Opportunities, priorities and options

This section summarises the priorities arising from the Needs Assessment and options for how they will be addressed. This could include options and priorities that:

- *may be considered in the development of the Activity Work Plan, and supported by Gold Coast Primary Health Network (GCPHN) flexible funding;*
- *may be undertaken using programme-specific funding; and*
- *may be led or undertaken by another agency.*

General Population Health

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
General Practice and Primary Care • While accreditation rates are currently high, there may be additional support required due to changes in RACGP Standards and Quality Practice Incentive Payment • Significant growth in general practice and general practitioners • Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza) • Potential to increase use of data in general practice software to proactively plan care	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 non-government agencies ○ transition to 5th Edition Standards of Accreditation ○ compliance with ePIP and QPIP. Entry Level Quality Improvement Tier 2	• General practice is supported to adopt evidence based best practice methods and meaningful use of digital systems to inform quality improvement • • Increase uptake of practice accreditation and Practice Incentive Payments • Timely provision of information, resources and or education to support changes in programs and policy that impact on general practice. • Embed continuous quality improvement methodologies and utilisation of health information management and other building blocks of high performing primary care • Increased access to high quality population health data to inform current and future GCPHN activities such as needs assessment and service development.	GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Practices enrolled are provided with quarterly reports which includes ○ a practice profile and ○ analysis of clinical data identifying key trends and areas for improvements • Support for effective data entry, data cleaning and quality assurance processes **Continuous quality improvement (CQI)** 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. **Population health management** Tier 4 Practice Support	• Improved management of patient health care in general practice • Reducing unnecessary referrals and admissions to hospital.	GCPHN

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. • Links with Primary Sense in section below		
General Practice and Primary Care • Clinical handover, particularly to general practice on discharge from hospitals remains a significant issue • Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza • Access to Information about services and resources to support general practice in key areas required • Potential to increase use of data in general practice software to proactively plan care • Current systems (including MBS payments and data) do not support population health approach and care-coordination	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. 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

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	• 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 GCPHN can do based on historic and current pseudonymised patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	
General Practice and Primary Care • While categories 4 and 5 ED presentations have remained stable, there has been strong growth in higher acuity categories, increasing demand on ED services • Access to Information about services and resources to support general practice in key areas required	Emergency Alternatives 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 • Usual GCPHN and GCH publications • Tonic advertising at pharmacy	Contribute to prevention of increasing numbers of Cat 4 and 5 presentations to ED	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Advertising through GCUH screens in foyer and emergency waiting areas. 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 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	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. • 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 GCPHN can do based on historic and current pseudonymised patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	GCPHN with key stakeholders
General Practice and Primary Care • Access to Information about services and resources to support general practice in key areas required	Access to information and resources 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 Clinical Prioritisation Criteria protocols introduced in Queensland • Review and update of existing referral templates to ensure they align to current evidence and GCH systems and protocols	• Achieving increased access to contemporary evidence-based resources and localised service and referral information. • 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.	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• 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. Work cooperatively with the National Health Service Directory to ensure effective information sharing. This activity links closely with practice support activities and other program activities.		
Cancer • High rates of melanoma across the region. • Higher rates of colorectal cancer and breast cancer but lower rates of screening compared to national rates. • Low community awareness of eligibility for screening in Gold Coast region, men in particular.	Public Awareness - Cancer Public awareness campaigns promoting screening and skin checks through usual communication channels including information and resources on the website "HealthyGC", GCPHN publications, social and traditional media, targeting particular hot spot areas. General practice support – help desk Help desk support to general practice to support general enquiries including access to resources for cancer. General Practice Support – Quality Improvement Quality improvement activities (tier 3) in general practice support to include prevention as potential focus area including recall and reminder of potentially eligible patients for screening options through Health Assessments and skin checks.	• Increase in awareness and uptake of screening services for breast, bowel and cervical screening. • Increased skin cancer and prostate cancer check.	GCPHN GCPHN GCPHN
Immunisation	Public Awareness – Immunisation		GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Lower rates of children fully immunised in the Gold Coast particularly hinterland, Surfers Paradise and Mudgeeraba-Tallebudgera. • Lower rates of HPV vaccination in Gold Coast compared to the national figure. • Higher rates of hospitalisation for pneumonia and influenza in Gold Coast compared to the national figure.	Public awareness campaigns promoting early childhood, HPV and influenza vaccinations through usual communications channels including information and resources on the website "HealthyGC", GCPHN publications, social and traditional media, targeting particular hot spot areas. **General practice support – help desk** Help desk support to general practice to support general enquiries including access to resources for immunisation. **General Practice Support – Quality Improvement** Quality improvement activities (tier 3) in general practice support to include prevention as potential focus area including recall / reminder of potentially eligible patients for vaccinations	• Increase in awareness and uptake of vaccinations.	GCPHN
Persistent Pain • 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	**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	• Improved self-management of pain • Reduced use of pain medication • Reduced hospital presentations	Contractor
Chronic Disease	**Integrated Care Alliance**	Create a single integrated healthcare system for the Gold Coast by:	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Better systems to support care coordination. • 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.	• 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.	• 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.	
Chronic Disease • Better systems to support care coordination. • 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.	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 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	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. • 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 GCPHN can do based on historic and current pseudonymised patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	GCPHN with key stakeholders

