Australian Government

Department of Health

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An Australian Government Initiative

Activity Work Plan 2020-2022:

Core Funding

GP Support Funding

This Core Activity Work Plan template has the following parts:

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

Gold Coast PHN

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

Overview

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

Important documents to guide planning

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

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

Formatting requirements

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

1. (a) Planned PHN activities for 2019-20, 2020-21 and 2021-22

▪ Core Flexible Funding Stream

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

ACTIVITY TITLE	**CF1 Chronic Disease Management - Turning Pain into Gain**
Existing, Modified, or New Activity	Existing Activity CF 2017.5 Turning Pain into Gain
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Chronic Disease management
Needs Assessment Priority	**Identified local health needs and service issues** • High rates of musculoskeletal conditions in Gold Coast North and Coolangatta • Ageing population means more musculoskeletal conditions projected • Pain management frequently focusses on medication • High levels of opioid dispensing across region, particularly Southport • Need for more awareness and support for prevention and self-management • Focus on multidisciplinary and coordinated care Persistent Pain Needs Assessment (page 121 of 359 of full Needs Assessment submitted) • Better systems to support care coordination required. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients • Need for greater focus on prevention, early identification and self-management Chronic Disease Needs Assessment (page 135 of 359 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** Continuation of Persistent Pain Program Opportunities, Priorities and Options (page 338 of 359 of full Needs Assessment submitted) Primary Sense: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above)

	• Highlights patients at risk of chronic disease to target proactive health assessment (Page 335 of 359 of Full Needs Assessment submitted) Access to information and resources • Localised referral guidelines and templates for Gold Coast Health, updated to reflect the Clinical Prioritisation Criteria protocols introduced to Queensland • Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources (Page 336 of 359 of full Needs Assessment submitted)
Aim of Activity	Describe what this activity will aim to achieve, and how it will address the identified need (300 word limit). This activity: • promotes improved primary care and chronic pain management through assessment, self- management training, education, and peer support to patients, with limited access to allied health services where required. Expected results of this activity include the following local performance measures: • improved patient's confidence in self-management, • Improved patient reported clinical outcomes and overall patient satisfaction. • Improved general practitioner's confidence in managing patients with chronic disease management • Improved patient reported clinical outcomes and overall patient satisfaction. • Improved clinician reported experience of care and workforce satisfaction.
Description of Activity	Turning Pain into Gain is an innovative primary care model of service delivery which combines a number of evidence-based interventions to deliver a patient centred self-management program with the following service components included: • Individual patient assessment including support to navigate to appropriate service providers and recommendations to patient's GP • Patient self-management education program • Access to digitally supported cycle of care decision support tools and resources for healthcare providers • Access to Additional Allied Health Services where required in addition to MBS funded services. • GP and Allied Health Education Program • Peer to peer support group • Refresher workshops for participants at 6 months, 9 months and 12 months' post program.
Target population cohort	Gold Coast (SA4) residents who comply with the following eligibility criteria:

	• Have suffered chronic or persistent pain which has lasted for more than 3-6 months (The youth focussed component of the program (20-35yrs) has been co-designed with patients and health care providers.)
Indigenous specific	No
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	This program was originally designed and developed in consultation and collaboration with GCH specialist pain and chronic disease services, General practitioners, allied health , public and private specialist Local provider has developed a strong reputation and respect across the primary and secondary care system within the Gold Coast and nationally.
Collaboration	The activity involves ongoing collaboration: **Gold Coast Health/Integrated Care Alliance** Joint work to support the development of this activity and to support ongoing implementation and maintenance of the redesigned models of care. **GPs, allied health and other primary care providers, public/private specialists.** Referrers to the program and access to education sessions **Contractor** Delivers the program in collaboration with a range of specifically identified allied health providers (who have undergone an audit process to ensure suitability and alignment to program outcomes) **Gold Coast Hospital and Health Services** GCH Specialist Pain Clinic Collaboration with Provider to ensure alignment of programs and effective use of referral pathways by specialists and general practitioners.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/06/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known

	☒ Continuing service provider / contract extension Turning Pain into Gain will continue to be commissioned from the same provider. ☐ Direct engagement. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes It was originally co-designed and is continually reviewed and modified in consultation with key stakeholders and partners. 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details N/A
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

ACTIVITY TITLE	CF2 Chronic Disease Management - Wound Management
Existing, Modified, or New Activity	Modified Activity CF 2017.5 Wound Management
Program Key Priority Area	Choose from the following Population Health If Other (please provide details): Chronic Disease management

Needs Assessment Priority	**Identified local health needs and service issues** • Better systems to support care coordination required. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients • Need for greater focus on prevention, early identification and self-management Chronic Disease Needs Assessment (page 135 of 359 of full Needs Assessment submitted) • Comparatively high rates of potentially preventable hospitalisations (including for **cellulitis**) General Practice and Primary Care Needs Assessment (page 16 of 359 of Needs Assessment submitted) • The cost of wound management products (consumables such as particular bandages and dressings) that are used to treat the patient is a barrier to delivery services by general practice. • General Practitioners on the Gold Coast indicated wound management education is required. Chronic disease Needs Assessment (Pages 145 and 146 of 359 of Needs Assessment submitted) **Possible Options identified in Needs Assessment** Integrated Care Alliance • Support the implementation of new integrated models of care. • Preliminary work to develop models of care have been completed for a range of disease conditions. Implementation requirements are currently being scoped. (one of which was **Chronic Wound Care**) Opportunities, Priorities and Options (page 333 of 359 of full Needs Assessment submitted) Access to information and resources • Localised referral guidelines and templates for Gold Coast Health, updated to reflect the Clinical Prioritisation Criteria protocols introduced to Queensland • Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources (Page 336 of 359 of full Needs Assessment submitted)
Aim of Activity	Describe what this activity will aim to achieve, and how it will address the identified need This activity: • Promotes evidence - based resources including reference sites, guidelines and pathways to assist participating primary care clinicians with wound management in their own clinical setting to include direct clinical supervision and professional development of participating nurses and general practitioners at the Chronic and Complex Wound Clinic.

	Expected results of this activity include the following local performance measures: • improved patient's confidence in self-management, • Improved patient reported clinical outcomes and overall patient satisfaction. • Improved general practitioner's confidence in managing patients with chronic disease management • Improved patient reported clinical outcomes and overall patient satisfaction. • Improved clinician reported experience of care and workforce satisfaction. • Reduction of PPH related to chronic wounds
Description of Activity	The Chronic Disease Management Activity promotes improved primary care and chronic conditions management through enhanced primary care services that provide general practice and multidisciplinary assessment, self-management training, education, and peer support to patients and primary care health professionals, with prioritised access to allied health services where required. These include the following programs: General Practitioner with Special Interest (Chronic and Complex Wound Care) The Chronic Wound Service is an innovative primary care model which combines a number of evidence-based interventions to deliver a patient centred model of care with the following service components included: • To pilot a primary care- based model (GP specialist clinic) of care for patients with chronic and complex wounds whilst maintaining close relationships with the patients' usual general practitioner and tertiary services. • To increase capability of the general practice workforce to manage chronic and complex wounds • To promote access and use of evidenced-based guidelines, resources, templates and chronic wound management planning templates to all clinicians on the Gold Coast Access to timely GP wound specialist advice via phone for clinical support and training. This activity addresses the needs by providing coordinated and integrated health services focussed on provision of evidence-based interventions, and information through a medical home model.
Target population cohort	Gold Coast (SA4) residents who comply with the following eligibility criteria: • Have a complex and chronic wound requiring ongoing service within primary care.
Indigenous specific	No
Coverage	Gold Coast PHN Region (Gold Coast SA4)

Consultation	Consultation with contractors as part of ongoing contract monitoring and performance management processes including specific feedback from: o referring GPs and practice nurses across the Gold Coast o patients and families o Gold Coast Health and private specialists
Collaboration	The activity involves the following collaboration: **Gold Coast Health/Integrated Care Alliance** Joint work to support the development of this activity and to support ongoing implementation and maintenance of the redesigned models of care. **GPs, allied health and other primary care providers, public/private specialists** In the development of models of care, subsequent translation of these into information and resources to support implementation of the activity in general practice and RACFs; working closely with participating practices and GPs to ensure their engagement, feedback and input into ongoing service delivery **General Practitioners** Referrers to the program and access to education sessions **Contractor** Delivers the program **Gold Coast Hospital and Health Services** • GCH Wound Services Collaboration with Contractor to ensure alignment of programs and effective use of referral pathways by specialists and general practitioners.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/06/2019 Activity end date: 30/06/2021 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Wound Clinic Service delivery start date: January 2020 Service delivery end date: June 2021 Any other relevant milestones? • Wound Service Delivery Commence 1 January 2020

	• Pilot of the GC Wound Services (January 2020 – June 2021) • Review and evaluation of pilot GC Wound Services model (2021)
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider ☒ Direct engagement. GCPHN has had a long-standing relationship with both the hospital and health services and primary care in relation to review of existing wound services and preferred models of care. The pilot program (GP specialist Wound) Clinic has been established with a GP with long standing recognition and respect within the Gold Coast and nationally for expertise and speciality in management of wounds within primary care. This reputation will ensure the clinic will be maximised and utilised with referral from general practitioners and GCH specialists who have confidence in the skills and expertise with the GP Specialist Wound Clinic. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details GCPHN has have a long-standing work program in relation to Chronic Wound Services across the Gold Coast region and recommendations from the Integrated Care Alliance co-design workshops have informed the model of care design.
Decommissioning	1a. Does this activity include any decommissioning of services?

