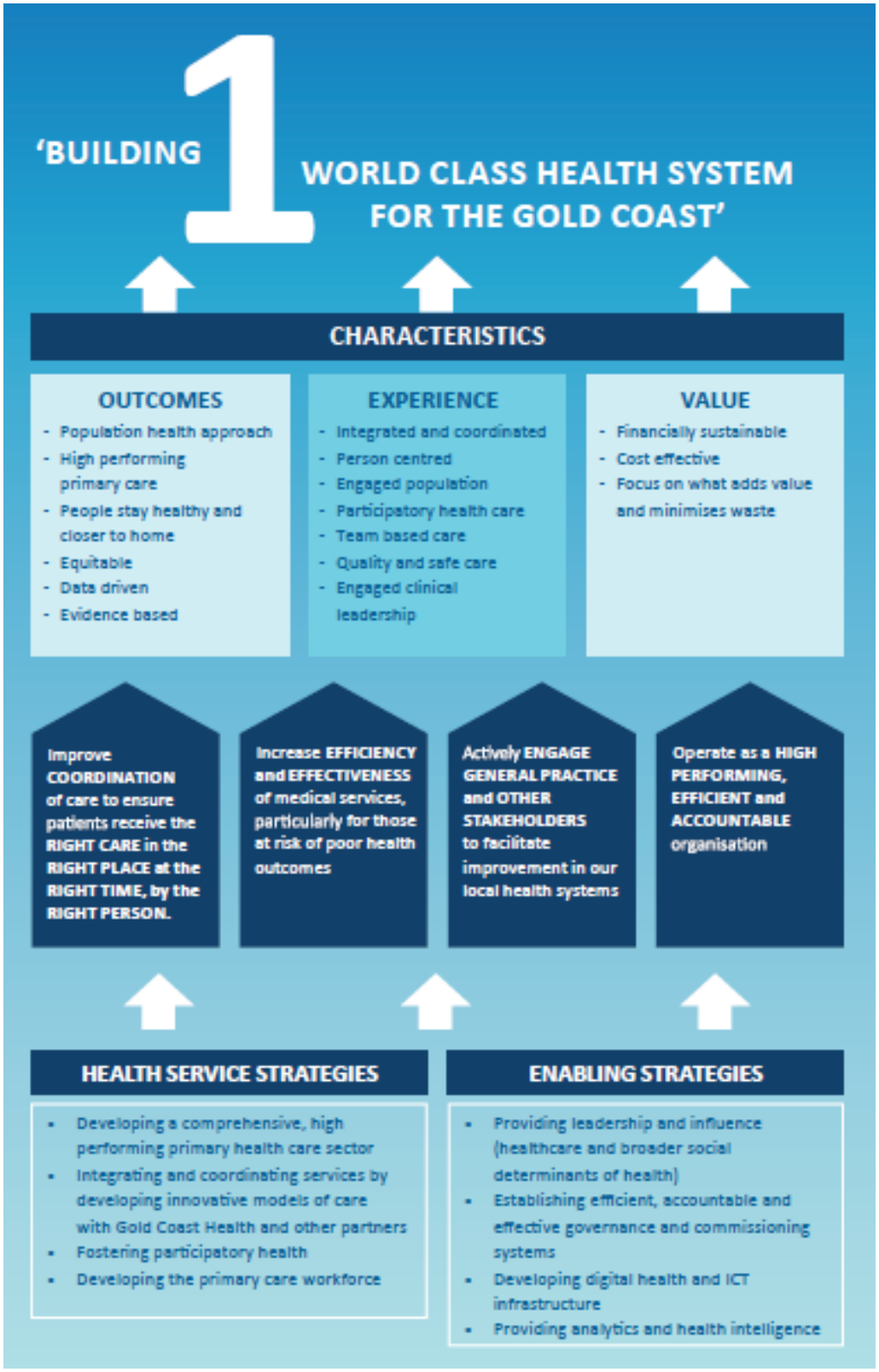
1. (a) Strategic Vision for PHN

Please provide a link to your organisation's strategic vision published on your website.

Local Context

On 1 July 2015, the Primary Care Gold Coast commenced as the Gold Coast PHN, establishing its vision and goals aligned with Commonwealth government expectations. Our Vision is 'Building one world class health system for the Gold Coast". GCPHN's Strategic plan sets out what the characteristics of one world class health system for the Gold Coast are as depicted in the below diagram. The Strategic Goals and Strategies to achieve our Vision are underpinned by a commitment to the Triple Aims of improving Outcomes, Experience and Value.




'BUILDING 1 WORLD CLASS HEALTH SYSTEM FOR THE GOLD COAST'
CHARACTERISTICS
OUTCOMES
- Population health approach
- High performing primary care
- People stay healthy and closer to home
- Equitable
- Data driven
- Evidence based
EXPERIENCE
- Integrated and coordinated
- Person centred
- Engaged population
- Participatory health care
- Team based care
- Quality and safe care
- Engaged clinical leadership
VALUE
- Financially sustainable
- Cost effective
- Focus on what adds value and minimises waste
Improve COORDINATION of care to ensure patients receive the RIGHT CARE in the RIGHT PLACE at the RIGHT TIME, by the RIGHT PERSON.
Increase EFFICIENCY and EFFECTIVENESS of medical services, particularly for those at risk of poor health outcomes
Actively ENGAGE GENERAL PRACTICE and OTHER STAKEHOLDERS to facilitate improvement in our local health systems
Operate as a HIGH PERFORMING, EFFICIENT and ACCOUNTABLE organisation
HEALTH SERVICE STRATEGIES
- Developing a comprehensive, high performing primary health care sector
- Integrating and coordinating services by developing innovative models of care with Gold Coast Health and other partners
- Fostering participatory health
- Developing the primary care workforce
ENABLING STRATEGIES
- Providing leadership and influence (healthcare and broader social determinants of health)
- Establishing efficient, accountable and effective governance and commissioning systems
- Developing digital health and ICT infrastructure
- Providing analytics and health intelligence

GCPHN Values

1. (b) Planned PHN activities

– Core Flexible Funding Stream 2018-19

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	CF 2017.1 Integrated Care Alliance (ICA) – HealthPathways Development
Existing, Modified, or New Activity	Modified activity (2016-18 Activity Work Plan – Reference NP 2017.1 Integrated Care Alliance (ICA)).
Program Key Priority Area	Select one of the following: Digital Health If Other (please provide details): System Integration (HSI Component)
Needs Assessment Priority Area (eg. 1, 2, 3)	Lines 16 and 17 pages 23 - 28 Section 4 page 56 Chronic disease care coordination Communication and co-ordination to support holistic transition of care for patients; focus on relationships between primary and acute services Section 4 page 56 • Chronic disease care coordination • Use digital health platforms and health pathways • Joint training opportunities • Preventable hospitalisations Investigate options to co-case conference with GPs/health workers/care coordination in the care of A&TSI patients to ensure everyone involved with the patient is kept abreast of the client progress and care plan. The need for health pathways and information and resources to support standardised care across the continuum between Primary, Community and Secondary Sectors has been identified in the needs assessment across a number of health service areas, including mental health, AODs, Aboriginal and Torres Strait Islander Health and Chronic Disease Management. The needs assessment recommended investigating options to address this need including the use of clinical and service navigation tools and improved access to information and resources.
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 an e-library solution (Healthpathways).** 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 • P7 - Rate of GP style emergency department (ED) presentations • P11 - Rate of discharge summaries uploaded to My Health Record • P12 - Rate of potentially preventable hospitalisations • O14 - PHN stakeholder engagement
Description of Activity	**Implement HealthPathways to support the implementation of new models of care.** Following a review of the chronic disease services on Gold Coast in November 2016 which was inclusive of the initial work achieved by the GCIC program, and further planning with GCHHS in early 2017, a decision was made by GCHHS and GCPHN to form an Integrated Care Alliance (ICA), to further progress the integration agenda beyond the conclusion of the GCIC program in September18. **HSI Component** - Work has commenced on development of new integrated models of care for 17 disease conditions, commencing with broad based community and MDT workshops in September 2017. GCPHN will fund GP and primary care practitioners to attend and participate in models of care development. These workshops will continue to refine models of care to 30 December 2018. From 1 September 18 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. This phase will be complete by 31 December 2018. The

<table>
<tr><td></td><td>development and redesigned models of care will facilitate improved experience and outcomes for patients and the workforce across the continuum of care.