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Chronic Disease • Better systems to support care coordination. • 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.	**Access to information and resources** 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 Clinical Prioritisation Criteria protocols introduced in Queensland • Review and update of existing referral templates to ensure they align to current evidence and GCH systems and protocols • 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. Work cooperatively with the National Health Service Directory to ensure effective information sharing. This activity links closely with practice support activities and other program activities. **Population health management** Using the learnings from previous Comprehensive Over 75 Care Plan project evaluation, support implementation of comprehensive proactive management of complex and at-risk patients through a quality improvement model in general practice.	• Achieving increased access to contemporary evidence-based resources and localised service and referral information. • 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.	GCPHN with GCH GCPHN GCPHN

Opportunities, priorities and options			
Priority	**Possible Options**	**Expected Outcome**	**Potential Lead**
	General Practice Support – Quality Improvement Quality improvement activities (tier 3) in general practice support to include prevention as a potential focus area including recall and reminder of potentially eligible patients for health checks and referral to lifestyle modification programs.		

Aged Care
• High numbers of preventable hospital admissions for older adults are recorded for Chronic Obstructive Pulmonary Disease (COPD), urinary tract infections, angina and heart failure
• Lack of established clinical coordination tools and processes that result in fragmentation of the local health system in patient centred care – management and problematic after-hours management
• Low use of advanced care directives, plans and deficits in confidence and capacity of staff to provide adequate and/or quality palliative care.
• Over 80% of residents in residential aged care presenting with increasing complexity of care, including dementia behaviour management, mental health, palliative and end of life care.
• Limited uptake of existing Education, training and resources to RACF's, GPs and health care professionals in early identification and management of Palliative Care – End of Life.
• Limited capacity to provide a coordinated and sustained coverage for palliative and end of life care within RACF's out of hours.
	Enhanced Primary Care In RACFs
	• Engage RACF staff to "champion" and support GPs to drive comprehensive multidisciplinary care planning including completion and use of advance care planning utilising evidenced based pathways and resources (including My Health Record).
	• Embedding RACGP Silver Book guidelines by providing access to a 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 staff on:
	  • Qld End of Life Care planning and advanced care planning.
	  • ISBAR clinical communication tool
	  • Use of My Health Record
	
	After hours advice and support
	Provide a point of contact for RACF clinical staff to communicate with expert clinical staff to provide advice and guidance to facilitate an alternative to hospital transfer for acute, subacute and outpatient services and to facilitate early and proactive planning of transfers between GCHHS and RACFs.
	