	No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

ACTIVITY TITLE	**CF3 Health Service Access for Hard to Reach Populations - Community Connectors**
Existing, Modified, or New Activity	Existing Activity ***CF 2019.3*** *Health Service Access for Hard to Reach Populations – (Community Connectors)*
Program Key Priority Area	Aboriginal and Torres Strait Islander Health If Other (please provide details): Culturally and Linguistically Diverse Populations (CALD)

Needs Assessment Priority	**Identified local health needs and service issues**
	• Access to Information about services and resources to support general practice in key areas required
	• Page 1 of General Practice and Primary Care Needs Assessment Summary (page 17 of 359 full Needs Assessment submitted) Effective service engagement with people who
	  o are from culturally and linguistically diverse (CALD) backgrounds
	  o identify as Aboriginal and/or Torres Strait Islander
	• A local workforce comprised of peer support workers, life coaches and support workers able to provide client-centred, trauma-informed, culturally and recovery-oriented support in both outreach and centre-based settings.
	
	The National Psychosocial Support Needs Assessment Summary (page 235 of 359 of full Needs Assessment submitted)
	
	Data, research and consultation with service users, service providers and community members identified the following groups as high risk / hard to reach on the Gold Coast including:
	
	• Culturally and Linguistically Diverse people (CALD)
	• Aboriginal and Torres Strait Islander people
	• Access to psychological services for the CALD population is limited
	• Interpreters used in psychological interventions would benefit from training in mental health
	Mental Health Hard to Reach Groups Needs Assessment Summary (page 252 of 359 of full Needs Assessment Submitted)
	
	• Limited services in the northern part of the region where there are large child and youth populations and significant demand for Mental Health (MH) services for this cohort, including services for Aboriginal and Torres Strait Islander Children

	Youth Mental Health, Including Children Needs Assessment Summary (page 266 of 359 of full Needs Assessment submitted) • Barriers to accessing residential rehabilitation due to upfront financial costs, childcare responsibilities and funds to cover housing costs while in rehabilitation. • Small Aboriginal and Torres Strait Islander workforce which limits the capacity of providers to work with clients who require treatment. • Cultural competency of mainstream alcohol and other drugs treatment services requires improvement to confidently, safely and effectively work with Aboriginal and Torres Strait Islander people. Alcohol and Other Drugs Needs Assessment (page 295 of 359 of full Needs Assessment submitted) • Cultural competency, transport and cost affect access to services for Aboriginal and Torres Strait Islander people • Focus on chronic disease early identification and self-management • Large growth in Aboriginal and Torres Strait Islander population in Ormeau-Oxenford • Gaps remain in terms of life expectancy and many contributing factors Higher rates of Aboriginal and Torres Strait Islander people with diabetes and COPD in the region and higher rates of smoking Aboriginal and Torres Strait Islander Health Needs Assessment (page 310 of 359 of full Needs Assessment submitted) • Access and awareness of appropriate services • Mainstream services that are culturally appropriate and safe • Limited Australian and Torres Strait Islander workforce in specialist mental health services including suicide support Aboriginal and Torres Strait Islander Mental Health and Suicide Needs Assessment (page 310 of 359 of full Needs Assessment submitted)
Aim of Activity	Aim: To increase and improve the access and referral pathways to health and related services for people from culturally and linguistically diverse backgrounds, and/or who identify as Aboriginal or Torres Strait Islander. To highlight well-established, trusted and respected service providers already specialising in engaging with hard to reach groups, to provide an integrated approach to navigating services and enhancing cultural awareness and understanding across the Gold Coast region. For example: • Primary and secondary health care services including mental health, Alcohol and drug treatment and suicide prevention services as well as other chronic disease services. • Child and Family services • Homelessness services • Legal services • Financial support services • Housing services • Employment services

	• NDIS
Description of Activity	Based on the co-designed model of service, continued quality improvement towards the service delivery will be monitored and reported against, with a continued focus to improving health and social outcomes for hard to reach groups in the Gold Coast region. This is being achieved through: • Increasing awareness of and maximising links between services for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities, including those provided by Commonwealth and state/territory governments, AMSs, and other specialist organisations. • Continue to support services across the health and social sectors in educating, developing and implementing strategies to improve access to primary care for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities, i.e. supporting self-identification, providing coaching support to mainstream health provider, providing advocacy on behalf of people accessing services. • Collaborating with local Indigenous health services and mainstream health services in a partnership approach for the delivery of primary care services. The Health Services for Hard to Reach Populations – Community Connectors service has been implemented with the first 6 months demonstrating success with achieving the aims above. The service will continue to be monitored and work undertaken to record the evolution of the model as it develops through continuous quality improvement.
Target population cohort	Aboriginal and Torres Strait Islander people and Culturally and linguistically Diverse people
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector, The model was co-designed with the indigenous community and the services provided by an indigenous provider and will be reviewed after one year of operating with community and service user input.
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	Co-design and consultations with community, providers (health and social Service), clients with lived experience and other funders/Commissioners Ongoing feedback mechanisms once service is established to ensure effective implementations.

Collaboration	GCPHN works in collaboration with the following stakeholders to complete and inform the needs assessment and determine locally appropriate and integrated service solution: 1. the Karulbo Partnership (a local regular meeting with representation from organisations working in relation to A&TSI health and wellbeing with around 30 attendees at meetings) 2. the A&TSI community 3. Kalwun (AMS), 4. Krurungal (ATSI Providers) 5. CURA – CALD providers 6. Institute of Urban Indigenous Health (IUIH) 7. Gold Coast Health – Aboriginal & Torres Strait Islander Services 8. Other health and social service providers.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/06/2019 Activity end date: 30/06/2021 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: October 2019 Service delivery end date: June 2021 Any other relevant milestones Milestones: 1. Consultation and Co-design -May – August 2019- Completed 2. Procurement of Services -August – September 2019- Completed 3. Service Delivery Commenced -1 October 2019-Completed 4. Ongoing implementation of the service delivery through business as usual – quarterly performance meetings and regular relationship manager engagement 5. Review program-Oct – Dec 2020- 6. Decide future commissioning approach for program-Dec 2020-
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension

	☒ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. GCPHN has long standing relationships with key identified providers targeting services for the Aboriginal and Torres Strait Islander and Culturally and Linguistically diverse communities and will work with them and the community to determine the model of service and procurement approach that will possibly be a direct approach given the strength of these providers with their communities. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No Should the program prove successful consideration will be given to approaching other government agencies of Department of Communities etc to co-fund and potentially extend the program. 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

ACTIVITY TITLE	**CF4 Enhanced Primary Care *(*PMP Clinical Educator – Palliative)**
Existing, Modified, or New Activity	Modified Activity CF 2017.6 Enhanced Primary Care in RACFs.

Program Key Priority Area	Aged Care If Other (please provide details): Palliative Care The Gold Coast Primary Health Network (PHN)'s Palliative Care Health Needs Assessment identified the need for better collaboration and coordination across palliative care services. This is particularly important in the sector due to patients' frequent transitions between emergency department, hospital inpatient wards, residential aged care facilities (RACFs), community care and General Practices. Additionally, it has been identified that not all primary palliative care providers have the capacity and capability to deliver generalist high-quality palliative care and end of life care. This is evident across RACFs' staff. Main issues found within RACFs located on the Gold Coast region are lack of education and access of information regarding the provision of palliative care, advance care planning and future care planning strategies for residents.
Needs Assessment Priority	**Local health needs and service issues – GCPHN Needs Assessment 2019 Aged care and Pallaitve 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 afterhours 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. 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 and for RACFs there are also issues with

	accessing facilities, coordination with onsite nursing staff and communication with deputising services.
Aim of Activity	Increase knowledge, confidence and skills of RACF staff and primary care (nursing staff and General Practitioners) to provide high-quality palliative and end of life (EOL) care within the identified facilities. Objectives • Enhance RACF Staff and GP knowledge and confidence in providing palliative care to residents • Enhance RACF Staff and GP knowledge and referral pathways to services that can support the residents including access to Specialist Palliative Care and Interact Services. • Enhance RACF Staff and GP knowledge of resources available to them to support advanced care planning and end of life care • reduce potentially preventable hospitalisation • improve the experiences for residents, clinicians and staff
Description of Activity	The findings from the initial audit and service screening activities from the 5 RACF identified from the initial project PMP Clinical Nurse Educator CF2019.4 have now been identified and designed to under the following service components. The service components will be underpinned by a coordinated approach to educating the aged care nurses and General Practitioners with three projects running simultaneously including the: • Palliative Approach Nurse Education, support RACFs to embed within their routine clinical practice a comprehensive evidence-based palliative approach to care, thereby improving resident and family outcomes. o Work in collaboration and partnership with InterAct team who provide clinical nursing care and intervention to patients residing in RACFs; o Educate facilities to promote and support an Emergency Department bypass model for specialist palliative care patients in RACFs o Facilitate the provision of appropriate pathways for specialist palliative care; o Support quality, timely and responsive care services to RACF residents delivered through a GP led multi-disciplinary primary health care team; o Support enhancement of a robust clinical governance framework to support the delivery of high quality, safe, evidence-based Specialist palliative care in RACF;