Flexible funding component - The major body of work for GCPHN in 18/19 will involve the implementation of a 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. HealthPathways may be selected as the e-library solution (see Commissioning method below) which will be used as the electronic infrastructure to support the implementation of the new models of care.

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.</td></tr>
<tr><td>Target population cohort</td><td>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.</td></tr>
<tr><td>Consultation - HSI Component</td><td>HSI funding in 18/19 will continue to support:
Staff Engagement with GCH and private providers to determine a shared approach to improving patient outcomes and reducing avoidable hospitalisations through the development of models of care and the selection of HealthPathways.
GCPHN staff will support this through engaging with a broad range of health professionals and consumers to identify and design the models of care for translation onto health pathways. GCPN staff will provided a program management function to support the commissioning of HealthPathways development.</td></tr>
<tr><td>Collaboration - HSI Component</td><td><table><tr><th>Stakeholder</th><th>Role</th></tr><tr><td>Gold Coast Health</td><td>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.</td></tr><tr><td>GPs and allied health and private specialists</td><td>In the development of models of care and the subsequent translation of these onto HealthPathways</td></tr></table></td></tr>
</table>

<table>
<tr><td></td><td><table><tr><td>Consumers</td><td>to ensure models of care are developed with appropriate consideration of consumers input and needs.</td></tr></table></td></tr>
<tr><td>HSI Component – Other</td><td>Provide a summary of other HSI components required for this activity eg. staff, planning, contract administration, monitoring and evaluation.<table><tr><th>HSI component</th><th>Contribution to this activity</th></tr><tr><td>Staff and management</td><td>Engagement, consultation, planning, service design, program/project management</td></tr><tr><td>Needs assessment, planning and engagement</td><td>Consumer and primary care engagement</td></tr><tr><td>Procurement and contract management</td><td>Agreements for clinical engagement, procurement of HealthPathways etc</td></tr><tr><td>Performance monitoring, reporting and evaluation</td><td>Regular reporting and evaluation plan</td></tr><tr><td>Practice support</td><td>General practice engagement and change management support</td></tr></table></td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>The joint meeting of the GCPHN/ GCHHS board meeting in June 18 adopted a recommendation to endorse the further development of the ICA based on a proposal for a five year plan. Activity for 18/19 will include:
Implementation plan complete by 30 June 18
Finalisation of the models of care with mobilisation to commence on 1 October for three MoC
Fast tracking of a e-library (HealthPathways) solutions on which to host agreed pathways and models of care
Complete mobilisation of all MoC by 30 June 2019 hosted on a commissioned e-library (HealthPathways) solution.</td></tr>
<tr><td>Coverage</td><td>ICA – whole of Gold Coast region population (approximating GC LGA and GC HHS regions)</td></tr>
</table>

Commissioning method (if known)	GCH and GCPHN have agreed to fast tracking of a e-library (HealthPathways) solution on which to host agreed pathways and models of care. This will involve a rapid assessment (July-Sept 18) of potential options for a e-library. Given that HealthPathways is being used by most jurisdictions in Qld, and considerable synergies in learning and implementation, and continuous development can be achieved by a consistent tool, it is highly likely (dependant on the rapid review recommendations) that a direct approach to market will be made to commission *Streamliners* or another organisation to implement HealthPathways. Except for a program management function (described in HSI Component above) no staff costs will be incurred in the implementation of HealthPathways**.**

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	CF 2017.2 Transfer of Care
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan – Reference NP 2017.2 Transfer of Care).
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details):
Needs Assessment Priority Area (eg. 1, 2, 3)	Line 33 pages 49 -51 Section 4 page 59 Interoperability, General Practice Liaison Officer (GPLO) and My Health Record Poor interoperability, use and understanding of clinical data systems between primary, secondary and other services further inhibits information sharing and care-coordination - GPLO to continue to improve referral templates and guidelines through the CPC process. Review quality of referrals and address issues identified through education/information to general practice. - Focus on discharge information to primary care - Support the implementation of State-wide clinical prioritisation criteria
Aim of Activity	The aim of GCPHN's contribution to this program is to respond to identified health priorities by commissioning a team of health professionals to improve patient care across the continuum of care – specifically electronic discharge summaries, outpatient letters and standardised referrals from general practice. Poor clinical handover results in poor health outcomes, higher re-admission rates, and medication errors. 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 • P7 - Rate of GP style emergency department (ED) presentations • P11 - Rate of discharge summaries uploaded to My Health Record • P12 - Rate of potentially preventable hospitalisations • O14 - PHN stakeholder engagement

	Expected results of this activity include the following local performance measures: • improvement in number / percentage of electronic discharge summaries completed • improvement in number / percentage of discharge summaries sent within 48 hours of discharge • increased number / percentage of appropriate e-referrals to GCH.

Description of Activity	**A jointly funded General Practice Liaison Unit (GPLU) established with the Gold Coast Hospital (GCH) to improve clinical handover.**
	• The Unit is staffed by a GPLO (a GP), a program manager, project officer and administrative officer who have joint reporting and accountability to GCH and GCPHN
	• GPLU will work with GCH and primary care clinicians to:
	  ○ improve timely communication including discharge summaries and clinical results to primary care
	  ○ improve timeliness and quality of discharge summaries and clinical results
	  ○ reduce unnecessary referrals to specialist outpatients
	  ○ improve referral templates and guidelines including supporting the implementation of State-wide Queensland Health clinical prioritisation criteria through development of templates, testing and communication with general practice
	  ○ review quality of referrals and address issues identified
	  ○ implement an annual education calendar of events for general practice
	  ○ provide initial advice on implications and requirements of any GCH led workforce redesign and clinical and service changes and support broader consultation if required.
	• Engagement with private hospitals will leverage some experiences in working with the public system, but also account for the unique differences in clinical handover experienced by private specialists and public hospitals. Initial meetings with private hospitals in 1718 have developed some strategies to progress into 18/19, particularly relating to the uptake of MHR.

Target population cohort	Gold Coast residents who access GCH public services

<table>
<tr><td>Consultation - HSI Component</td><td>Extensive consultation undertaken with senior GCH staff and other members of the Executive Steering Committee to determine priorities for the GPLU.</td></tr>
<tr><td>Collaboration - HSI Component</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>GCPHN and Gold Coast Health</td><td>Joint management of GPLU through includes bi annual meeting between meetings of the GCH and GCPHN Executive Steering the GCH and GCPHN Boards, monthly Committee (ESC) which included executive managers, a general practitioner and community provider representatives. This activity is a strong collaborative partnership between the GCH Services and GCPHN.</td></tr>
<tr><td>Queensland Health
CheckUP General Practice Liaison Officer network</td><td>CheckUp has a 3-year contract with Queensland Health (2016-2019) to support Queensland Health GPLO Network</td></tr>
<tr><td>Private hospitals and specialists</td><td>Joint strategies to improve clinical handover</td></tr>
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<tr><td>HSI Component – Other</td><td>
<table>
<tr><td>HSI component</td><td>Contribution to this activity</td></tr>
<tr><td>Staff and management</td><td>PHN Exec, Program Management</td></tr>
<tr><td>Procurement and contract management</td><td>Agreements with GCH</td></tr>
<tr><td>Performance monitoring, reporting and evaluation</td><td>Regular reporting and evaluation plan</td></tr>
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</td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Continues to 30 June 2019</td></tr>
<tr><td>Coverage</td><td>Gold Coast PHN Region (Gold Coast SA4)</td></tr>
<tr><td>Commissioning method (if known)</td><td>This program has been commissioned to GCH since 2016/17 through a direct approach. All staff are employed by GCH but joint governance and reporting relationships exists between GCPHN and GCH to ensure the program remains aligned to GCPHN needs assessment. Joint work plans are developed, agreed and monitored regularly, with associated KPIs monitoring. There is no other services that provide this functionality, nor any duplication of any other State funded services.