	Dementia advice and support
		• Development of strong partnerships with community palliative care supports and services and GPs
		• Implementation and adoption of clinical guidelines and protocols focused on key best practices for generalist primary palliative care within RACFs
		• Engagement of RACF staff in training to increase role appropriate competence in primary palliative care skills
		• Enhanced clinical competency of professionals within RACF in primary palliative care management
		• Increased awareness of palliative care clinical management and its integration into patient centred care
		• Decrease in avoidable admissions to emergency department
		• Increase the number of Advance Care Plans and uploads to My Health Record.
			GCPHN with partners
			
			Gold Coast Health / other contractor

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	Explore opportunities to build capacity in the sector to deliver improved care particularly for people with increasing complexity of care needs, specifically behaviour management for people with dementia. **Mental Health and wellbeing for RACF residents** Explore opportunities to build capacity in the sector to deliver improved mental health and wellness services in RACFs.		
Palliative Care • Maintaining the role of GPs in coordinating care for palliative patients is important to clinicians, consumers and carers but this is difficult because: ○ Some GPs and other primary care providers may not regularly provide palliative care, influencing levels of knowledge and confidence ○ Low levels of uptake and awareness of existing palliative care-related training and information resources ○ Care coordination involving a person's different care providers and family is seen as important but can be difficult due to funding arrangements and lack of dedicated resources to operationally support ○ GPs experience challenges in making palliative care-related attendances particularly in the after-hours period due a range of factors including MBS payments, capacity, limited access to information on current treatment/medications. For RACFs there are also issues with accessing facilities, coordination with onsite	**Primary Health Palliative Care Project:** Support for general practice to deliver palliative care services • Web based platform providing general practitioners with easy access to localised information and existing evidence based resources • Care coordination with specialist palliative care services and other members of MDT including optimum business processes (e.g. MBS item numbers) • Training and education • Trialling a GP Palliative Care Network for RACF's which will support GPs interested in providing quality palliative care, accepting transfer of care from other GPs, etc. If successful, this approach will be extending across the district • Developing shared care palliative care models with GPs providing most of the care, supported by ready access to specialists as needed • Ongoing educational opportunities for GPs provided by the GCH Palliative Care Service through annual in-service programs about symptom management and medication, and use of Program in the Experience of the	• Improved practical advice and support for families • Improved awareness by health, community and aged care providers regarding family access to bereavement support.	GCPHN through Greater Choices for At Home Palliative Care with Gold Coast Health and other key stakeholders

Opportunities, priorities and options			
Priority	**Possible Options**	**Expected Outcome**	**Potential Lead**
nursing staff and communication with deputising services. • Fatigue and burnout for families supporting loved ones at home is a significant issue, particularly those with limited practical and social support • There is low uptake, awareness and confidence reported for advance care planning amongst both service providers and community members. • Effectiveness of local palliative care services in an inpatient setting typically exceeds patient outcome benchmarks, but achieving similar outcomes in the community setting is challenging due to limited resourcing. • Limited funding is available to support community services to provide after-hours in-home care, offer respite nursing support or purchase appropriate equipment to enable palliative care to be provide in a patient's home (including residents of RACFs) • Families report difficulty with understanding and navigating the palliative journey of loved ones including equipment requirements	Palliative Approach (PEPA). This provides GPs with an opportunity to work in palliative care units. • Strengthening the approaches used by GPs to advance care planning and exploring ways to involve practice nurses in advance care planning and ongoing care • Providing education to community and hospital pharmacists about current palliative care medications, dosing regimens and side effects. **Palliative Care Volunteers Network** Commission suitable service provider to recruit, train, manage and provide ongoing support to volunteers to support palliative patients and carers with appropriate tasks and activities. **Community Awareness and Education** Modest media campaign and leveraging community engagement opportunities to encourage people to talk more openly about dying, death and bereavement, and to make plans for the end of life inclusive of Advance Care Plans. **Enhanced Primary Care** • System navigation for people requiring palliative care and primary care providers supporting them with a focus on proactive coordinated care. • Agreed pathways developed and evaluated that provides triage, consultancy, clinical support, and advice for patients, carers , clinical staff and GPs, so patient care can be delivered in the facility where appropriate, and transfer to hospital is avoided.	• Increased network of volunteers to support palliative care patients and their carers • Increased knowledge and uptake of Advance Care Plan (ACP) • Improved health, community and aged care provider understanding of end-of-life care, and appropriate referrals to specialist palliative care • The generalist healthcare workforce supported and mentored to increase capacity, knowledge and skills • Workforce better equipped to support an ageing population • Improved public understanding of end-of-life and palliative care • Increased uptake of ACP	