	o Identify and implement systems and mechanisms that ensure ongoing sustainability of the project outcomes beyond the Project period. • Resources and Events conduct educational events and develop promote online educational resources for RACFs as a sustainable strategy to support Advance Care Plan (ACP) Champions and RASS Palliative Nurse Approach in RACFs to provide quality end-of-life care to residents and their families. o Provide educational support and resources within RACFs to assist in raising the confidence of staff and GP caring for specialist palliative patients. o Provision of onsite education on clinical/care coordination services with an emphasis on clinical handover and End-of-Life (EOL) care. o Education, training, information and resources to support RACF staff, visiting health professionals, family of residents in the delivery of the Project. • Advance Care Planning: support RACFs to embed an evidence-based ACP program, adapted for individual facilities, in their routine clinical care to support high quality EOL care for residents and their families This component links closely with • CF4 Enhanced Primary Care (PMP Clinical Educator- Palliative) • HSI 3 Integrated Care Alliance (ICA) – Development and Implementation (including development of health pathways and shared care) • Greater Choices for At Home Palliative Care (GCFAHPC) Project
Target population cohort	Residents of a selected group (approximately 5) Gold Coast RACFs, who are at risk of poor health outcomes due to geriatric syndromes, complex comorbid chronic disease sets, palliative care, frailty and barriers to access to timely appropriate health care.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No
Coverage	Targeted Residential Aged Care Facilities (5) and the 20 regular GPs who currently provide services
Consultation	Extensive engagement and consultation have been completed as part of phase one of the project in the deep dive process within the 5 RACFs and 20 G.ps servicing the RACFs and GCHHS frail Aged Collaborative project Team. Joint working groups and consultation activities have been undertaken with the GCPHN Clinical and Community Advisory Group, GCH, General Practice, Primary Care Sector, Peak bodies, other State agencies and consumers. Many of these mechanisms will continue in order to provide ongoing feedback and input to ensure ongoing engagement and continuous improvement:

Collaboration	**Gold Coast Health/Integrated Care Alliance** Joint work with GCHHS Frail Aged Collaborative continues to support the development of this activity and to support ongoing implementation and maintenance of the redesigned models of care. Clinical and Executive leadership continues with GCHHS and SPCS to provide senior governance to the project group, with a particular focus on ongoing clinical outreach support and education for general practice and RACFs. **GPs, allied health and other primary care providers, public/private specialists.** Continued linking and collaboration to support the subsequent translation of identified pathways of care and related policies and procedures; working closely with participating practices and GPs to ensure their engagement, feedback and input into ongoing service delivery.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2020 Activity end date: 30/06/2021 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: 1/07/2020 *Service delivery end date: June 2021* • Conduct and document focus groups with RACFs staff, GPs and residents/families/carers as part of evaluating the commencement of project with initial 5 RACFs (July 2020 -August 2020) • Refinement of education and quality improvement support package and service model for RACF staff and GPs (August - September 2020) • Implementation of the education and quality improvement support program (education and support package and service model) in 5 current and additional 5 RACFs (October –May 2021) • Collection and documentation of program data (ongoing – May 2021) • Project Evaluation completed June 2021 Any other relevant milestone • Service Agreement Extended for additional 12 months and Agreed by 1 July 2020 • Extended Ethics approval for formal evaluation with GCHHS Research Team and GCPHN approved July 2020

Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☒ Direct engagement. The GCH service are the only specialist (secondary) public hospital and community health palliative provider locally. As part of the Integrated Care Alliance redesigned models of care, agreement has been reached between the PHN and the GCH about the commitment of the GCH to providing extended services as outreach into RACFs and to support optimal primary care in RACFs. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No Should the role prove to be effective Gold Coast Health have indicated that they would continue to fund the position as a recurrent role within their services from 1 July 2021. 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details Continued quality improvement towards the service delivery model will be monitored and reported against with the Gold Coast Hospital and Health service, participating pilot RACF sites, Model of Care Steering committee and the GCPHN Aged – Palliative care Leadership Group. GCPHN has have a long-standing work relationship with these key stakeholders and Services across the Gold Coast region and recommendations and feedback will be included in the redesign and monitoring of the project.
Decommissioning	1a. Does this activity include any decommissioning of services?

	No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

ACTIVITY TITLE	**CF5 AOD Alcohol and Other Drugs Home Detox Program**
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. New Activity If activity is existing or modified, provide the relevant reference/s from previous Activity Work Plan/s where possible. Note: *This activity is connected to 2020-21 AH3 Alcohol and Other Drugs After Hours – Treatment*
Program Key Priority Area	Choose from the following: Alcohol and Other Drugs If Other (please provide details):
Needs Assessment Priority	Gold Coast PHN Needs Assessment 2019, Page P1 in the Alcohol and Other Drugs Needs Assessment Summary (page 71 of 271 in Needs Assessment documentation as submitted to DoH). • *Increased detoxification, pre-treatment, residential rehabilitation and aftercare services* • *Flexible outreach treatment services with a focus on vulnerable target groups.* (Page 352 of 359 2019 Full Needs Assessment submitted) • *Demand for treatment outstrips capacity, and wait lists are common, people often disengage while waiting to get into treatment* • *Limited detox capacity on the Gold Coast. Barrier for people wanting to access rehabilitation as they are required to detox prior to rehabilitation. Flexible options including in-home detox are required to meet this need.* (Page 233 of 279 2018 Full Needs Assessment)
Aim of Activity	This activity aims to pilot an in-home withdrawal management (detox) program in the Gold Coast region. • Increase availability of withdrawal management treatment • Increase timely access to withdrawal management treatment

	• Improve continuity of care for clients accessing treatment through supported transition of care between services, particularly on completion of detox and into residential rehabilitation • Improve AOD treatment outcomes for clients • Reduce harm associated with drugs and alcohol use, with a focus on methamphetamine use

Description of Activity	**Home Detox program**
	
	This activity will see GCPHN co-fund in partnership with QuIHN, an innovative and much needed in-home detox program within the Gold Coast region. The program will be a pilot to support the development and testing the feasibility and efficacy of the model, which will see the provision of home visits to clients engaged in the detox program and support these clients safely through detox in their own homes.
	
	Withdrawal Care Guidelines have been developed to support the delivery of this program. These are evidence-based guidelines that were developed for QuIHN clinicians that will enable them to support their clients in conjunction with the medical team who are engaged in the program to safely manage the withdrawal period.
	
	Service Model details:
	
	• The program will be delivered by a Nurse Practitioner (alcohol and drugs) and overseen by a Registered Nurse.
	• The Nurse Practitioner will develop a service model that includes assessments, risk management, policies and procedures.
	• Clients of the program will be (based on assessment criteria):
	  ○ Individuals who are existing clients of QuIHN identified as requiring detox
	  ○ Individuals seeking detox who are referred directly to the program from eligible referrers
	• Prior to undertaking a home detox, the client will be assessed for additional health concerns, risk assessments will be undertaken, support plans will be developed and implemented and a contract with the client entered into to commence the treatment.
	• Some individuals who complete the detox program will require further treatment in residential rehabilitation or through outpatient rehabilitation programs. QuIHN will work in partnership with external agencies to support identified clients to transition to the required service.
	• This service will not be provided to clients seeking to detox from severe alcohol use, who will be referred to residential detox services.

	QuIHN will undertake an external evaluation for this trial program in collaboration with GCPHN. The evaluation methodology and scope will be determined in the early phase of model implementation.
Target population cohort	Individuals 18+ requiring withdrawal management treatment for alcohol and/or other drug use Individuals requiring detox for severe alcohol use cannot be supported by this program and will be re-referred to other appropriate treatment services.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Outline coverage of the activity. Where area covered is not the whole PHN region, provide the statistical area as defined in the Australian Bureau of Statistics (ABS), or LGA. This activity will cover the full GCPHN area.
Consultation	Increased withdrawal management and detox treatment has consistently been identified as a high priority in the region. Gold Coast providers experience high demand for treatment and report difficulty accessing detox services for clients who require this treatment prior to entering residential rehabilitation. This need has been identified over several years throughout various co-design processes for AOD and mental health services, during AOD specific capacity building working groups and the development of PHN needs assessments. The Joint Regional Plan consultation has highlighted the absence and need for more of, and alternative models of, detox treatment and has built on the intelligence we had in relation to the complexity of accessing detox at the right place, at the right time and by the right service. In the development of the model QuIHN has undertaken a range of planning and their own consultation process internally and externally to the service.
Collaboration	Stakeholder/Partners: • Gold Coast Health: Collaborative working relationship, Referrals • Aboriginal and Torres Strait Islander services, mental health services: Referrals • AOD and mental health services: Collaborative working relationship, Referrals • General Practice including after- hours services: Service information and referrals
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):