No GCPHN staff are funded through this program. The commissioning of this program to GCH enables greater access to the acute care clinicians and systems required to improve the clinical handover to</td></tr>
</table>

	general practice. GCPHN has found that previous GPLU teams employed by GCPHN did not have the access, or influence to enact change within GCH. The GCH employed team still retains influence with general practice though the GP on the team.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	CF 2017.4 Access to health services for the homeless (HealthyGC+)
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan – Reference NP 2017.4 Access to health services for the homeless (HealthyGC+))
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details): Hard to Reach
Needs Assessment Priority Area (eg. 1, 2, 3)	Line 19 page 30 – 34 Social disadvantage and homelessness Section 4 page 52 Access to health services for people of low socio-economic status, homelessness and social disadvantage
Aim of Activity	This activity aims to utilise podiatry and social work services as a gateway to broader referrals to primary health care services including mental health services for people who are homeless or are at risk of homelessness at St John's Drop-In-Centre. Relevant PHN Program National Performance and Quality Framework measures: • P1 - PHN activities address prioritised needs and national priorities • P2 – Health System Improvement and Innovation • O14 - PHN stakeholder engagement
Description of Activity	Known as HealthyGC+ this activity services disadvantaged, homeless and vulnerable clients visiting St John's Drop-In-Centre. The service is operated as a collaborative, person centred model between Surfers Paradise Crisis Care and Southern Cross University. This activity addresses the needs of this hard to reach group, many of whom that attend the centre do not seek primary health care services due to self-esteem, confidence, and or mental health issues. This model also utilises supervised student clinics. Podiatry services are delivered on site by students from Southern Cross University with appropriate clinical supervision. Podiatry students can make referrals to other relevant agencies, including General Practices and subsequently mental health services in the local area. 28 x 4 hour clinics will be delivered in 18/19. This project links very closely with the provision of social work services at the centre which is funded under Hard to Reach Psychological Services.

<table>
<tr><td></td><td>Expected results in increases access for vulnerable population groups through the delivery of podiatry services and referrals to other health services for the target group. It also provides workforce development for Podiatry students</td></tr>
<tr><td>Target population cohort</td><td>People who are homeless or at risk of homelessness</td></tr>
<tr><td>Consultation - HSI Component</td><td>Discussions were held with Southern Cross University around the success of the project to date as well as how to engage hard to reach vulnerable and homeless clients. This included feedback from clients on the value of the podiatry services which had been collected as part of their monitoring and evaluation.

Surfers Paradise Anglican Crisis Care (SPACC) also confirmed their view that the podiatry services were valued by clients and provided a good method of engaging this hard to reach group.</td></tr>
<tr><td>Collaboration - HSI Component</td><td><table><tr><th>Stakeholder</th><th>Role</th></tr><tr><td>Southern Cross University</td><td>Service delivery (podiatry) through student lead clinics</td></tr><tr><td>Surfers Paradise Anglican Crisis Care (SPACC).</td><td>Provision of venue and logistical support</td></tr></table></td></tr>
<tr><td>HSI Component – Other</td><td><table><tr><td>HSI component</td><td>Contribution to this activity</td></tr><tr><td>Staff and management</td><td>PHN Exec, Management and Project officer/s</td></tr><tr><td>Needs assessment, planning and engagement</td><td>Consumer and primary care engagement</td></tr><tr><td>Procurement and contract management</td><td>Agreements with Contractor</td></tr><tr><td>Performance monitoring, reporting and evaluation</td><td>Regular reporting and evaluation plan</td></tr></table></td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Project originally established in 2015/16, continuing to June 2019</td></tr>
<tr><td>Coverage</td><td>Surfers Paradise Anglican Crisis Care “St John’s Drop in Centre”, Surfers Paradise SA3</td></tr>
<tr><td>Commissioning method (if known)</td><td>Contract variation - GCPHN will renew its existing contract for primary allied health podiatry services with Southern Cross University who provide podiatry students and qualified Podiatry Supervisor. Original contracted through direct approach to Southern Cross University as a part of the existing collaborative.</td></tr>
</table>

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	CF 2017.5 Turning Pain into Gain
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan – Reference NP 2017.5 Turning Pain into Gain)
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details): Chronic Disease
Needs Assessment Priority Area (eg. 1, 2, 3)	**Local health needs and service issues GCPHN Needs Assessment Persistent Pain Summary 2017** • High rates of musculoskeletal conditions in Gold Coast North and Coolangatta • Ageing population means more musculoskeletal conditions projected • Pain-related GP treatments frequently focus on prescribing 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
Aim of Activity	The aim of this activity is to promote self-management of pain through education and peer support, with limited allied health services where required. 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 • 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 persistent pain.

Description of Activity	Turning Pain into Gain is an innovative primary care model 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 • Development of 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 This activity addresses the needs by providing coordinated health services focussed on provision of evidence-based interventions, and information through a self-management 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 • Require improved self-management strategies and skills to optimise ongoing care • Are able to participate in group education • Have an English language capacity sufficient to understand the written and spoken materials being presented • Are able to give voluntary, informed consent for the ongoing collection of audit data.
Consultation - HSI Component	Consultation with contractors as part of ongoing contract monitoring and performance management processes including specific feedback from: ○ referring GPs and practice nurses ○ patients and families ○ specialists ○ Griffith University evaluation of program

<table>
<tr><td></td><td>The youth focussed component of the program (20-35yrs) has been co-designed with patients and health care providers. Pain Management is included as a priority area within the Integrated care Alliance</td></tr>
<tr><td>Collaboration - HSI Component</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>General Practitioners</td><td>Referrers to the program and offered annual education sessions</td></tr>
<tr><td>Contractor</td><td>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)</td></tr>
<tr><td>GCPHN</td><td>Promotion of program
Gold Coast Region Needs Assessment for Persistent Pain</td></tr>
<tr><td>GCH Pain Clinic</td><td>Collaboration with Contractor to ensure alignment of programs and effective use of referral pathways by specialists and general practitioners.</td></tr>
<tr><td>Griffith University</td><td>Evaluation</td></tr>
</table>
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<tr><td>HSI Component – Other</td><td>
<table>
<tr><td>HSI component</td><td>Contribution to this activity</td></tr>
<tr><td>Staff and management</td><td>PHN Exec, Management and Project officer/s</td></tr>
<tr><td>Needs assessment, planning and engagement, communications</td><td>Consumer and primary care engagement</td></tr>
<tr><td>Procurement and contract management</td><td>Agreements for contractors etc</td></tr>
<tr><td>Performance monitoring, reporting and evaluation</td><td>Regular reporting and evaluation plan</td></tr>
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</td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Continues to 30 June 2019</td></tr>
<tr><td>Coverage</td><td>Gold Coast PHN Region (Gold Coast SA4)</td></tr>
<tr><td>Commissioning method (if known)</td><td>Contract extension with existing provider.</td></tr>
</table>