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Training and education for implementation of clinical care coordination to GPs and MDS • Develop a regional palliative patient centered management strategy and process that can be implemented regionally • In consultation with local partners develop a quality improvement system to better support general practitioners ensuring coordinated care for their palliative and end of life patients • Dedicated support for GP practices including services to enhance palliative care co-ordination and to develop and implement comprehensive proactive care plans.		

Primary Mental Health Care (including Suicide Prevention)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Low intensity mental health services • Flexible evidence-based services are required and could include the review and possible adaptation of existing funded groups and alternative service models. • Low uptake of group-based services funded by GCPHN. • 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.	Psychological group programs Review of commissioned psychological group programs aimed at people with mild mental health issues from hard to reach groups as listed under target population cohort. New Access Review beyond blue New Access program, with a focus on the northern growth corridor of the Gold Coast, which commenced 1st January 2018. Public Awareness Public awareness campaign promoting increased referrals across the stepped care continuum in particular low intensity mental health services. Access to information and resources Access to information and resources that supports referrals and access to appropriate evidence based electronic (digital) mental health services. See also Access to Information	• Improve targeting of evidence based psychological interventions to most appropriately support people with, or at risk of, mild mental illness. • Increased service delivery options for people with mild mental health needs particularly in the northern growth corridor • Increased access to services • Enhance the capacity and effectiveness of the funded organisations, General Practice	Contracted providers Beyond blue GCPHN GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	and Resources above General Population Health section.	and the broader sector to meet the needs of their client group	
National Psychosocial Services • Short-term, non-clinical, recovery-focussed psychosocial support services for people of all ages • Ensure effective engagement with key vulnerable groups • 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 • Promotion of psychosocial services to general practice and other stakeholders to support complementary use with other primary health interventions • Efficient referral pathways to increase accessibility to new psychosocial services	Commission services with existing provider Work with existing contracted provider delivering clinical care coordination services for people with severe mental illness to implement the provision of psychosocial support for people with severe mental illness. Commission short-term, non-clinical, recovery-focussed psychosocial support services to address the most frequently identified areas of unmet psychosocial need: - Obtaining employment/volunteering opportunities - Managing physical health issues - Engaging in a fulfilling social life - Participating in daytime activities Ensure effective engagement with key vulnerable groups: - Culturally and linguistically diverse - (CALD) backgrounds - Those who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+) - Identify as Aboriginal and/or Torres Strait Islander Public Awareness Public awareness campaign promoting increased referrals across the stepped care continuum in psychosocial support services. Access to information and resources Access to information and resources that supports referrals and access to appropriate to evidence based electronic (digital) mental	• Continuity of support and services for previous Partners In Recovery clients particularly those who are not eligible for NDIS services. • Alignment with Gold Coast Health service provision to ensure maximum coverage of potential clients without duplication of services.	Contracted provider GCPHN GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	health services. See also Access to Information and Resources.		
Mental Health - Suicide Prevention • GCPHN funded psychological services for suicide prevention are well utilised but opportunity exists to better target those most at risk. • Education and support required for general practice and mental health services workforce particularly in relation to consistent approaches to risk assessment and safety planning. • Work in partnership with Gold Coast Health to ensure care planning and discharge processes are inclusive for all participants. • Develop clear referral pathways and supported connections to appropriate community supports and reinforcing the central coordinating role of the medical home (linking back to the GP)	Post Hospital Suicide Prevention Review of commissioned service, Lotus – a non-clinical support and transition services to people who may have recently attempted suicide, or are at risk of suicide, and have presented at either Robina or Gold Coast University hospitals, or be an inpatient being discharged from one of these facilities. Community workers provide coordination, linkage and referrals to services who can provide longer term support, in line with the individual's needs. Look for additional opportunities to expand the capacity of this or similar services to ensure coverage for this target cohort. Expanded Horizons Continue funding group programs specifically for LGBTIQAP+ youth, residing on the Gold Coast. Psychological Services Program (PSP) Continue provision of psychological services through the hard to reach response detailed below. Additionally, GPs can refer through to the Better Access program. Regional Plan Development of a regional mental health and suicide prevention plan	Reduction in suicide presentations	GCPHN with GCH Wesley Mission Brisbane Contracted providers GCPHN GCH and other key stakeholders
Mental Health – hard to reach Data, research and consultation with service users, service providers and community members identified the	Psychological Services Program (PSP) Continue to commission PSP targeting identified high need/hard to reach groups.	Psychological services provided with adequate coverage for each target group.	Contracted providers

