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 PHN flexible funding*
- *may be undertaken using programme-specific funding; and*
- *may be led or undertaken by another agency.*

Additional rows may be added as required.

General Population Health

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
General Practice and Primary Care • Support for general practices participating in Practice Incentive Program Quality Improvement (PIP QI) Incentive submitting data through the CAT Plus or Primary Sense through specified improvement measures or any other area that meets the need of the practice population. • Growth in general practice and general practitioners • Gold Coast rates for potentially preventable hospitalisations above the National rate in 2017/18. • Additional support for general practices patient consent arrangements in relation to PIP QI • Established use of secure messaging in Australia, however, a range of systems are currently used with a lack of service compatibility between systems. This means systems, potentially are not able to communicate with each other	General practice support • Continuation of support in 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 • Practices enrolled in PIP QI are provided with quarterly reports which include 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. • Continue to improve data quality through ensuring effective data entry, data cleaning and quality assurance processes. • Maintain 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.	• General practice is supported in the adoption of evidence based best practice methods and meaningful use of digital systems to inform quality improvement, promoting the uptake of practice accreditation and ensuring timely provision of information, resources and or education to support changes in programs and policy that impact on general practice. • General practice adoption of 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.	GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
limiting clinical care coordination, operational and administrative efficiency	• Practice support continue to support general practices with patient consent arrangements • Maintain supporting providers and raising awareness (general practice, specialist and Allied health) regarding secure messaging. Primary Care Improvement • This program will continue to move beyond basic practice support and encompasses 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. This also links with Primary Sense in section below. By identifying the most appropriate tools to assist GPs and general practice to analyse general practice data to assist with proactive planned care of patients with the overall aim of managing patient health care in general practice while reducing unnecessary referrals and admissions to hospital.	• Clinical and social expected outcomes of secure exchange of clinical information through secure messaging • Facilities access to clinical information to improve patient care • Reduced time managing paper-based correspondence • Improved communication between health acre care providers as part of an end-to-end clinical workflow • Improved privacy and security of patient information	GCPHN
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	Integrated Care Alliance • Continue to 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. The models and implementation requirements are currently being scoped.	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.	GCPHN with Gold Coast Health (GCH)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• 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	• A major body of work for GCPHN involves the implementation of shared care frameworks and pathways to enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work. This will include the electronic infrastructure to support the implementation of the new models of care. **Primary Sense** Continue refinement and implementation in practices of automated pseudonymised data extraction and analysis of the health profile of the entire practice population - 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: • 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 • Public Health Surveillance, dashboard updates every five minutes with condition/ symptoms of interest such as influenza/influenzas symptoms. •	• 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 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 by the right person. • 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.	GCPHN with key stakeholders

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
General Practice and Primary Care • While categories 4 and 5 ED presentations have remained stable, there has been 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 • Continue promotion of after-hours doctor's services, online and telephone services to improve awareness of options and help people make appropriate and informed decisions. 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 • Advertising through GCUH screens in foyer and emergency waiting areas.	• Contribute to prevention of increasing numbers of Emergency Department presentations • Reduce the burden in Emergency Departments by reducing the number of unnecessary or inappropriate presentations	GCPHN with GCH
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 GCHHS systems and protocols • Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources In addition, other software options as well as the structure of the current HealthyGC website	• 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
	are currently being reviewed and compared to ensure the service continues to function in the most effective and efficient way. 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.		
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	Public Awareness/Campaign - Cancer • Maintain public awareness campaigns promoting screening and skin checks through usual communication channels including information and resources on website (HealthyGC), GCPHN publications, social and traditional media, targeting particular hot spot areas. General Practice Support – Quality Improvement • Quality improvement activities in general practice support to include prevention as potential focus area including recall / reminder of potentially eligible patients for screening options through Health Assessments and skin checks.	• Increase in awareness and uptake of screening services for breast, bowl and cervical screening. • Increased skin cancer and prostate cancer checks.	GCPHN GCPHN
Immunisation • Lower rates of children fully immunised in Gold Coast particularly Hinterland, Surfers Paradise and Mudgeeraba-Tallebudgera. • Lower rates of HPV vaccination in Gold Coast compared to the national figure.	Public Awareness – Immunisation • Continue public awareness campaigns promoting early childhood, HPV and influenza vaccinations through usual communications channels including information and resources on website (HealthyGC), GCPHN publications, social and traditional media, targeting particular hot spot areas (including areas with overall high percentage of children fully immunised but also high number of	• Increase in awareness and uptake of vaccinations.	GCPHN GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	children not fully immunised- Ormeau-Oxenford and Nerang. General Practice Support – Quality Improvement • Quality improvement activities in general practice support to include prevention as potential focus area including recall / reminder of potentially eligible patients for vaccinations		
Persistent Pain • High rates of musculoskeletal conditions in Southport, Gold Coast North, Ormeau-Oxenford and Coolangatta. • Ageing population means more musculoskeletal conditions projected • Pain management frequently focusses on medication • High levels of opioid dispensing across region compared to national rate, particularly Southport • Need for more awareness and support for prevention and self-management • Focus on multidisciplinary and coordinated care	Continuation of Turning Pain into Gain (Persistent Pain) program with the following service components included: • 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.	Contractor
After-hours • Increasing rates of non-urgent general practice after-hours services among people aged 80 years and over • Ageing population indicates more people accessing after-hours general practice services • Gold Coast rate for potentially preventable hospitalisations above the national rate in 2017-18	Primary Sense • Continue refinement and implementation in practices of 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:	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	GCPHN with stakeholders