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	CF 2017.6 Enhanced Primary Care in RACFs.
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan. Refer - NP 2017.9 Enhanced Primary Care in RACFs).
Program Key Priority Area	Select one of the following: Aged Care If Other (please provide details): Primary Care delivering services to residents of Residential Aged Care Facilities (RACFs)
Needs Assessment Priority Area (eg. 1, 2, 3)	**Local health needs and service issues – GCPHN Needs Assessment 2017 Older Adults Summary** • 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 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 • P2 – Health System Improvement and Innovation • P4 - Support provided to general practices and other health care providers • P7 - Rate of GP style emergency department (ED) presentations • P8 - Measure of patient experience of access to GP • 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 • AC2 - Rate of people aged 75 and over with a GP health assessment • 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 RACF enrolled to engage a designated Clinical Nurse to "Champion" one day a week and support General Practitioners to drive comprehensive multidisciplinary care planning including advanced care planning utilising evidenced based pathways and resources. The program includes
	
	• Embedding RACGP Silver book guidelines by providing access to simplified cycle of care and decision support tools aligned to the Guidelines
	
	• Provision of education and training to support General Practitioners and RACF Clinical Nurses and other RACF and GP on
	  ○ Qld End of Life Care planning and advanced care planning.
	  ○ ISBAR clinical communication tool
	• Ensuring RACF management involvement and leadership through regular meetings and reporting.
	• Supporting & coaching of "champions" within targeted RACFs.
	
	This component links closely with "HSI 2018.1 Access to information and resources" activity

Target population cohort	Residents of six Gold Coast RACFs , who are at risk of poor health outcomes due to geriatric syndromes, complex comorbid chronic disease sets, frailty and barriers to access to timely appropriate health care.
Consultation - HSI Component	This activity has been developed based on extensive consultation with General Practices, RACFs and Gold Coast Health as well as through the Multidisciplinary Aged Care Service Providers, following the lessons learned from the Better Health Care Connections – Multidisciplinary Aged Care Coordination Project 2014-2017. Final Evaluation Report March 2018.

<table>
<tr><td></td><td></td></tr>
<tr><td>Collaboration - HSI Component</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>General Practice, RACFs and Multidisciplinary Service Providers</td><td>implementing the model</td></tr>
<tr><td>Gold Coast Health</td><td>Supporting collaboration and RACF/GP through a range of frail aged strategies including alignment to the QLD State Wide End of Life Strategy and outreach Services offered locally
Training and support to staff implementing Advance Care Planning.</td></tr>
<tr><td>RACGP</td><td>Advice and direction with the utilisation of the RACGP Silver book guidelines - Medical care of older persons in residential aged care facilities</td></tr>
<tr><td>Metro South Brisbane Hospital and Health Service</td><td>administration of advance care planning documentation</td></tr>
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</td></tr>
<tr><td>HSI Component – Other</td><td>
<table>
<tr><td>HSI component</td><td>Contribution to this activity</td></tr>
<tr><td>Staff and management</td><td>PHN Exec, Management and Project officer/s</td></tr>
<tr><td>Needs assessment, planning and engagement</td><td>Consumer and primary care engagement</td></tr>
<tr><td>Procurement and contract management</td><td>Agreements for contractors etc</td></tr>
<tr><td>Performance monitoring, reporting and evaluation</td><td>Regular reporting and evaluation plan</td></tr>
<tr><td>Practice support</td><td>General practice engagement</td></tr>
</table>
</td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Continuing to June 2019</td></tr>
<tr><td>Coverage</td><td>Targeted Residential Aged Care Facilities within Gold Coast PHN region and their Regular GPs</td></tr>
<tr><td>Commissioning method (if known)</td><td>Service Agreement with RACFs who have expressed an interest in participating in the program</td></tr>
</table>

(c) Planned PHN activities

– Core Operational Funding Stream: Health Systems Improvement 2018-19

– General Practice Support Funding 2018-19

Please complete this table for Core Operational Funding Stream b) Health Systems Improvement (HSI)[3] and planned activities under the General Practice Support Funding Schedule only. Stream a) Corporate Governance, should not be included. Do not include HSI activities previously specified in 1. (b) Planned PHN activities – Core Flexible Funding 2018-19.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	HSI 2018.1 Access to information and resources
HSI/GPS Priority Area	Select one of the following: Other (please specify) If Other, please provide details: Provision of health service information and resources to support primary care and system Integration. Also provides communication and engagement channel to support the community and sectors around Population health needs analysis, annual planning, health system service codesign, procuring and contracting, performance monitoring, quality, risk and evaluation, and stakeholder engagement
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan – Reference NP 2018.6 Access to information and resources (renamed from service access))
Aim of Activity	The activity aims for general practice, consumers, primary care sector and community providers to have access to readily available, evidence based information, resources, service and referral options, tailored specifically to the Gold Coast region. 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 • P13 - Numbers of health professionals available

	• O14 - PHN stakeholder engagement
Description of Activity	The activity addressed the needs through delivery of a patient centred, coordinated services is hampered by fragmented local services that are difficult for providers and the community to navigate. This issue is raised in most sector consultations and features in other priority areas such as aged care, chronic disease, mental health and AODs. Access to information to support referral and through a comprehensive web based health and wellbeing information portal has been identified as a way to provide locally tailored and contemporary information to general practice, primary care service providers and the broader community. GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing 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 • professional resources • patient facing resources • a detailed local service directory. In addition, other software options will be reviewed and compared to ensure the service continues to function in the most effective and efficient way. Increase direct links to local service provider information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways. Engage stakeholders to explore options for most effective ways to increase communication, awareness and referral and service pathways between service providers. Work cooperatively with National Health Service Directory 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

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- 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.
</td></tr>
<tr><td>Supporting the primary health care sector</td><td>

Outline how the activity will support the primary health care sector.

The activities enable the primary health care sector to be inform, be engaged in and shape the access, referral pathways, needs assessment, planning and co-design of current primary and intermediate care services as well as 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
- To inform, be engaged and contribute through an extensive set of communications and engagement channels and programs
</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>GCPHN staff and General Practice Staff</td><td>Implementation & engagement</td></tr>
<tr><td>Peak bodies including RACGP, AGPAL and GPA</td><td>Consultation to ensure activity aligns to the standards.</td></tr>
<tr><td>GCPHN Primary Health Care Improvement Committee comprising local general practice staff</td><td>provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities.</td></tr>
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	General Practice Gold Coast (GPGC)	Linkage to ensure collaboration and partnership
	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.
Duration	Continuing to June 2019	
Coverage	Gold Coast PHN Region (Gold Coast SA4)	
Expected Outcome	Outline the expected outcome of this activity as it relates to the PHN objectives. The activities ensure that the primary health care sector are kept informed, with opportunity to be engaged in and shape the access, referral pathways, needs assessment, planning and co-design of current primary and intermediate care services as well as 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 To ensure Primary Care and General Practice are informed, engaged in and contribute through an extensive set of communications and engagement channels and programs	

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. HSI or GPS)	HSI 2018.2 Commissioning Systems and Stakeholder Engagement
HSI/GPS Priority Area	Select one of the following: Other (please specify) If Other, please provide details: Population health needs analysis, annual planning, health system service codesign, procuring and contracting, performance monitoring, quality, risk and evaluation, and stakeholder engagement
Existing, Modified, or New Activity	Existing activity (2016-18 covered in core operational activity).
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 • O6 - PHN Board approves strategic plan • O5 - PHN Board has a regular review of its performance • 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 Flexible Funding, 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

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- Market assessment and Service co-design
- Procurement and contracting
- Performance monitoring, Quality, Risk and Evaluation
- Stakeholder Engagement, communications and marketing