Opportunities, priorities and options			
Priority	**Possible Options**	**Expected Outcome**	**Potential Lead**
following groups as high risk / hard to reach on the Gold Coast: • People who are currently homeless, or are at risk of homelessness • Culturally and Linguistically Diverse people (CALD) • People who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+) • Women experiencing perinatal depression • Aboriginal and Torres Strait Islander people • Children (aged 0-12) who have, or are at risk of developing a mental, childhood behavioral or emotional disorder (including a specific focus on children in care) • People who self-harm or who are at increased risk of suicide.	Review model to further refine and target most at risk clients. See also Suicide prevention, Children and Young People and Aboriginal and Torres Strait Islander Mental Health, and Severe and Complex Mental Health sections above and below.		
Mental Health – children and youth • Wrap around support for youth through outreach opportunities and flexible service entry points. • Early intervention and therapeutic services for children aged 0 to 14 with a focus on the northern growth corridor. • 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 Aboriginal and Torres Strait Islander children.	headspace In accordance with the DoH funding agreement, continue to commission headspace while undertaking a co-design process with key stakeholders, including consumers and carers. Review model of care to align clinical staging model Psychological Services Program (PSP) Continue to fund PSP services for children and review considering children in care as a particular focussed target group. Northern Gold Coast	Headspace funded under current arrangement until June 2019 See above	headspace Contracted providers

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead

• Education, training and support to engage schools and the broader education workforce in early identification and intervention.
• Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs. Addressing these issues is hampered by:
  ○ Long wait times for assessment and treatment in the public system
  ○ Costs of private services
  ○ Issues with transfer of information
  ○ Limited knowledge and adherence to guidelines
	Explore opportunities to increase service delivery options for children in northern Gold Coast area.
	
	Multi-agency coordinated care planning
	Support mechanisms which enable multi-agency coordination for children and young people with complex needs to address the full range of health and social issues who are currently receiving services from a range of health and social services providers
		Increased service options in northern Gold Coast area
		
		Coordinated care planning
			GCPHN with potential providers

Mental Health - Severe and Complex • Coordinated shared care planning that is available across primary care, community and the hospital and health service. • Education and training for general practice to better support severe and complex patients, including physical health and referral pathways. • Increased opportunities to support greater engagement in service delivery by peer workers and people with a lived experience. • Centralised intake across the stepped care model to ensure people receive the appropriate support and referral based on their needs. • Develop efficient pathways to support person centered transfer of care	**Clinical Care Coordination** Monitor and review the newly established Clinical Care Coordination Service “Plus Social” targeting people with severe and complex mental health conditions and offering access through and after hours drop in centre to further refine support provided to clients. **Public Awareness** Public awareness campaign promoting increased referrals across the stepped care continuum in particular for severe and complex. **Access to Information and resources** Access to information and resources that supports referrals and access to mental health	Increased access to services for people with severe and complex mental health issues Improved mental health for clients	Contracted providers