	Activity start date: 1/07/2020 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: August 2020 Service delivery end date: June 2022 Any other relevant milestones? During the term of this activity plan the following milestones are anticipated: 1. Pilot implementation including recruitment, development of policies and procedures, establishment of referral pathways (July - September 2020) 2. Development of evaluation framework (October – December 2020) 3. Service delivery and business as usual, quarterly performance meetings and regular relationship manager engagement (October 2020 – June 2021) 4. Evaluation outcome to inform ongoing pilot activity or future procurement approach (July – September 2021)
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☒ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) In late 2019 QuIHN approached GCPHN with a funding proposal to pilot an innovative service model to support clients who are appropriate to receive in-home detox treatment. QuIHN has been commissioned by GCPHN since January 2017 and has been reviewed to be high performing provider and well respected in the region. They were assessed as having the capability to manage and govern this activity. GCPHN sees this a unique and exciting opportunity to support the introduction of a new service model to meet the growing demand for detox treatment. 2a. Is this activity being co-designed? No

	2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

ACTIVITY TITLE	**CF 6 Integrated Care Alliance (ICA) Pathways Non-staff expenses (license/storage costs)**
Existing, Modified, or New Activity	Modified Activity CF 2017.1 Integrated Care Alliance (ICA) – Health Pathways (Healthygc) Also relates to ***HSI2 - Access to information and resources*** as the publication portal for Gold Coast health pathways information and resources and ***HSI 3 Integrated Care Alliance (ICA) – Alliance Development and implementation*** (including development of health pathways and shared care for the clinical engagement and development of the specialist content for the health pathways
Program Key Priority Area	Digital Health / Area population Health
Needs Assessment Priority	**Identified health needs and service issues** • Access to Information about services and resources to support general practice in key areas is required. Page 1 of General Practice and Primary Care Needs Assessment Summary (Page 22 of 279 of full Needs Assessment Submitted) • Better systems to support care coordination required • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients

	Page 1 of Chronic Disease Needs Assessment Summary (page 71 of 279 full Needs Assessment submitted) • Access to clear communication and accessible information for patients, families and health care professionals • Current systems not always established for the provision of clinical care coordination of end of life care between providers Page 1 of Palliative Care Needs Assessment Summary (page 130 of 279 of full Needs Assessment submitted) • Promotion of low intensity services to General Practice to support complementary use with other primary health interventions • Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services Page 1 of Low intensity Mental Health Services Needs Assessment Summary (page 168 of 279 of full Needs Assessment submitted) • Efficient referral pathways to increase accessibility to new psychosocial services • Improved service coordination for individuals with severe mental illness and associated psychosocial functional impairment, while considering support available across levels of government, the community and relevant sectors Page 2 of National Psychosocial Support (NPS) Needs Assessment Summary (page 174 of 279 of full Needs Assessment submitted) • Develop clear referral pathways and supported connections to appropriate community supports Page 1 of Mental health Suicide Prevention Needs Assessment Summary (page 179 of 2779 of full Needs Assessment submitted) For children in care- • Issues with transfer of information • Limited knowledge and adherence to guidelines/frameworks by health care providers Page 1 Mental Health – Children and Youth Needs Assessment Summary (page 200 of 279 of full Needs Assessment submitted) • Develop efficient pathways to support person centred transfer of care between acute and primary care services (general practice, allied health and community services) Page 1 of Mental Health Severe and Complex Needs Assessment Summary (page 210 of 279 of full Needs Assessment submitted). • Provision of training and resources, including referral pathways, for general practice to support patients with substance use issues including ice Page 1 of Alcohol and Other Drugs Needs Assessment Summary (page 224 of 279 of full Needs Assessment submitted) • Access and awareness of appropriate services

	Page 1 of Aboriginal and Torres Strait Islander Mental health and Suicide Needs Assessment Summary (Page249 of 279 of full Needs Assessment submitted)
	
	Possible Options identified in Needs Assessment
	
	Integrated Care Alliance
	
	• Support the implementation of new integrated models of care
	• Preliminary work to develop models of care have been completed for a range of disease conditions. I implementation requirements are currently being scoped.
	• A major body of work for GCPHN involves the implementation of a e-library solution to enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work.
	Page 3 of Opportunities Priorities and Options (page 256 of 279 of full Needs Assessment)
	
	Access to information and resources
	
	• GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing web portal featuring:
	  ○ 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.
	Page 5 of Opportunities Priorities and Options (page 258 of 279 of full Needs Assessment)

Aim of Activity	This activity aims to provide for the license and storage costs associated with ***HSI 2 - Access to information and resources*** as the publication portal for Gold Coast health pathways information and resources and ***HSI 3 Integrated Care Alliance (ICA) – Alliance Development and implementation*** (including development of health pathways and shared care for the clinical engagement and development of the specialist content for the health pathways. Together these activities increase access to appropriate timely, coordinated, high quality information and resources to support standardised care across the continuum between Primary, Community and Secondary Sectors. It aims to provide a stable, reliable, accurate digital platform that provides general practice, primary care service providers and the broader community access to

	the necessary curated, up-to-date information and resources that support access to service options, referral and optimal care management. In 2018/19 GCPHN and GCHHS decided not to implement the Streamliners *HealthPathways* system, based on cost, but rather agreed to revise GCPHN's HealthyGC website to better address this need and be a local solution that performed this function. This is achieved through design, delivery and maintenance of a comprehensive web based health and wellbeing information portal that was identified as critical to integrated care within all model of care workshops. This has been identified as a key way for general practice, primary care service providers, secondary care providers and the broader community to access locally tailored and contemporary information.
Description of Activity	This activity provides for the Non-staff associated expenses of HealthyGC website (License and storage costs). Note that the staff costs associated with the maintenance and development of content are funded through the HSI stream activity ***HSI 2 Access to information and resources***. Also note that the ***HIS 3 Integrated Care Alliance (ICA) – Alliance Development and implementation*** covers the activity and costs for the clinical engagement and development of the specialist content for the health pathways and shared care. This activity covers the costs of licensing, hosting and other associated online publication costs to support Gold Coast health and integrated care referral and localised service pathways information. HealthyGC website is an open access, publicly available website for consumers and the community which enables access to a generated compilation of appropriate, evidenced-based quality health resources, service information and links.
Target population cohort	Whole PHN region, but with priority being given to publication of information about Palliative Care, Aged Care RACF, Mental Health, AOD treatment services.
Indigenous specific	No
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	Extensive consultation has been undertaken as part of Integrated Care Alliance's model of care development and the development of the Deep Dive Needs Assessment and Regional Planning for Palliative Care and Aged Care RACF completed December 2018. Joint working groups and consultation activities have been undertaken with the GCH, General Practice, Primary Care Sector, Peak bodies, other State agencies and consumers. Many of these mechanisms will continue in order to provide ongoing stakeholder feedback and input to the usability and fitness for purpose of the Gold Coast's health pathways publication platform.

	Further detailed consultation is being undertaken during 2019 to complement the review and co-design of the HealthyGC website in collaboration with health pathways and share care component of the ***HSI 2- Access to information and resources*** activity.
Collaboration	**Gold Coast Health/Integrated Care Alliance** Joint work to support the development of this portal as the Gold Coast's knowledge platform and e-library solution to support implementation of the redesigned models of care. To provide Clinical and Executive leadership engagement in senior governance group, with a particular focus on clinical leadership engagement. **GPs, allied health and other primary care providers, public/private specialists** In the development of models of care, subsequent translation of these into mapped health pathway information and resources and to support end user requirements and testing of the publication platform for the pathways material **Consumers** Engagement with consumer advisory committee to ensure models of care, resulting health pathways materials and publication platform are fit for purpose for consumer end users; to include input into design, development, testing and continuous quality improvement
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.

	☐ Open tender ☒ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details Co-design involved over 200 clinicals through over 50 workshops over a 12-month period to design optimal model of care for 20 high use conditions are determined by clinicians. The results of the workshops were developed into draft models of care that were reviewed by the clinical reference group, the consumer reference group, and then approved by Alliance Leadership Group. Co-design will continue to be used to ensure that the models of care are translated into online resources such as pathways and clinical prioritisation criteria to enable seamless transfer of care between clinicals and sectors.
Decommissioning	1a. Does this activity include any decommissioning of services? No

ACTIVITY TITLE	**CF7 Primary Sense™ Population Health Management and audit tool -**
Existing, Modified, or New Activity	Existing Activity Previous title/code: GPS 2019.2 Primary Sense™ Population Health Management and audit tool
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details):

Needs Assessment Priority	**Identified local health needs and service issues** **General Practice and Primary Care Summary Needs Assessment:** • More than half of GPs surveyed said mental health issues caused them the most concern for the future followed by obesity, diabetes, aged care and the ageing population, drug addiction and chronic pain and palliative care. • High quality, evidenced based care planning processes support delivery of comprehensive quality health care. Access for GPs to the best evidence based GP Care Plan template and process should be supported. Access to Information about services and resources to support general practice in key areas required • Fee for service and current MBS structures do not incentivise best practice for chronic disease management, screening or prevention activity and is a particular impediment for practice nurses • Currently limited ability to use general practice data to implement proactive care and data is of variable quality. This will become increasingly important as Quality Practice Incentive Payment implemented • Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza) • My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers • Potential to increase use of data in general practice software to proactively plan care. • Frequently current systems (including MBS payments and data) do not support population health approach and care-coordination Pages I7-35 of General Practice and Primary Care Health Needs Assessment (Extra information added which was requested from DOH to link that shows the activity meets core flexible funding stream requirements. GCPHN 2019 needs assessment was informed by numerous data sources and consultation with service providers, users and key stakeholders to identify local health needs and service issues. A theme that was highlighted with service providers, stakeholders and analysing data was GCPHN needed to invest in an IT system like Primary Sense to support moving from single person focussed care to management of the Practice Population. This was highlighted in the below two needs assessments.