• Focus on preventive health interventions and early disease management in primary care and community-based settings to prevent potentially preventable hospotalisation • While categories four and five Emergency Department presentations have remained stable, there has been growth in higher acuity categories, increasing demand on ED services.	• 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 • Public Health Surveillance, dashboard updates every five minutes with condition/ symptoms of interest such as influenza/influenzas symptoms. **Access to information and resources (Healthy gc)** GCPHN will continue to host, develop the I.T infrastructure, update and market the existing web portal featuring • Access to timely up to date health information. **Safe spaces (PCCS)** • Continue to fund after-hours drop-in service for primary mental health care services for people with severe and complex mental illness in the form of community based safe space. **Emergency Alternatives** • Continue promotion of after-hours doctor's services, online and telephone services to improve awareness of options and help people make appropriate and informed decisions. GCPHN anticipate this will continue to assist reduce the burden in Emergency departments by reducing the number of unnecessary or inappropriate presentations. Activities include:	patients get the right care at the right time by the right person. • 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. • Direct links to local service providers information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways • Support for 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 • Increase awareness of the community about other services and options available to the community, when to use them and when it is appropriate to go to an emergency department • Reduce the burden in Emergency Departments by reducing the number of unnecessary or inappropriate presentations.	GCPHN with GCH GCPHN GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• 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 • Advertising through GCUH screens in foyer and emergency waiting areas. InterACT program for hospital avoidance • Work with Gold Coast Health after-hours nurse navigation "Interact" program to complement the Gold Coast Health ED/MAU hospital avoidance among RACF residents.	• Reduced rate of people from RACFs attending ED/MAU at Gold Coast University Hospital and Robna Hospital.	GCPHN with GCH
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.	Integrated Care Alliance • Continue to 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. The models and implementation requirements are currently being scoped. • A major body of work for GCPHN involves the implementation of shared care frameworks and pathways and enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work.	Create a single integrated healthcare system for the Gold Coast by: • Improving the coordination of care to endure consumers receive the right care at the right place by the right person • Increasing effectiveness and efficiency of health services for consumers • Engaging and supporting clinicians to facilitate improvements in our heath system.	GCPHN with GCH
Chronic Disease • Better systems to support care coordination. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients.	Primary Sense • Continue refinement and implementation in practices of 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	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.	GCPHN with key stakeholders including RACGP

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Need for greater focus on prevention, early identification and self-management. • High rates of smoking and harmful alcohol intake across the region.	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 • Public Health Surveillance, dashboard updates every five minutes with condition/ symptoms of interest such as influenza/influenzas symptoms.	• 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..	
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 GCHHs systems and protocols. • Other clinical and service navigation support information including the emerging the new models of care • Professional resources • Patient facing resources	• Improvement in health outcomes in the community.	GCPHN with GCH GCPHN GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	In addition, other software options as well as the structure of the current HealthyGC website are currently being reviewed and compared to ensure the service continues to function in the most effective and efficient way. 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. **Population health management** • Using the learnings from previous Comprehensive over 75 Complex Care Planning, continue to support implementation of comprehensive proactive management of complex and at-risk patients through a quality improvement model in general practice. **General Practice Support – Quality Improvement** • Quality improvement activities in general practice support to include prevention as potential focus area including recall / reminder of potentially eligible patients for health checks and referral to lifestyle modification programs. **Chronic disease care model** Support the implementation of chronic disease care model proposed by Government aimed at improving the health outcomes of patients aged 70 and over and those with a chronic condition in Primary Care.		