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
between acute and primary services (general practice, allied health and community services).	services. See also Access to Information and Resources above. Multi-agency coordinated care planning Support mechanisms which enable multi-agency coordination for people with complex needs to address the full range of health and social issues who are currently receiving services from a range of health and social services providers		
Aboriginal and Torres Strait Islander Mental Health	See Aboriginal and Torres Strait Islander Health and Alcohol and other drugs section below		
Mental Health Overarching Stepped Care Approach	Regional Plan Development of a regional mental health and suicide prevention plan. Public Awareness Public awareness campaign promoting increased referrals across the stepped care continuum. Access to Information and resources Access to information and resources that supports referrals and access to mental health services. See also Access to Information and Resources above. Centralised information intake and triage This will assist GCPHN funded services to support more appropriate referral of clients	People requiring mental health support will be able to access the right care, at the right time, in the right place, from the right provider.	GCPHN with GCH and other stakeholders GCPHN GCPHN with GCH Contracted provider

Opportunities, priorities and options			
Priority	**Possible Options**	**Expected Outcome**	**Potential Lead**
	according to their needs across the stepped care continuum. Education and training Training and education as part of workforce and sector support including: demand management, commissioning general practice training, sector capacity building and general practice referral pathways (links with workforce). Multi-agency coordinated care planning Support mechanisms which enable multi-agency coordination for people with complex needs to address the full range of health and social issues who are currently receiving services from a range of health and social services providers		GCPHN with content experts

Alcohol and Other Drug

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Alcohol and Other Drug • Capacity of detoxification, residential rehabilitation and aftercare services is limited to the provision of flexible support and follow up for clients. • Flexible outreach treatment services with a focus on vulnerable target groups including young people is needed.	AOD Mainstream Monitor and evaluate effectiveness of services which commenced 1 January 2017 (AOD Mainstream) to deliver innovative responses to increase existing treatment sector capacity (focused in Northern Gold Coast) in the following areas: • early treatment support • post treatment support Review services with a view to driving continuous quality improvement and alignment with State and Commonwealth government investment.	Timely access to services to capture clients wanting to address their drug use and maximize the effectiveness of the intervention.	GCPHN with Lives Lived Well
	AOD Youth Outreach Monitor and evaluate effectiveness of services to deliver innovative outreach AOD intervention services to young people. Review services with a view to driving continuous quality improvement and alignment with State and Commonwealth government investment.	Increased access for young people to AOD services	GCPHN with Lives Lived Well
	Multi-agency coordinated care planning Support mechanisms which enable multi-agency coordination for people with complex needs including alcohol and other drug use to address the full range of health and social issues who are currently receiving services from a range of health and social services providers.		

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Alcohol and Other Drug • Provision of training and resources, including referral pathways, for General Practice to support patients with substance use issues including ice.	Access to information and resources Access to information and resources that supports referrals and access to appropriate services above.	Enhance the capacity and effectiveness of the funded organisations, General Practice and the broader alcohol and other drugs (AOD) treatment sector and their ability to meet the needs of their client group.	GCPHN
Alcohol and Other Drug • Provision of training and resources, including referral pathways, for general practice to support patients with substance use issues including ice.	Training and Education Training and education as part of workforce and sector support including: demand management, commissioning general practice training, sector capacity building and general practice referral pathways (links with workforce).	Enhance the capacity and effectiveness of funded organisations, General Practice and the broader alcohol and other drugs (AOD) treatment sector and their ability to meet the needs of their client group.	Key stakeholders with GCPHN support
Aboriginal and Torres Strait Islander - Mental Health and Suicide • Access and awareness of appropriate services.	Access to information and resources Access to information and resources that supports referrals and access to appropriate services. See also Access to Information and Resources above.	Facilitate local relationships and partner with mainstream and Indigenous services for the delivery of primary care services. Improve health equity for Aboriginal and Torres Strait Islander people by addressing access issues.	GCPHN in partnership with local service providers
Aboriginal and Torres Strait Islander - Mental Health and Suicide • Mainstream services that are culturally appropriate and safe.	See Cultural Competency section in Indigenous Health below	See Cultural Competency below	Kalwun with support from GCPHN
Aboriginal and Torres Strait Islander - Mental Health and	Coordinated Mental Health, AOD and suicide prevention		GCPHN with subcontractors Kalwun and Krurungal