	General Practice and Primary Care- local health need and service issue • 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 **Mental health – Low Intensity - local health need and service issue** • Demographic data collection on people experiencing or at risk of developing mild mental illness which can be extracted through Primary Sense. Data extracted from Primary Sense will inform the 2020 needs assessment submission. Local health needs that have been identified in several past submitted needs assessments will be analysed through Primary Sense and will have the capability to produce up to date data. Below are three needs assessments that Primary Sense data will inform to further identify local health needs and service issues on the Gold Coast. **Chronic Disease** Monitoring chronic disease prevalence in the 81 General Practices currently submitting data through Primary Sense on the Gold Coast can be extracted for the 2020 GCPHN needs assessment. **Persistent Pain** Primary Sense is assisting in the 2020 GCPHN persistent pain needs assessment process by identifying the number of patients presenting to their GP for back pain and the rate of prescriptions of opioid medicines which as outlined by AIHW is a local and international cause of concern. **Family and Domestic Violence** Primary Sense is assisting with the development of the 2020 family and domestic violence needs assessment by extracting GP encounters due to family and domestic violence. This data highly valuable as there is no dedicated MBS item number referenced to this.
Aim of Activity	To support general practices to make timely decisions for better health care for their respective populations through Primary Sense by: • integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms · identifying high risk groups for proactive care

	• relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time. • providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time. Primary Sense will enable a practice- based population health management approach to reduce unnecessary hospital use, by • Correctly identify which patient groups are suitable for appropriate evidence - based interventions at a local (GP) and regional (PHN) level · Correctly identify patients at risk of poor outcomes on the Gold Coast • Enabling patients to be more effectively managed in primary care and avoid preventable hospitalisations and ED presentations in hours, and after hours
Description of Activity	This element of the activity works with GPs 2019.2, 2020.5 to provide the automated Primary sense tool set that provides 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 related to avoidable admissions, ED presentations and potential mortality rates. Primary Sense is as an evidenced based decision assist tool to help inform timely decisions for better primary healthcare. Primary Sense is compatible with Medical Director and Best Practice software (comprising approximately 90% of the general practice software market in the Gold Coast)

	Further programming of medication safety alerts and reports will continue based on user feedback, and advice from key clinicians and academics. System and process enhancements may include • Optimising care/service navigation for selected populations based on demographics or diagnoses • Automated access to the Australian Immunisation Register from in the practice • Automation and time stamping of patient consent collection at the practice • Targeted patient selection and alerts for research project recruitment • Outcome monitoring for health activities – such as reduced adverse medication events • Computerised decision support mechanism for better guideline implementation • Audit and feedback for GP trainee education • Automated chart review for GP training and professional development • Linked databases to better understand potentially preventable hospital admissions • Quality Improvement Clusters – peer review process • Public Health – automated post-market surveillance. Post immunisation adverse event tracking • Public Health early warning of emerging outbreaks/symptom clusters
Target population cohort	Total practice population where Primary Sense™ is installed (up to 85% of general practices in the Gold Coast region)
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No
Coverage	Whole Gold Coast PHN region (SA4). This activity plan seeks to support the roll out of Primary Sense to provide geographical coverage for the whole PHN region but will be dependant of the practice software and willingness to participate. Currently there are 78 practices with Primary Sense™ and 620,000 individual patients in the database. Aim is to increase use of toolset up to 85% of practices in Gold Coast region
Consultation	The ongoing development is supported by feedback from the general practice users, with advice and guidance from key clinicians and academics on clinical

	enhancements to the system, and IT experts and academics on enhancement to cyber security. Johns Hopkins University regarding the use of the ACG Risk Stratification tool embedded in Primary Sense
Collaboration	GCPHN is seeking support from other PHNs to scale and further enhance the tool
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2020 Activity end date: 30/06/2021 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Planned to be in use in 50% (n=81) Gold Coast practices by June 2020 and potential expansion up to 85% (n=138) by June 2021 with future plan of up to 100% of eligible practices by June 2022 3 partner PHNs by June 2021
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed?

	No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details The Primary Sense™ Population Health Management and audit tool was extensively co-designed with the support of key national expert clinical advisors, local general practice users and our GCPHN Practice Support Team.
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, please provide a description of the proposed decommissioning process and any potential implications

(b) Planned PHN activities for 2019-20 to 2021-22

- **Core Health Systems Improvement Funding Stream**
- **General Practice Support funding**

ACTIVITY TITLE	**HSI 1 Commissioning Systems and Stakeholder Engagement**
Existing, Modified, or New Activity	Existing Activity HSI 2018.2 Commissioning Systems and Stakeholder Engagement
Program Key Priority Area	Digital Health
Needs Assessment Priority	**Identified health needs and service issues** General Practice and Primary Care • Access to Information about services and resources to support general practice in key areas is required. (Page 335 of 359 of full Needs Assessment submitted) Chronic Disease • Better systems to support care coordination required • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients (Page 340 of 359 full Needs Assessment submitted) Palliative Care • Access to clear communication and accessible information for patients, families and health care professionals • Current systems not always established for the provision of clinical care coordination of end of life care between providers (Page 196 of 359 of full Needs Assessment submitted) Low intensity mental health services • Promotion of low intensity services to General Practice to support complementary use with other primary health interventions • Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services (Page 347 of 359 of full Needs Assessment submitted) National Psychosocial services • Efficient referral pathways to increase accessibility to new psychosocial services

	(Page 348 of 359 of full Needs Assessment submitted) Mental health- Suicide Prevention • Develop clear referral pathways and supported connections to appropriate community supports (Page 349 of 359 of full Needs Assessment submitted) Mental health- Children and Youth • Issues with transfer of information • Limited knowledge and adherence to guidelines/frameworks by health care providers (Page 351 of 359 of full Needs Assessment submitted) Mental health- Severe and complex • Develop efficient pathways to support person centred transfer of care between acute and primary care services (general practice, allied health and community services) (Page 351 of 359 of full Needs Assessment submitted). Alcohol and other drugs • Provision of training and resources, including referral pathways, for general practice to support patients with substance use issues including ice (Page 352 of 359 of full Needs Assessment submitted) Aboriginal and Torres Strait Islander Mental health and Suicide • Access and awareness of appropriate services (Page 356 of 359 of full Needs Assessment submitted)
Aim of Activity	To provide commissioning excellence support to the PHN and partner activities towards supporting one world class health system for the Gold Coast and supporting high performing primary care.
Description of Activity	This activity provides the commissioning systems support for the PHN's activities including Flexible Funding, Health System Improvement, General Practice Support, After Hours and Other Funding programs including ITC, MH, AOD, Palliative Care. The activity provides the following functions and resourcing: • Needs assessment and annual planning • Market assessment and Service co-design • Procurement and contracting • Performance monitoring, Quality, Risk and Evaluation • Stakeholder Engagement, communications and marketing These activities enable the primary health care sector to be inform, be engaged in and shape the evaluation of current primary and intermediate care services as well as shape future services through:

	• Ensuring primary care inform the annual and specific needs assessment activities • Involving primary care sector in market assessment and Service co-design • Supporting primary care sector to engage in and inform commissioning through procurement and contracting activities • Providing data and information to the primary care sector that assists in their decision support and driving quality improvement of services and improved patient outcomes • Ensuring high quality, comprehensive and timely organisational systems that enable internal and provider performance monitoring and reporting, including all DoH and other funding body reporting deliverables • Maintaining comprehensive Quality Management Systems and Accreditation to support quality assurance of our products, services and processes, a mature risk management framework and Innovation, Research, Service review and Evaluation frameworks • Providing mature and comprehensive stakeholder engagement, relationship management, communications (traditional and online) and Commissioned services and program promotion campaigns; informing, engaging in and contributing through an extensive set of communications and engagement channels and programs.
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity. NA
Target population cohort	Healthcare system, providers and consumers in the whole PHN region i.e. Gold Coast PHN Region (Gold Coast SA4)
Indigenous specific	No
Coverage	whole PHN region i.e. Gold Coast PHN Region (Gold Coast SA4)
Consultation	**General Practice Gold Coast** Provide ongoing engagement opportunities, communication channels and advice about general practice in the Gold Coast; input into service review, development and evaluation; partner in delivering education and other quality improvement activities **Primary Care Partnership Council** Provide ongoing engagement opportunities, communication channels and advice about broader primary care sector and key State agencies in the Gold Coast; input into service review, development and evaluation **Karulbo Partnership** Provide ongoing engagement opportunities, communication channels and advice about engagement of Aboriginal and Torres Strait Islander People in PHN and partner activities and about culturally appropriate practices and

	service models in the Gold Coast; input into service review, development and evaluation **Gold Coast Health/Integrated Care Alliance with Gold Coast Health** Provide ongoing engagement opportunities, communication channels and advice and a formalised partnership through which the PHN consults with GCH board, executive, administrative and clinical leads about referral, care coordination, service integration and clinical handover in the Gold Coast; input into service review, development and evaluation; partner in delivering education, models of care development and other integration activities **Gold Coast Health specialists, academics and local providers** Engage with a variety of local, national and international health service specialist and researchers to access expert advice and input to Co-design, service development, evaluation and procurement activities **National Health Service Directory, 13 Health** Ongoing engagement to ensure a collaborative approach to each other's service directory
Collaboration	1.**General Practice Gold Coast -** Provide advice and input into the service review, development and engagement of Gold Coast General practice in PHN and partner activities **2. Primary Care Partnership Council -**Provide advice and input into the service review, development and engagement of Gold Coast Primary Care Sector in PHN and partner activities **3.Karulbo Partnership-** Provide advice and input into the service review, development and engagement of Aboriginal and Torres Strait Islander People in PHN and partner activities and about culturally appropriate practices and service models **4. Gold Coast Health General Practice Liaison Unit -**Provide advice and liaison between general practice and Gold Coast Health **5. Gold Coast Health/Integrated Care Alliance with Gold Coast Health-** Provide advice and input into referral, care coordination, service integration and clinical handover **6. Gold Coast Health specialists, academics and local providers-** Provide advice and engagement of Health Service Providers and researchers in Co-design and procurement **7. National Health Service Directory, 13 Health-** Link to each other's service directory and ensure sharing and refining service directory information across these services

	8. National PHN Collaborative and Qld/NT/Northern NSW PHN network Ongoing engagement to ensure a collaborative approach to development work and sharing of materials to ensure best use of public funding
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No

	3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details NA
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

ACTIVITY TITLE	**HSI 2 Access to information and resources (HealthyGC)**
Existing, Modified, or New Activity	Existing Activity HSI 2018.1 Access to information and resources If activity is existing or modified, provide the relevant reference/s from previous Activity Work Plan/s where possible. Also relates to ***CF 6 Integrated Care Alliance (ICA) Pathways Non-staff expenses (license/storage costs)*** which provides for this component of publication platform costs and ***HSI 3 Integrated Care Alliance (ICA) – Alliance Development and implementation*** (including development of health pathways and shared care) which provides for the clinical engagement and development of the specialist content for the health pathways
Program Key Priority Area	Population Health
Needs Assessment Priority	**Identified health needs and service issues** General Practice and Primary Care • Access to Information about services and resources to support general practice in key areas is required. (Page 335 of 359 of full Needs Assessment submitted) Chronic Disease • Better systems to support care coordination required • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients (Page 340 of 359 full Needs Assessment submitted) Palliative Care • Access to clear communication and accessible information for patients, families and health care professionals • Current systems not always established for the provision of clinical care coordination of end of life care between providers (Page 196 of 359 of full Needs Assessment submitted) Low intensity mental health services • Promotion of low intensity services to General Practice to support complementary use with other primary health interventions • Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services (Page 347 of 359 of full Needs Assessment submitted) National Psychosocial services • Efficient referral pathways to increase accessibility to new psychosocial services

	(Page 348 of 359 of full Needs Assessment submitted) Mental health- Suicide Prevention • Develop clear referral pathways and supported connections to appropriate community supports (Page 349 of 359 of full Needs Assessment submitted) Mental health- Children and Youth • Issues with transfer of information • Limited knowledge and adherence to guidelines/frameworks by health care providers (Page 351 of 359 of full Needs Assessment submitted) Mental health- Severe and complex • Develop efficient pathways to support person centred transfer of care between acute and primary care services (general practice, allied health and community services) (Page 351 of 359 of full Needs Assessment submitted). Alcohol and other drugs • Provision of training and resources, including referral pathways, for general practice to support patients with substance use issues including ice (Page 352 of 359 of full Needs Assessment submitted) Aboriginal and Torres Strait Islander Mental health and Suicide • Access and awareness of appropriate services (Page 356 of 359 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** Integrated Care Alliance • Support the implementation of new integrated models of care • Preliminary work to develop models of care have been completed for a range of disease conditions. I implementation requirements are currently being scoped. • A major body of work for GCPHN involves the implementation of a e-library solution to enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work. (Page 334 of 359 of full Needs Assessment submitted) Access to information and resources • GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing web portal featuring: o Localised referral guidelines and templates for Gold Coast Health, updated to reflect the Clinical Prioritisation Criteria protocols introduced in Queensland

	○ 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 (Page 336 of 359 of full Needs Assessment submitted)
Aim of Activity	This activity aims to provide general practice, consumers, primary care sector and community providers with access to readily available, evidence based information, resources, service and referral options, tailored specifically to the Gold Coast region through an extensive set of communications and engagement channels and programs particularly including HealthyGC online publication platform. Information is provided about GCPHN, our programs, services, service directory as well as health pathways information and resources through a stable, reliable, accurate, localised digital platform for general practice, primary care service providers and the broader community to access the necessary curated, up-to-date information and resources that support access to service options, referral and optimal care management. The activity aims to achieve the following National PHN Performance Framework targets: • P1 - PHN activities address prioritised needs and national priorities • P4 - Support provided to general practices and other health care providers • P7 - Rate of GP style emergency department (ED) presentations • O14 - PHN stakeholder engagement The activities ensure that the primary health care sector are kept informed, about service access, referral pathways, needs assessment, planning and co-design of current primary and intermediate care services as well as promote opportunities to shape future services through: • Providing health service access and referral information about available services, pathways and e-referral templates for the Gold Coast region • Ensuring primary care inform the annual and specific needs assessment activities • Communicating opportunities for primary care sector in market assessment and Service co-design • Supporting primary care sector to engage in and inform commissioning through procurement and contracting activities • Providing data and information to the primary care sector that assists in their decision support and driving quality improvement of services and improved patient outcomes
Description of Activity	The activity addresses the needs through delivery of a patient centred, coordinated, curated online platform of information and resources including

	but not limited to local service options, GCPHN and our programs and services, referral options, health pathways. GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing HealthyGC web portal featuring: • localised referral guidelines and templates for Gold Coast Health, updated to reflect the new Clinical Prioritisation Criteria protocols being introduced in Queensland • Review and update of existing referral templates to ensure they align to current evidence and GCHHS systems and protocols • An e-library of professional resources and educational material • patient facing resources • publication of health pathways information across a number of prioritised service areas/health issues • Links to local service directory/ies. During 2020/21, priority will be given to increasing pathways information to support improved navigation and access to local service provider information in PHN priority areas and other locally identified health topic areas, to ensure information and resources published online are kept current and appropriately curated to support appropriate, timely referrals and agreed service pathways. This links with the activity ***HSI 3 Integrated Care Alliance (ICA) – Alliance Development and implementation (including development of health pathways and shared care)*** for the clinical engagement and development of the specialist content for the health pathways that will be published on the GCPHN website. The outcomes of this work identifies effective ways to increase communication, awareness and referral and service pathways between service providers and improve user experience in line with contemporary e-solutions. The activity includes linking and liaison with the National Health Service Directory and other related directories to ensure most effective information sharing. This activity links closely with practice support activities and other program activities including the hosting of referral templates, resources and information to support local health decision assist tools including: • referral templates • resources, clinicians and consumers • professional development • resource directory Expected results include achieving increased access to contemporary evidence-based resources and localised service and referral information.