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

Aged Care
• High numbers of preventable hospital admissions for older adults are recorded for chronic obstructive pulmonary disorder, 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, G. Ps 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 General Practitioners 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 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
	  • 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, facilitate early and proactive planning of transfers between GCHHS and RACFs.
		• 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 in number of Advance Care Plans and upload to My Health Record.
			GCPHN with partners
			
			Gold Coast Health / other Contractor

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	**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	• Improved practical advice and support for families • Improved awareness by health, community and aged care providers regarding family access to bereavement support • Increased network of volunteers to support palliative care patients and	GCPHN through Greater Choices for At Home Palliative Care with Gold Coast Health and other key stakeholders HHS CNC's HHS Aboriginal Liaison Health Workers Kalwun Health Services

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
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 and for RACFs there are also issues with accessing facilities, coordination with onsite 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	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 GCHHS Palliative Care Service through annual in-service programs about symptom management and medication, and use of Program in the Experience of the Palliative Approach (PEPA) to provide GPs with an opportunity to work in palliative care units; and using existing formal meetings to reinforce these directions • Strengthening the approaches used by GPs to advance care planning and exploring ways to involve practice nurses in advance care planning and ongoing care through the Advance Project education and training. • Face to Face training workshops aimed at upskilling General Practitioners to uptake Advance Care Planning conversations. • Provide support and resources to General Practices to increase knowledge around Advance Care Planning documentation. • Provide education to Stakeholders and Consumers to the role of the Office of Advance Care Planning and the uploading of documents to the QLD Health Viewer. • Providing education to community and hospital Pharmacist about current palliative	their care increased knowledge and uptake of 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 uptake of ACP	Cura Multicultural

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
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	care medications, dosing regiments and side effects. • Provide education and training to Aboriginal and Torres Strait Islanders, upskilling Health Workers and Community Consumers. • Provide Education and training to the CALD Community Stakeholders and Consumers. **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 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** See below • System navigation for palliative care people 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 patient, carer , clinical 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 clinical care coordination to GPs and MDS • Develop a regional palliative patient centered management strategy and process that can be implemented regionally		

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• In consultation with local partners develop quality improvement system to better support general practitioners ensuring coordinated care for their palliative – end of life patients • dedicated support for G.P practices – services to enhance co-ordination for palliative care 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. 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. Demographic data collection on people experiencing or at risk of developing mild mental illness	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 Continue to review New Access program, with a focus on the northern growth corridor of the Gold Coast, which commenced 1st January 2018 Public Awareness Continuation of 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 and Resources above General Population Health section.	Improve targeting of evidence based psychological interventions and models of service to most appropriately support people with, or at risk of, mild mental illness. Enhance the capacity and effectiveness of the funded organisations, General Practice and the broader sector to meet the needs of their client group.	Contracted providers Beyond blue GCPHN GCPHN
National Psychosocial Services Short-term, non-clinical, recovery-focussed psychosocial support services for people of all ages Ensure effective engagement with key vulnerable groups	Coordinated of services • Maintain work with existing contracted provider delivering non-clinical Psychosocial 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-focused psychosocial support	Improve targeting of evidence based Psychosocial interventions and models of service to most appropriately support people with, or at risk of, mild mental illness.	Contracted provider

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
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	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 • Continue 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 health services. See also Access to Information and Resources.		GPCHN and contracted provider GCPHN
Mental Health - Suicide Prevention • PHN funded suicide prevention psychological services are well utilised but opportunity exists to better target those most at risk. • Education and support required for General Practice and mental	Lotus Suicide Prevention • Review of commissioned service – a non-clinical support and transition service 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	Lotus funded under current agreement until June 2020. Improve access to high-quality aftercare to support at risk individuals to stay safe; connect individuals to community-based services; connect individuals with support networks including families, friends and careers; and reduce distress and improve wellbeing.	GCPHN with GCH and Wesley Mission Queensland