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Suicide • Holistic service response for Indigenous clients, including mental health, suicide prevention and AOD.	services Monitor and evaluate effectiveness of services which commenced 1 January 2017 to deliver a holistic service response for Indigenous clients and identify opportunities for driving continuous quality improvement and alignment with State and Commonwealth government services.	Higher rates of successful engagement with Indigenous clients and more effective treatment.	
Alcohol and Other Drug • 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.	Capacity building Capacity building activities with the current GCPHN funded provider. Monitor and evaluate effectiveness of services and identify opportunities for driving continuous quality improvement and alignment with State and Commonwealth government services.	Increased capacity of local Indigenous service providers	GCPHN with subcontractor Krurungal

Indigenous Health (including Indigenous chronic disease)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Aboriginal and Torres Strait Islander Health Cultural competency affects access to services for Aboriginal and Torres Strait Islander people	Continue current arrangements with Kalwun Health Services including employment of Indigenous Health Project Officer (IHPO) mainstream to deliver Cultural Competency training. Review current curriculum content to ensure appropriateness and contemporary and establish systematic process to ensure currency in training. Embed processes to more effectively monitor Cultural Competency training for local service providers particularly those funded by GCPHN.	Increased number of Aboriginal and Torres Strait Islander health assessments by culturally competent trained workforce; improved coordination of care, supporting mainstream service providers to provide culturally appropriate services.	Kalwun with support from GCPHN
Aboriginal and Torres Strait Islander Health Focus on chronic disease early identification and self-management Gaps remain in terms of life expectancy and many contributing factors High numbers of Aboriginal and Torres Strait Islander people with diabetes, COPD and smoking in the region	Integrated Team Care Continue current Integrated Team Care arrangements with IUIH (DoH stipulated contracting IUIH to deliver the Care Coordination and Supplementary Services (CCSS) component through Brisbane North PHN as lead commissioner) and Kalwun Health Services locally. Continue to increase awareness of services for Aboriginal and Torres Strait Islander people. Explore further ability to obtain more detailed data to support monitoring of care coordination and self-management and the impact of access to transport and supplementary services. De-identified data collection, analysis and report generation on the clinical indicators (Diabetes, CKD, COPD, and CHD).	Improve health equity for Aboriginal and Torres Strait Islander people through culturally appropriate mainstream primary care, provide assistance to Aboriginal and Torres Strait Islander people to obtain primary health care as required. Provide care coordination services to eligible people with chronic disease who require coordinated, multidisciplinary care. Improve service users' capacity to self-manage conditions/health.	GCPHN in partnership with IUIH (via Brisbane North PHN) and Kalwun Health Services and mainstream primary care services.
Aboriginal and Torres Strait Islander Health Focus on chronic disease early identification and self-management	Primary Sense See Primary Sense above		GCPHN
Aboriginal and Torres Strait Islander - Mental Health and	Access to information and resources	Facilitate local relationships and partner with mainstream and Aboriginal and	GCPHN in partnership with local service providers.

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Suicide Access and awareness of appropriate services.	Access to information and resources that supports referrals and access to appropriate services. See also Access to Information and Resources above.	Torres Strait Islander services for the delivery of primary care services. Improve health equity for Aboriginal and Torres Strait Islander people by addressing access issues.	
Aboriginal and Torres Strait Islander - Mental Health and Suicide Mainstream services that are culturally appropriate and safe.	See Cultural Competency above	See Cultural Competency above	Kalwun with support from GCPHN
Aboriginal and Torres Strait Islander - Mental Health and Suicide Holistic service response for Aboriginal and Torres Strait Islander clients, including mental health, suicide prevention and AOD.	Coordinated Mental Health AOD and suicide prevention services Monitor and evaluate effectiveness of services which commenced January 2017 to deliver a holistic service response for Aboriginal and Torres Strait Islander clients and identify opportunities for driving continuous quality improvement and alignment with State government services.	Higher rates of successful engagement with Aboriginal and Torres Strait Islander clients and more effective treatment.	GCPHN with subcontractors Kalwun and Krurungal
Alcohol and Other Drug 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.	Aboriginal and Torres Strait Islander service capacity building Capacity building activities with current PHN funded provider.	Increased capacity of local Aboriginal and Torres Strait Islander service providers.	GCPHN with subcontractor Krurungal