</td></tr>
<tr><td>Supporting the primary health care sector</td><td>

The 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

</td></tr>
<tr><td>Collaboration</td><td>

Stakeholder	**Role**
General Practice Gold Coast	Advice and input into the service review, development and engagement of Gold Coast General practice in PHN and partner activities
Primary Care Partnership Council	Advice and input into the service review, development and engagement of Gold Coast Primary Care Sector in PHN and partner activities
Karulbo Partnership	Advice and input into the service review, development and engagement of Aboriginal and Torres Strait Islander People in PHN and partner activities
General Practice Liaison Unit	Liaison between general practice and Gold Coast Health
Gold Coast Health	Advice and input into referral, care coordination, service integration and clinical handover
Gold Coast Health specialists, academics and local providers	Health Service Provider engagement in Co-design and procurement.
National Health Service Directory, 13 Health	Sharing and refining service directory information

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Duration	Ongoing.
Coverage	whole PHN region
Expected Outcome	Outline the expected outcome of this activity as it relates to the PHN objectives. The activities will ensure that the primary health care sector is able to be informed, 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

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. HSI or GPS)	HSI 2018.3 Practice based population health management using Primary Sense
HSI/GPS Priority Area	Select one of the following: Population Health Planning If Other, please provide details:
Existing, Modified, or New Activity	New (developed from earlier project with using 2016-18 Innovation Grant funding)
Aim of Activity	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 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. 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
Supporting the primary health care sector	An evidenced based decision assist tool to help inform timely decisions for better primary healthcare. Primary Sense is compatible with Medical Director Software, with work already underway to make compatible with Best Practice
Collaboration	**Clinical advisory group** including academics, expert and local GPs
Duration	Test with 7 practices from 1 July 2018, roll out to commence once test period is validated
Coverage	The test practices are from various areas within the Gold Coast. Roll out will aim to provide geographical coverage, but will be dependant of the practice software and willingness to participate
Expected Outcome	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

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. HSI or GPS)	HSI 2018.5 Primary Care Improvement Program
HSI/GPS Priority Area	Select one of the following: General Practice Support If Other, please provide details:
Existing, Modified, or New Activity	Modified (inclusion of innovation activity from 2016/2018 sustaining support of quality improvement activity within a population health management model) incorporating recommendations from the Innovation activity evaluation. (2016-18 Activity Work Plan relevant Activity reference/s N NP 2017.10 Primary Care (General Practice) Improvement
Aim of Activity	The aim is to support general practice to adopt evidence based best practice methods to achieve high performing primary care in the Gold Coast. This aims to improve the quality of care through supporting continuous quality improvement methodologies and utilisation of health information management and other building blocks of high performing primary care to inform quality improvements in health care, specifically, the collection and use of clinical data.
Description of Activity	This program of work moves beyond GPS 2018.4 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, using health information to drive improvements and 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 (Advisor) and practice support officer who assist in driving and supporting the initiative through peer to peer support. • The General Practice determine their priority areas for improvement through review of their clinical data (provided by GCPHN) • GCPHN support the Practice to ○ Develop an action plan utilising a CQI methodology through peer to peer conversations.

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Develop tailored clinical audit reports to determine baselines measures and monitor improvement over time. (at specified intervals)
Schedules regular touch point meetings with the practices to review and monitor progress towards achievements/improvements.
Provides access to decision support tools including easily accessible cycles of care through GCPHN website.

Tier 4 Continuity of Care – Comprehensive Over 75 Care Plan Program
Each practice that enrols in this program has an allocated Practice Support Officer to facilitate improved comprehensive and patient centred care planning when completing the 75-year health assessment. GCPHN working with Bond University has developed a person centred, goal orientated care plan that aligns with MBS requirements.

Enrolment of General Practices identifying an interest in participating in this program
The program includes practice support to;

Implement a more comprehensive approach to care planning at the over 75 health assessment which has been designed to support Medicare Funding
Provide education and training in the use of the care plan 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 the patients.

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<tr><td>Supporting the primary health care sector</td><td>These activities support general practice to build capacity in utilising evidence-based practice to enhance practice and clinical improvements through the use of systematic methodologies.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>GCPHN staff and General Practice Staff</td><td>Implementation & engagement</td></tr>
<tr><td>Peak bodies including RACGP, AGPAL and GPA</td><td>Consultation to ensure activity aligns to the standards.</td></tr>
<tr><td>GCPHN Primary Health Care Improvement Committee comprising local general practice staff</td><td>provide input and advice into the current issues facing general practice, projects directly</td></tr>
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</table>

		interfacing with General Practice and GCPHN practice support activities.
	General Practice Gold Coast (GPGC)	Linkage to ensure collaboration and partnership
	Bond University	Supporting implementation and Evaluation of Comprehensive Care Plan (75 years and over)
Duration	1 July 2018 – 30 June 2019	
Coverage	Whole PHN region	
Expected Outcome	Relevant PHN Program National Performance and Quality Framework measures: • P1 - PHN activities address prioritised needs and national priorities • P2 – Health System Improvement and Innovation • P3 - Rate of general practice accreditation • P4 - Support provided to general practices and other health care providers • P7 - Rate of GP style emergency department (ED) presentations • P8 - Measure of patient experience of access to GP • P9 - Rate of GP Team Care Arrangements / Case Conferences • P12 - Rate of potentially preventable hospitalisations • DH2 – Rate of healthcare providers (GPs, Pharmacies, Allied Health practices) using specified digital health systems (smartforms, ereferrals, telehealth, medical objects) ** Refer ADHA1, ADHA2, ADHA3, ADHA4 measures • DH3 – Rate of accredited general practice sharing data with PHN • O12 - Rate of contracts that include both outputs and outcomes performance indicators • O14 - PHN stakeholder engagement	

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. HSI or GPS)	GPS 2018.4 Practice Support A. Tier 1 & 2
HSI/GPS Priority Area	General Practice Support
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan)
Aim of Activity	The aim is to support general practice in the adoption of evidence best practice methods and meaningful use of digital systems to inform quality improvement, promoting the uptake of practice accreditation and ensuring timely provision information, resources and or education to support changes in programs and policy that impact on general practice.
Description of Activity	A tiered approach to practice support utilises Practice Support Officers to support the general practice team. This activity relates specifically to Tier 1 and 2 where each practice has an allocated Practice Support Officer supporting them through; **Tier 1:** ○ Support in adoption of a Clinical Audit tool with Practice Data being submitted to GCPHN ○ Introduction of Primary Sense to Practices with Medical Director to trial and test ○ Information, resources and education (delivery of clinician and patient resources) provided though face to face, telephone, electronic bulletins, email networks and the post for areas such as; ○ Public health i.e. immunisation and cancer screening ○ e-referrals from primary to secondary/tertiary and non-government agencies ○ transition to 5th Edition Standards of Accreditation ○ compliance with ePIP **Tier 2:** Entry Level Quality Improvement

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GCPHN provides Practices enrolled are provided with Quarterly Reports which includes a practice profile and analysis of their clinical data identifying key trends and areas where improvements could be made in clinical outcomes or practice processes.
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

</td></tr>
<tr><td>Supporting the primary health care sector</td><td>Meaningful use of clinical data to drive General Practice Quality Improvement and provision of timely information on National and Local development to support business efficiency and clinical practice.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>GCPHN staff and General Practice Staff</td><td>Implementation & engagement</td></tr>
<tr><td>Peak bodies including RACGP, AGPAL and GPA</td><td>Consultation to ensure activity aligns to the standards.</td></tr>
<tr><td>GCPHN Primary Health Care Improvement Committee comprising local general practice staff</td><td>provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities.</td></tr>
<tr><td>General Practice Gold Coast (GPGC)</td><td>Linkage to ensure collaboration and partnership</td></tr>
<tr><td>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</td><td>Linkage to ensure collaboration and avoid duplication of training events.</td></tr>
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<tr><td>Duration</td><td>1 July 2018 – 30 June 2019</td></tr>
</table>