Associated Flexible Activity/ies:	***CF 6 Integrated Care Alliance (ICA) Pathways Non-staff expenses (license/storage costs)***
Target population cohort	Primary Care Sector (in particular General practice), local health system stakeholders and the community of the Gold Coast PHN Region (Gold Coast SA4)
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	whole PHN region i.e. Gold Coast PHN Region (Gold Coast SA4)
Consultation	**General Practice Gold Coast** Provide ongoing engagement opportunities, communication channels and advice about general practice in the Gold Coast; input into development and evaluation; partner in delivering educational information and resources for general practice **Primary Care Partnership Council** Provide ongoing engagement opportunities, communication channels and advice about broader primary care sector and key State agencies input **Karulbo Partnership** Provide ongoing engagement opportunities, communication channels and advice about engagement of Aboriginal and Torres Strait Islander People in PHN services and activities and about culturally appropriate practices **Gold Coast Health/Integrated Care Alliance with Gold Coast Health** Provide ongoing engagement opportunities, communication channels and advice and a formalised partnership through which the PHN consults with GCH board, executive, administrative and clinical leads about referral templates, service options, service integration and clinical handover information and resources for the Gold Coast; partner in delivering education information and resources, health pathways publication e-library and other integration activities **National Health Service Directory, 13 Health** Ongoing engagement to ensure a collaborative approach to each other's service directory
Collaboration	1. **GCPHN staff**. -Ongoing support

	2. General Practice Staff -Provide input and feedback as key users of the activity; ongoing user support **3. Gold Coast Health and Hospital Service/Integrated Care Alliance -**Provide input and feedback as key users of the activity; ongoing maintenance of the content **4. Peak bodies including RACGP, AGPAL and GPA-** Consultation to ensure activity aligns to the standards **5. GCPHN Primary Health Care Improvement Committee -**Comprises local general practice staff who provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities **6. General Practice Gold Coast (GPGC) -** Linkage to ensure collaboration and partnership with general practice in the Gold Coast **7. Primary Care Training Providers -**Including Pharmacy Guild, Pharmaceutical Society of Australia, General Practice Gold Coast, National Prescribing Service, Australian Primary Health Care Nurses Association, Gold Coast Medical Association, Royal Australian College of General Practitioners, Local Universities. To ensure linkage, coordination and a collaborative approach to avoid duplication of training events and address gaps
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones? - Review and refresh of main website architecture and tranche 1 of content migration/health pathways information for key priorities published by 31 October 2019 - tranche 2 and 3 of content migration/health pathways information for key priorities published by 31 October 2021
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known

	☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Request for Proposal process undertaken in January – March 2019 with expected commencement of review consultancy by End March 2019. Completion of review consultancy expected end October 2019. 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details Stakeholders engaged at all times
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implication

ACTIVITY TITLE	**HSI 3 Integrated Care Alliance (ICA) – Development and Implementation (including development of health pathways and shared care)**
Existing, Modified, or New Activity	Modified Activity Modified activity (2016-18 Activity Work Plan – Reference NP 2017.1 Integrated Care Alliance (ICA)). Also relates ***CF 6 Integrated Care Alliance (ICA) Pathways Non-staff expenses (license/storage costs)*** in relation to publication platform costs and ***HSI 2 Access to information and resources*** as the publication portal for Gold Coast health pathways information and resources**.** The work also relates to the Greater Choices for at home palliative care program activities.
Program Key Priority Area	Digital Health and area population health
Needs Assessment Priority	**Identified health needs and service issues** • Access to Information about services and resources to support general practice in key areas is required. Page 1 of General Practice and Primary Care Needs Assessment Summary (Page 22 of 279 of full Needs Assessment Submitted) • Better systems to support care coordination required • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients Page 1 of Chronic Disease Needs Assessment Summary (page 71 of 279 full Needs Assessment submitted) • Access to clear communication and accessible information for patients, families and health care professionals • Current systems not always established for the provision of clinical care coordination of end of life care between providers Page 1 of Palliative Care Needs Assessment Summary (page 130 of 279 of full Needs Assessment submitted) • Promotion of low intensity services to General Practice to support complementary use with other primary health interventions • Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services Page 1 of Low intensity Mental Health Services Needs Assessment Summary (page 168 of 279 of full Needs Assessment submitted) • Efficient referral pathways to increase accessibility to new psychosocial services • Improved service coordination for individuals with severe mental illness and associated psychosocial functional impairment, while considering support available across levels of government, the community and relevant sectors

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

	○ 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. Page 5 of Opportunities Priorities and Options (page 258 of 279 of full Needs Assessment)
Aim of Activity	**Overall Program Objectives:** Create a single integrated healthcare system for the Gold Coast by: • Improving the coordination of care to ensure consumers receive the right care at the right place at the right time by the right person. • Increasing the effectiveness and efficiency of health services for consumers. • Engaging and supporting clinicians to facilitate improvements in our health system. The aim of GCPHN's contribution to this program is to develop and redesign models of care that facilitate improved experience and outcomes for patients and the workforce across the continuum of care, and to enable these through the development and implementation of ICT/Analytics solutions to support that (equivalent local solution for Health pathways and shared care) (refer activity ***CF3 and HSI 2)***. This activity includes development of a model for localised Gold Coast health pathways and shared care frameworks, which will provide general practice, consumers, primary care sector, community and secondary providers with access to readily available, evidence based information, resources, service and referral options, tailored locally to the Gold Coast region. To ensure Primary Care and General Practice are informed, engaged in and contribute through an extensive program of engagement to develop, implement and review the health pathways and shared care in line with locally agreed models of care developed by the Integrated Care Alliance and other joint programs. Also to support adoption and ongoing maintenance of health pathways, including localisation of integrated care service pathways for the Gold Coast region
Description of Activity	Continue to develop and implement new integrated models of care for the prioritised diseases/conditions, commencing with broad based community and MDT workshops. GCPHN will fund GP and primary care practitioners to attend and participate in models of care development and implementation. These

	workshops will continue to refine models of care throughout 2019-2022. From 1 July 2019 completed models of care will pass through a series of assurance gateways providing validation against the criteria of: consumer acceptability, financial sustainability, quality and safety, workforce implications and ICT compatibility with implementation commencing for Palliative Care in the first instance. The development and redesigned models of care will facilitate improved experience and outcomes for patients and the workforce across the continuum of care. Implement health pathways and shared care to support the implementation of new models of care. The activity addresses the needs through delivery of a patient centred, coordinated program to develop health pathways and shared care (as required) information and resources that include local service options for nationally and locally identified priority areas (including but not limited to: palliative care, aged care RACF, mental health, AODs treatment services). During 2019/20, the focus will be on developing local exemplars for two of the above priority areas commencing with Palliative care as detailed in the **Greater Choices for at home palliative care program activities.** This activity will develop • localised referral guidelines and templates for Gold Coast Health, updated to reflect the new Clinical Prioritisation Criteria protocols being introduced in Queensland • Review and update of existing referral templates to ensure they align to current evidence and GCHHS systems and protocols • Develop, curate and maintain the locally agreed content and provide that to the publication platform to support maintenance of an e-library of professional resources and educational material as well as patient facing resources as determined appropriate • agreed health pathways and shared care across a number of prioritised service areas/health issues commencing with the identified priority areas (listed above). Priority will be given to engaging local clinicians towards increasing agreed pathways information that support improved navigation and access to local service providers. This will focus on PHN priority areas and other locally identified health topic areas, to ensure information and resources published online are kept current and appropriately curated to support appropriate, timely referrals and agreed service pathways. The activity will engage stakeholders and particularly clinicians to explore options for most effective ways to increase communication, awareness and referral and service pathways between service providers and improve user experience in line with contemporary digitally optimised solutions. During 2019, the agreed format and framework will be developed along with a localised how to guide to support the development and roll out of a program of health pathway and shared care development throughout 2020-2022.

	Another key body of work for GCPHN in 19/20 will involve the implementation of an updated e-library solution to host and enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work. The e-library solutions is addressed through activities ***CF 6 Integrated Care Alliance (ICA) –Pathways Non-staff expenses (license/storage cost)*** in relation to publication platform costs ((equivalent to the Streamliners® licensing costs) and ***HSI 2 Access to information and resources*** in relation to the broader staffing costs associated with the broader website, stakeholder engagement and commissioning systems supporting activities **.** Expected results include achieving increased access to contemporary evidence-based resources and localised service and referral information. An evaluation framework is being developed to support this work. ICA performance indicators are in development and will include measures against the triple aim of population health, patient and practitioner experience and value for money. Measures of system performance will be included.
Associated Flexible Activity/ies:	***CF 6 Integrated Care Alliance (ICA) Pathways Non-staff expenses (license/storage costs)*** in relation to publication platform costs ***HSI2 Access to information and resources*** in relation to the broader staffing costs associated with the broader communications channels, website administration, content management system, stakeholder management and commissioning systems supporting activities
Target population cohort	ICA target population is whole of Gold Coast population, primarily accessing public health services initially. Work has commenced to explore how the private hospital and specialists can adopt these models as care and systems.
Indigenous specific	No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Primary Care Sector (in particular General practice), local health system stakeholders and the community of the Gold Coast PHN Region (Gold Coast SA4)
Consultation	**General practices, GPs and General Practice Gold Coast** Provide ongoing engagement opportunities, communication channels and advice about general practice in the Gold Coast; input into design, development, implementation, maintenance and evaluation; partner in delivering educational information and resources for general practice **Primary Care Partnership Council** Provide ongoing engagement opportunities, communication channels and advice about broader primary care sector and key State agencies input into health pathways and shared care development and maintenance