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
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 into GP)	facilities. Community workers provide coordination, linkage, and referrals to services who can provide longer term support, in line with the individual's needs. **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. Additionally, GPs can refer through to Better Access. **The Way Back Support Service** • Implement The Way Back Support Service, a non-clinical support service focused on providing practical psychosocial support to people experiencing suicidal crisis or following a suicide attempt. **Joint Regional Plan** • Develop a Suicide Prevention Action Plan as part of the Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drugs Services in the Gold Coast region.	At risk LGBTIQAP+ youth are supported to access culturally safe supports and build connections with like-minded peers. Improve targeting of evidence based psychological interventions and models of service to most appropriately support people at risk of suicide. The Way Back will improve access to high-quality aftercare to support at risk individuals to stay safe; connect individuals to community-based services; connect individuals with support networks including families, friends and careers; and reduce distress and improve wellbeing. The Joint Regional Plan will align future needs assessment and service planning while also identifying key pieces of work in the short term that will develop new ways of working together to improve outcomes with existing resources. The Joint Regional Plan aims to lay the groundwork for collaborative action by: • Developing a better shared understanding of current service system • Identifying specific opportunities for the future service system • Establishing joint governance	GCPHN with Wesley Mission Queensland GCPHN with contracted providers GCPHN, GCH, (with support from Beyond Blue) and service provider GCPHN in partnership with GCH to lead the work in collaboration with: • Lived experience representatives • Clinical representatives from primary and tertiary sectors • Gold Coast Health Mental Health Directorate • Gold Coast Health Strategy & Planning Directorate • Gold Coast Primary Health Network representatives • Aboriginal and Torres Strait Islander community representatives.

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
		structures to leverage in the future	
Mental Health – hard to reach Data, research and consultation with service users, service providers and community members identified the following groups as high risk / hard to reach on the Gold Coast: • 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 behavioural or emotional disorder (including a specific focus on children in care) • People who self-harm or who are at increased risk of suicide.	Psychological Services Program (PSP) • Continue to commission PSP targeting identified high need/hard to reach groups. • 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.	• Psychological services are provided for each target group. • Improve targeting of evidence based psychological interventions and models of service to most appropriately support people with, or at risk of, mild and moderate mental illness.	Contracted providers
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 across 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	headspace • In accordance with Department of Health funding agreement, continue to commission headspace whilst undertaking a co-design process with key stakeholders, including consumers and carers. A second headspace is planned to open on the northern Gold Coast in 2020.	• Headspace funded under current arrangement until 30th June 2022 • Increased access to care for young people (aged 12-18) who are at significant risk or have severe mental illness. Improved mental health for clients.	headspace contracted providers GCPHN with potential providers

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
demand for Mental Health (MH) services for this cohort, including services for Aboriginal and Torres Strait Islander Children. • Education, training and support to engage schools and 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	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 • Maintain exploring opportunities to increase service delivery options for children in Northern Gold Coast area. Youth Enhanced Initiative • Continue funding Lighthouse service which prioritises care for young people (12-18) who are at significant risk or have severe mental health.		GCPHN with Lives Lived Well
Mental Health - Severe and Complex • Coordinated shared care planning that is available across primary care, community and the hospital and health service. • Clear and efficient health pathways to better support severe and complex patients through Primary Care, community and the hospital and health service. • 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.	Coordinated services • Continue to monitor and review Plus Social program targeting people with severe and complex mental health conditions and offering access through after-hours drop-in-centre to further refine support provided to clients. Review and refine intake and referral process to support access from Primary care. Public Awareness • Public awareness campaign promoting increased referrals across the stepped care continuum in particular for severe and complex. Access to Information and resources	• Increased access to services for people with severe and complex mental health issues. Improved mental health for clients	Contracted provider

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Develop efficient pathways to support person centered transfer of care between acute and primary services (general practice, allied health and community services). • Transition to NDIS creates uncertainty for providers in their sustainability to provide services to individuals that are not NDIS eligible.	• Access to information and resources that supports referrals and access to mental health services. See also Access to Information and Resources. Youth Enhanced Initiative • (See above, Mental health- Severe and Complex)		

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Alcohol and Other Drug • Increased detoxification, pre-treatment, residential rehabilitation and aftercare services • Flexible outreach treatment services with a focus on vulnerable target groups including young people. • Promotion of alcohol and other drug treatment services to support early identification • Provision of training and resources including referral pathways, for General Practice to support patients with substance use issues including ice • Enhance collaborative between mainstream and Aboriginal and Torres Strait Islander workforce to support increased access to treatment. • Cultural competency of mainstream alcohol and other drugs treatment services requires improvement to confidently, safely and effectively work	AOD Mainstream • Continue to 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 • Continue to explore outcomes focussed activities and improved data collection. AOD Youth Outreach • Continuation of monitoring and evaluating effectiveness of services to deliver innovative outreach AOD intervention services to young people.	• Timely access to services to capture clients wanting to address their drug use and maximize the effectiveness of the intervention • Increased access for young people to AOD services.	GCPHN with Lives Lived Well GCPHN with Lives Lived Well