Coverage	Whole GCPHN region.
Expected Outcome	Relevant PHN Program National Performance and Quality Framework measures: • P1 - PHN activities address prioritised needs and national priorities • P2 – Health System Improvement and Innovation • P3 - Rate of general practice accreditation • P4 - Support provided to general practices and other health care providers • P7 - Rate of GP style emergency department (ED) presentations • P8 - Measure of patient experience of access to GP • P9 - Rate of GP Team Care Arrangements / Case Conferences • P12 - Rate of potentially preventable hospitalisations • DH2 – Rate of healthcare providers (GPs, Pharmacies, Allied Health practices) using specified digital health systems (smartforms, ereferrals, telehealth, medical objects) ** Refer ADHA1, ADHA2, ADHA3, ADHA4 measures • DH3 – Rate of accredited general practice sharing data with PHN • AC1 - Rate of MBS services provided by primary care providers in residential aged care facilities • AC2 - Rate of people aged 75 and over with a GP health assessment • O12 - Rate of contracts that include both outputs and outcomes performance indicators • O14 - PHN stakeholder engagement • PH1 - Rate of children fully immunised at 5 years • PH2 - Cancer screening rates for cervical, bowel and breast cancer

[3] HSI funding is to be used to deliver core functions within the PHN program such as population health planning, system integration and stakeholder engagement, as well as support to general practice which is not funded under the General Practice Support Funding Schedule. PHNs are able to use flexible funding to commission referral or health pathways activities (including non-staff costs such as 'Streamliners') but all associated PHN staff costs must be funded from HSI funding. HealthPathways activity to be undertaken by commissioned services should be separately identified as a Core Flexible Activity in *1. (b) Planned PHN activities – Core Flexible Funding Stream 2018-19*.

PHNs cannot commission frontline services using HSI funding. PHNs may use HSI funding to subcontract specific activities under this stream, for example a health data analyst or consultant may be contracted to identify priorities for improved care coordination. Contracted or consultant arrangements are particularly appropriate for time-limited and specialist projects.

Practice support is to be provided through HSI funding and must be primarily delivered through PHN employees. Practice support cannot be commissioned out to a third party. Practice Support includes general practice support not funded under the General Practice Support Funding Schedule and support provided by your PHN to other practices, eg. allied health practices.

4. (a) Strategic Vision for After Hours Funding

Please outline, in no more than 500 words, an overview of the PHN's strategic vision for the period covering this Activity Work Plan that demonstrates how the PHN will achieve the After Hours key objectives of:

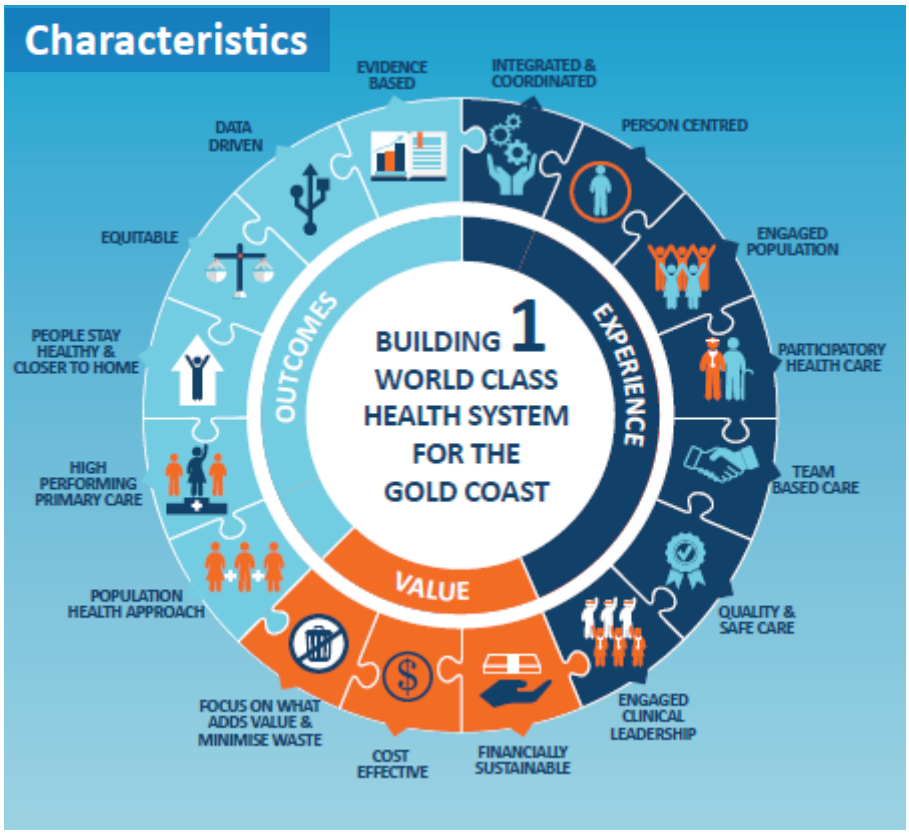
- increasing the efficiency and effectiveness of After Hours Primary Health Care for patients, particularly those with limited access to Health Services; and
- improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care.

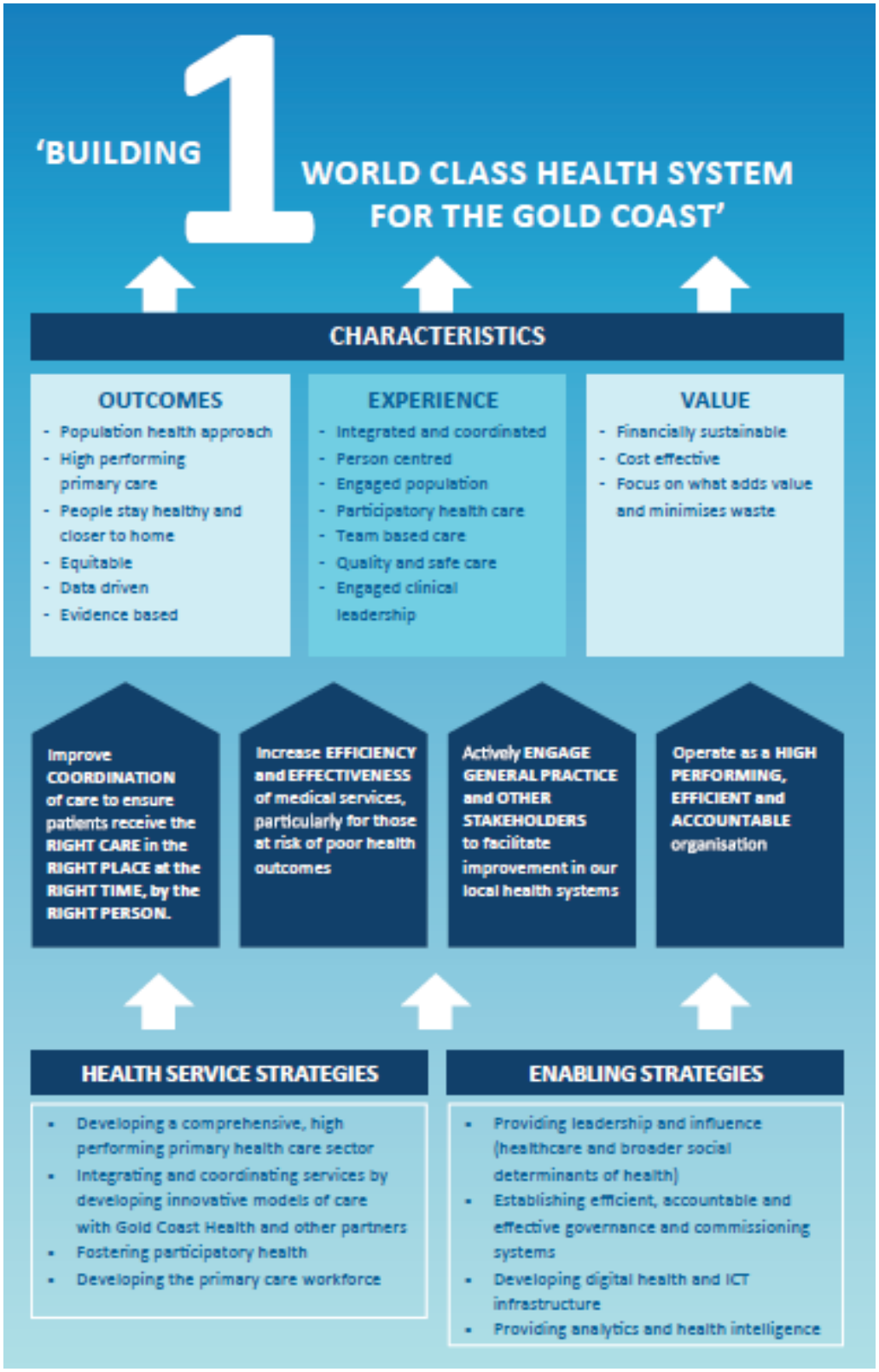
In 2018-19 and onwards, your organisation is required to:

- Implement innovative and locally-tailored solutions for after hours services, based on community need; and
- Work to address gaps in after hours service provision.

Local Context

On 1 July 2015, the Primary Care Gold Coast commenced as the Gold Coast PHN, establishing its vision and goals aligned with Commonwealth government expectations. Our Vision is 'Building one world class health system for the Gold Coast". GCPHN's Strategic plan sets out what the characteristics of one world class health system for the Gold Coast are as depicted in the below diagram. The Strategic Goals and Strategies to achieve our Vision are underpinned by a commitment to the Triple Aims of improving Outcomes, Experience and Value.




'BUILDING 1 WORLD CLASS HEALTH SYSTEM FOR THE GOLD COAST'
CHARACTERISTICS
OUTCOMES
- Population health approach
- High performing primary care
- People stay healthy and closer to home
- Equitable
- Data driven
- Evidence based
EXPERIENCE
- Integrated and coordinated
- Person centred
- Engaged population
- Participatory health care
- Team based care
- Quality and safe care
- Engaged clinical leadership
VALUE
- Financially sustainable
- Cost effective
- Focus on what adds value and minimises waste
Improve COORDINATION of care to ensure patients receive the RIGHT CARE in the RIGHT PLACE at the RIGHT TIME, by the RIGHT PERSON.
Increase EFFICIENCY and EFFECTIVENESS of medical services, particularly for those at risk of poor health outcomes
Actively ENGAGE GENERAL PRACTICE and OTHER STAKEHOLDERS to facilitate improvement in our local health systems
Operate as a HIGH PERFORMING, EFFICIENT and ACCOUNTABLE organisation
HEALTH SERVICE STRATEGIES
- Developing a comprehensive, high performing primary health care sector
- Integrating and coordinating services by developing innovative models of care with Gold Coast Health and other partners
- Fostering participatory health
- Developing the primary care workforce
ENABLING STRATEGIES
- Providing leadership and influence (healthcare and broader social determinants of health)
- Establishing efficient, accountable and effective governance and commissioning systems
- Developing digital health and ICT infrastructure
- Providing analytics and health intelligence

GCPHN Values

4. (b) Planned PHN Activities

– After Hours Primary Health Care Funding 2018-19

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. AH 1)	AH 1.1 Hospital avoidance – RACFs after hours
Existing, Modified, or New Activity	Modified and links with CF 2017.5 Enhanced Primary Care in RACFs. Relates to 2016-18 Activity Work Plan AH 1.1 Hospital avoidance – RACFs after hours and NP 2017.9 Enhanced Primary Care in RACFs).
Needs Assessment Priority Area (eg. 1, 2, 3)	• Lines 26, 27 and 28 pages 41-44 Section 4 Aged Care pathways and coordination page 58 • System navigation for older people and primary care providers supporting them with a focus on proactive co-ordinated care. • Agreed pathways developed and evaluated that provides triage, consultancy, clinical support, and advice for Residential Aged Care Facilities (RACF) staff and GPs, so that care for patients can be delivered in the facility where appropriate, and transfer to hospital is avoided. Training and education for implementation of pathways to RACFs, GPs and MDS • Detailed service mapping to identify current services in acute and community to identify duplicates and gaps within the system that supports older person. • Develop a regional solution through pathways and process that can be implemented regionally • Up to date information to support access and referral online GCPHN Needs assessment 2017– Older Adults • High Number of Hospital Admissions for people living in RACFs. Data from GCH indicated 6396 Emergency Department Presentations of RACF residents between July 2017 – May 2017. An average of 19 ED presentations per day as well as a large number of RACF patients attending outpatients appointments • low uptake and awareness of advance care planning (documents & Legal requirements and end of life care

Aim of Activity	The aim of this activity is to build on the collaboration with the Residential Care facilities, Gold Coast Health (GCH), general practitioners and medical deputising services to reduce the need to transfer of frail aged patients to the hospital after hours. This activity builds on the learning from the Better Health Care connection program which included the provision of an external service co-ordination role to the RACF providing support general practitioners and medical deputising services. 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 • P7 - Rate of GP style emergency department (ED) presentations • P8 - Measure of patient experience of access to GP • 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 • AC2 - Rate of people aged 75 and over with a GP health assessment in residential care • O12 - Rate of contracts that include both outputs and outcomes performance indicators • O14 - PHN stakeholder engagement
Description of Activity	GCPHN support RACF's to engage an existing staff member (nursing) for up to 12 hours a week to assume the role as Champion (Service Co-ordinator) with responsibility of working with general practitioner and medical deputising services to implement consist cycle of care aligned with the RAGCP silver book guidelines ensuring co-ordinated multidisciplinary care and care planning. A key role of the Service Co-ordinator will be to develop, champion and embed the process and program into the RACF so that the GCPHN can eventually relinquish its support. The activity will be governed by a Sponsor Group including GCPHN, RACF, GP, medical deputising services and representatives of the GCH so that there will be close monitoring of progress against milestones and outcomes. Services include

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Education of RACF (Service Navigators) in proactive care planning including advanced care planning
Education of Medical Deputising Services
More effective communications between all multidisciplinary team in the resident's care
Increasing number of residents Advanced care plans
Increase use of my health record
Increase use of access to telehealth
Increased access to specialist services where required to meet patient needs.

The activities involve continued extension of the GC HHS Aged Care Response Team to provide an after-hours clinical nurse services (Nurse Grade 7). The Service would be available Monday to Friday 1530 – 2400, Saturday, Sunday and Public Holidays 1200 -2030. The key aims of the program would be;

support the provision of care within the RACF where possible with General Practitioner providing medical governance
support the timely transfer of individuals across the GCHHS-residential aged care interface
ensure continuity of care and a consistent high quality approach to guide the transfer of individuals across the interface
provide a point of contact for RACF clinical staff to communicate with GCHHS clinical services
facilitate an alternative to hospital transfer for acute, subacute and outpatient services
facilitate early and proactive planning of transfers between GCHHS and RACFs.