Opportunities, priorities and options			
Priority	**Possible Options**	**Expected Outcome**	**Potential Lead**
with Aboriginal and Torres Strait Islander people.	• Review services with a view to driving continuous quality improvement and alignment with State and Commonwealth government investment. Access to Information and resources • Access to information and resources that supports referrals and access to appropriate services. • Training and Education • Training and education as part of workforce and sector support including demand management, commission general management, commissioning general practice training, sector capacity building and general practice referral pathways (links with workforce) Capacity building • Capacity building activities with current PHN funded provider. Monitor and evaluate effectiveness of services and identify opportunities for driving continuous quality improvement and alignment with State Commonwealth government services.	• 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. • Increased capacity of local Indigenous service providers	GCPHN Key stakeholders with GCPHN support GCPHN with subcontractor Kalwun
Mental Health overarching stepped Care approach	Joint Regional Plan • Development of a Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drugs Services in the Gold Coast region. Public Awareness	The Joint Regional Plan will align future needs assessment and service planning while also identifying key pieces of work in the short term that will develop new ways of working together to improve outcomes with existing resources. The Joint Regional Plan aims to lay the groundwork for collaborative action by: • Developing a better shared understanding of current service	GCPHN in partnership with GCH to lead the work in collaboration with: • Lived experience representatives • Clinical representatives from primary and tertiary sectors • Gold Coast Health Mental Health Directorate • Gold Coast Health Strategy & Planning Directorate • Gold Coast Primary Health Network representatives

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Continuation with 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. Centralised information intake and triage • For GCPHN funded services to support more appropriate referral of clients according to their needs across the stepped care continuum. Including review and implementation of the intake assessment and referral mental health services guidance. Education and training • Continue 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).	system • Identifying specific opportunities for the future service system • Establishing joint governance structures to leverage in the future	• Aboriginal and Torres Strait Islander community representatives. GCPHN GCPHN with GCH Contracted provider
Aboriginal and Torres Strait Islander - Mental Health and Suicide	See Aboriginal and Torres Strait Islander Health and Alcohol and other drugs section below		

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 • Focus on chronic disease early identification and self-management • Gaps remain in terms of life expectancy and many	• Continue current arrangements with Kalwun Health Services including employment of IHPO mainstream to deliver cultural competency training (See also workforce). Review current curriculum content to ensure appropriateness and contemporary and establish systematic process to ensure currency in training. • Implant processes to more effectively monitor cultural competency training for local service providers particularly those funded by GCPHN. Integrated Team Care • Continue current Integrated Team Care arrangements with	• 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. • Improve health equity for Aboriginal and Torres strait Islander people through culturally appropriate mainstream primary care, provide	Kalwun with support from GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
contributing factors • High number of Aboriginal and Torres Strait Islander people with diabetes, COPD and smoking in the region	IUIH (Department of Health 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). Primary Sense • Continue refinement and implementation in practices of 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 • Public Health Surveillance, dashboard updates every five minutes with condition/ symptoms of interest such as influenza/influenzas symptoms.	assistance to Aboriginal and Torres Strait Islander People to obtain primary health care as required, and provide care coordination services to eligible people with chronic disease who require coordinated, multidisciplinary care. Improve service users' capacity to self-manage conditions/health. 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 by the right person. • 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	GCPHN in partnership with IUIH (Via Brisbane North PHN) and Kalwun Health Services and mainstream primary care services. GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
		modelling and tracking outcomes over time.	
Aboriginal and Torres Strait Islander - Mental Health and Suicide • Access and awareness of appropriate services. • Mainstream services that are culturally appropriate and safe • Holistic service response aligned social and emotional wellbeing framework for Indigenous clients, including mental health, suicide prevention, and alcohol and other drugs	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. • See cultural competency section above Coordinated Mental Health Alcohol and other Drug suicide prevention services • Continue to monitor and evaluate effectiveness of services which commenced 1st January 2017 to deliver holistic service response for Aboriginal and Torres Strait Islander clients and identify opportunities for driving continuous quality improvement and alignment with State government services.	• Facilitate local relationships and partner with mainstream and Aboriginal and 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. • See cultural competency section above • Higher rates of successful engagement with Aboriginal and Torres Strait Islander clients and more effective treatment.	GCPHN in partnership with local service providers. Kalwun with support from GCPHN
Aboriginal and Torres Strait Islander- 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 Kalwun