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<tr><td>Target population cohort</td><td>Residents living in RACFs in the GC PHN region</td></tr>
<tr><td>Consultation</td><td>These activities have been developed in collaboration with the GCH, RACF's and general practitioners and medical deputising services. The activities build on existing relationships and will ensure greater collaboration across services.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder/Partners</th><th>Role</th></tr>
<tr><td>GCH</td><td>Partner in Service Navigation work and providing of after-hours nursing services</td></tr>
<tr><td>General Practice including after-hours services</td><td>Working with RACF service navigators to implement RACP Sliver book guidelines and After- hours nursing services</td></tr>
<tr><td>Multidisciplinary Service Providers</td><td>Linkage into comprehensive care planning for residents</td></tr>
<tr><td>RACFs</td><td></td></tr>
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		Partners in the After-Hours nursing services, target RACF yet to be determined
Indigenous Specific	No	
Duration	After hours Nursing Service – June 2019	
Coverage	Gold Coast PHN Region (Gold Coast SA4) – focus on RACF with highest percentage of avoidable hospital admissions	
Commissioning method (if relevant)	Direct Approach- partnership with GCH for provision of Specialist Nursing Services – GCH to manage an expression of interest for the Nursing positions across GCH, RACF and local market.	

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. AH 1)	AH 1.2 Mental Health After Hours
Existing, Modified, or New Activity	New
Needs Assessment Priority Area (eg. 1, 2, 3)	Provide the number, title and page reference for the priority as identified in Section 4 of your Needs Assessment that this activity is addressing. If this activity is a 'possible option' in Section 4 of the Needs Assessment, provide details.
Aim of Activity	The community based safe space aims to support people to proactively manage their mental health by allowing access through a drop-in arrangement when the person identifies symptoms of becoming unwell and their primary care provider is not accessible. 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 • P7 - Rate of GP style emergency department (ED) presentations • P12 - Rate of potentially preventable hospitalisations • O12 - Rate of contracts that include both outputs and outcomes performance indicators • O14 - PHN stakeholder engagement • MH4 - Formalised partnerships with other local health care providers (MH indicator regional integration)
Description of Activity	**Community Safe Space** This service will commenced 1 July 2018 will reduce barriers to accessing mental health support by providing people with a welcoming 'no wrong door' option to accessing support, advice, referrals to other services and care planning. This is particularly important when considering the needs of young people and those in identified hard to reach groups, who may find it difficult to reach out for help or maintain engagement with a service. It will also work to support greater collaboration in a person's care through supporting referrals to other services, taking into consideration digital health supports, while maintaining continuity of care and coordination with the consumers GP or primary care provider. GCPHN has commissioned a Providers who will provide this After Hours Service in conjunction with the Clinical Care Co-ordination for Severe and Complex mental health, service information and intake for

	psychological services. The service will operate a community "drop in" type space which includes after hours clinical and psychosocial support including but not limited to; • Assessment • Care Co-ordination • Groups • Service Information After hours has been defined as: • 6pm to 11pm weeknights • 12pm to 11pm Saturdays • 8am to 11pm Sunday and Public Holidays
Target population cohort	• Individuals who identify that their mental health symptoms are escalating or are in mental distress and their primary care provider is unavailable or inaccessible. • Individuals that require mental health support that do not have a primary care provider and cannot access clinical support at the time they require it. • Individuals that have experienced or are experiencing barriers to accessing primary mental health care or other mental health supports. • Individuals identified as hard to reach as specified in the 2016 GCPHN Mental Health Needs Assessment healthygc.com.au/Programs-Services/Mental-Health-Resources
Consultation	GCPHN led a targeted consultation process between September and October 2017 to build on findings from the broad consultation undertaken in 2016. The 2017 workshops were conducted, with representatives from Queensland Government agencies, consumers, carers and community service providers from the non-government sector and clinical service providers, with over 120 people participating. These workshops focused on understanding the vision stakeholders held for mental health on the Gold Coast; assessing and prioritising contemporary models of care (drawn from local, State, national and international practice) and, importantly, identifying the outcomes that both consumers and providers want to achieve. This co-design approach elicited greater clarity of the desired service components and models of care that would meet the identified needs of people living with severe and complex mental illness on the Gold Coast.

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<tr><td>Collaboration</td><td><table>
<tr><th>Stakeholder/Partners</th><th>Role</th></tr>
<tr><td>GCH</td><td>Collaborative working relationship commenced</td></tr>
<tr><td>General Practice including after-hours services</td><td>Service information and advice service will target general practitioners and psychiatrists first to assist in the management of people with mental health across the stepped care model</td></tr>
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<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Service Delivery 1 July 2018 – 30 June 2021 (Three years)</td></tr>
<tr><td>Coverage</td><td>The GCPHN region (GC SA4 region)</td></tr>
<tr><td>Commissioning method (if relevant)</td><td>Request for Proposal, Successful Provider will provide this After Hours as well as Service and Clinical Care Co-ordination for Severe and Complex mental health as well as service information, intake for psychological services.</td></tr>
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Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. AH 1)	AH 1.3 Emergency Alternatives to hospital
Existing, Modified, or New Activity	New Activity
Needs Assessment Priority Area (eg. 1, 2, 3)	7 – Primary Healthcare • Low proportion of people visiting GPs compared to national levels in the after hours period • High numbers of people admitted to hospital and/or presenting to ED • High rates of non-urgent after-hours GP attendances with concerns of variability of quality • High rates of hospitalisation for kidney and urinary tract infections, cellulitis, COPD and diabetes complications 5 – Older Adults • High number of hospital admissions for UTIs, COPD and cardiovascular disease
Aim of Activity	The aim of this activity is to assist emergency department congestion/ unnecessary presentations. Educate the community about the options including afterhours services as an alternative to EDs. Relevant PHN Program National Performance and Quality Framework measures: • P1 - PHN activities address prioritised needs and national priorities • P2 – Health System Improvement and Innovation • P7 - Rate of GP style emergency department (ED) presentations • O14 - PHN stakeholder engagement
Description of Activity	This activity will increase the awareness of the community about other services and options available to them, when to use them and when it is appropriate to go to emergency departments. This will involve promotion of after-hours doctor's services, online and telephone services to improve awareness of options and help people make appropriate and informed decisions. We anticipate this will assist to reduce the burden in Emergency departments by reducing the number of unnecessary or inappropriate presentations. Activities include: • Collateral development and distribution, including magnets, brochures and posters. To be distributed through general practice and GCH emergency department. • Online advertising, social media and radio advertising

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- Usual GCPHN and GCH publications
- Tonic advertising at pharmacy
- Advertising through GCUH screens in foyer and emergency waiting areas.

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<tr><td>Target population cohort</td><td>Residents living in the GCPHN region</td></tr>
<tr><td>Consultation</td><td>These activities have been developed in collaboration with the GCH, other After Hours providers and general practitioners and medical deputising services. The activities build on existing relationships and will ensure greater collaboration across services.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder/Partners</th><th>Role</th></tr>
<tr><td>GCH</td><td>Partner in provision of campaign. GCH has agreed to use the campaign within their ED departments, promote online through their Social Media Channels, external facing website and internal intranet and has provided images and a contact within their ED to be the ‘face’ of the campaign and also provide comments from any media enquiries.</td></tr>
<tr><td>General Practice including after-hours services</td><td>Working with general practice staff to promote after- hours alternatives and educate the community through displaying collateral within practices.</td></tr>
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<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>To June 2019</td></tr>
<tr><td>Coverage</td><td>Gold Coast PHN Region (Gold Coast SA4) – focus on broad campaign</td></tr>
<tr><td>Commissioning method (if relevant)</td><td>Direct delivery in partnership with GCH for provision of campaign and specialist input.</td></tr>
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