	Karulbo Partnership Provide ongoing engagement opportunities, communication channels and advice about engagement of Aboriginal and Torres Strait Islander People in PHN services and activities and about culturally appropriate practices **Gold Coast Health/Integrated Care Alliance with Gold Coast Health** Provide ongoing engagement opportunities, communication channels and advice and a formalised partnership through which the PHN consults with GCH board, executive, administrative and clinical leads about health pathways, shared care, referral templates, service options, service integration and clinical handover information and resources for the Gold Coast; partner in delivering education information and resources, health pathways and shared care publication e-library and other integration activities
Collaboration	1.**Gold Coast Health and Hospital Service/Integrated Care Alliance -**Role is to Provide input and feedback as key users of the activity; co-design of enhancements to the activity as part of the review, implementation and Ongoing maintenance of the content – ICA – Alliance Group member – Model of care development input from specialists – Executive leadership engagement in senior governance group. – Clinical engagement in every level of governance, with a particular focus on clinical governance. 2.**GCPHN Primary Health Care Improvement Committee-**Comprises local general practice staff who provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities **3. GPs and allied health and private specialists -**Input to the development of models of care and the subsequent translation of these onto health pathways solution and e-library **4. Consumers (representative groups and individuals)-**Input to the development of models of care to ensure they are developed with appropriate consideration of consumers input and needs. **5. General Practice Gold Coast (GPGC)-** Linkage to ensure collaboration and partnership to ensure health pathways and shared care support and actively engage with general practice in the Gold Coast **6. Primary Care Training Providers-** Including Pharmacy Guild, Pharmaceutical Society of Australia, General Practice Gold Coast, National Prescribing Service, Australian Primary Health Care Nurses Association, Gold Coast Medical Association, Royal Australian College of General Practitioners, Local Universities. To support coordination and a collaborative approach to training and ongoing continuous professional development events that support the health pathways implementation

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

	No 4a. Co-design or Co-commissioning details Co-design involved over 200 clinicals through over 50 workshops over a 12-month period to design optimal model of care for 20 high use conditions are determined by clinicians. The results of the workshops were developed into draft models of care that were reviewed by the clinical reference group, the consumer reference group, and then approved by Alliance Leadership Group. Co-design will continue to be used to ensure that the models of care are translated into online resources such as pathways and clinical prioritisation criteria to enable seamless transfer of care between clinicals and sectors.
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potentially implications.

ACTIVITY TITLE	*HSI 4 Regional mental health and suicide prevention plan*
Existing, Modified, or New Activity	Modified Activity Primary Mental Health Care 2016-2019 8.1 Development of regional mental health and suicide prevention plan
Program Key Priority Area	Mental Health Priority Area 8. Regional mental health and suicide prevention plan
Needs Assessment Priority	Department of Health requirement in Deed and in COAG Agreement Mental Health Overarching stepped care approach – Development of a Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drugs Services in the Gold Coast region (p. 21 of Opportunities, priorities and options, page 353 of Full Needs Assessment submitted) Mental Health- Suicide Prevention– Development of a Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drugs Services in the Gold Coast region (p. 17 of Opportunities, priorities and options, page 353 of Full Needs Assessment submitted)
Aim of Activity	People with lived experience of mental illness, suicide, misuse of alcohol and other drugs as well as their carers face a wide range of issues when trying to access treatment and support. This includes fragmentation of services and pathways, gaps, duplication and inefficiencies in service provision, and a lack of person-centred care. The mental health, suicide prevention and alcohol and other drugs sector is in the midst of significant reform with new policy directions introduced at national and state levels. While there is broad strategic alignment at a National and State level, the multiple layers of responsibility, funding and regulation create a complex environment and there is a need for a regional platform to lead this reform at a local level. This activity aims to progress the implementation of the Foundational Joint Regional Mental Health and Suicide Prevention Plan (the Plan) by providing oversite for regional sector collaboration. This includes, supporting the sector to work better together towards shared priorities and more effectively use available resources to meet regional needs in the short term. The Plan will also drive evidence-based service development to address identified gaps and deliver on regional priorities which have been developed and delivered in partnership with local communities. Building on the foundational plan, the activity will contribute to a more detailed joint planning, including a comprehensive service development plan.
Description of Activity	Building on previous collaboration, the foundational planning process established joint governance structures between GCPHN and Gold Coast Health and delivered a Plan with shared priorities. GCPHN will dedicate a project position to coordinate and progress the implementation of this Plan. Activity

	will include review and modification of joint governance structures to support implementation and oversee accountability to the Plan. Additionally, GCPHN will work in collaboration with Gold Coast Health to use the NMHSPF to undertake further mapping of existing services as part of the commitment and expectation of more detailed service planning. Consumers and carers, NGO service providers, general practice and other mental health service providers will continue to be engaged to progress specific coordination and integration regional priorities jointly agreed upon in the Plan. This activity links closely to the activity in Mental Health Priority Area: Regional mental health and suicide prevention plan
Associated Flexible Activity/ies:	MH1, MH2, MH3, MH4, MH5, MH7, MH8, MH9; AOD1, AOD2, AOD3
Target population cohort	GCPHN population with mental health needs, with a particular focus on a number of population cohorts including children and young people, adults, older people, Aboriginal and Torres Strait Islander people, people with drug and alcohol issues and people at risk of suicide.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No While not predominantly supporting the Aboriginal and Torres Strait Islander community, the Gold Coast AMS and more broadly the Aboriginal and Torres Strait Islander Partnership group Karulbo will be actively engaged in the implementation of the Plan.
Coverage	Whole of Gold Coast PHN Region (Gold Coast SA4)
Consultation	In addition to the joint governance arrangements, a number of specific working groups will be established to progress key pieces of work in the plan. Existing groups will be actively engaged including mental health consumer and carer groups and panels, the local Aboriginal and Torres Strait Islander Partnership Group, local Mental Health and Drug and Alcohol sector at multiple times during the process.
Collaboration	1. Gold Coast Primary Health Network – Project partner delivering coordination, engagement, data and planning expertise 2. Gold Coast Health – project partner contributing clinical, data, operational and planning expertise
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):

	Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and approach to market	This project will be delivered by GCPHN and Gold Coast Health staff 1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes 4a. Co-design or Co-commissioning details Activity was undertaken as a Joint development project between Gold Coast Health (HHS) and GCPHN

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

ACTIVITY TITLE	***HSI 5 PALLIATIVE CARE***
Existing, Modified, or New Activity	Modified Activity Modified Finalisation of work commenced in Greater Choice for at Home Palliative Care
Program Key Priority Area	Workforce
Needs Assessment Priority	Palliative Care Needs Assessments (Page 343 of Full Needs Assessment submitted) • Limited uptake of ACPs • Care coordination and support to general practice to be the centre of care where possible • RACFs service high numbers of palliative patients • Current systems not always supportive to ensure planning, commissioning and delivery of integrated and coordinated service matrix. • Access to integrated palliative care system across the health and social sector so people are supported as early as possible • Current limitations for ensuring that patient choice and wishes are respected. • Options for better conversations about death and dying; and involvement • Need to ensure people can access good quality end of life care 24/7 • Access to clear communication, and accessible information for patients, families and healthcare professionals • Provisions of care required to allow patients achieving their preferred place of death • Current systems not always established for the provision of clinical coordination of end of life care between providers • To ensure all providers are skilled and competent in delivering high quality palliative and EOL care.
Aim of Activity	To build the capacity and skills of general practitioners in providing palliative care to people with a life-limiting illness. This will be achieved through the provision of coordinated care, and improved information transfer between service providers, with patients and families. This will be available to all GPs across the Gold Coast region. The Key Aims of the Activity

	• To provide a high quality, effective and supportive framework for Shared Care and Health Pathways for General Practitioners and the local community in order to support local general practitioners to deliver optimal palliative care for their patients. The model ensures GPs are supported by a clinical specialist, referral to local specialists (as necessitated) according to current management guidelines. • Promote and support the role of general practitioners in providing continuity of care and end of life support in the community for people experiencing a progressive, life limiting illness. The Key Objectives of the Activity are: • Increased confidence reported by GPs in the region to deliver palliative care • Increased uptake of advance care planning • Increased palliative care-related attendances by GPs into patient's homes and RACFs • Increased number of linkages and partnerships with non-health related community organisations relating to raising awareness about palliative care and death and dying • Increased effectiveness of clinical handovers of palliative patients reported by hospital clinicians, GPs, community clinicians and RACF staff • Improve health, death and compassion literacy within the Gold Coast community • Increased number of people accessing palliative care services and their carers and families reporting that they feel better connected to information and supports • Increased number of linkages and partnerships with non-health related community organisations relating to raising awareness about palliative care and death and dying.
Description of Activity	**The key activities are:** **1. Palliative Care Health Pathways and Shared Care** Finalisation and Implementation of Shared Care Model and Health Pathways integrating Primary Care with interdisciplinary palliative care specialist teams to improve access to quality palliative home care / Residential Aged Care addressing multiple domains of end-of-life issues and needs. Implementation Program • Implement and trial the final arrangement of works from market testing and embed training and education within the GCHHS, community and Primary care. • Revise the Palliative Care products/resources and upload to online platform

	• Implement the principles of shared care framework for the seamless transfer of the care from the hospital or specialist service setting to general practice. • Trial the Shared care prescribing guidelines and local policies to enable general practitioners (GPs) to accept responsibility for monitoring of medicines/treatments in primary care, in agreement with the initiating specialist service. • Trail shared care principles and framework linked to and complemented by local integrated care pathways and shared care policies. **2. Living Matters Resource implementation for Primary Care linking to Advance Care Planning P.I.P. Q. I program.** **3. Development and Implementation of a Quality Improvement Toolkit for General Practice in Advance Care Planning** Utilising the lessons learns from the "Hammond Care "Advance Care Project finalise and implement a quality improvement toolkit to be available for all General Practices on the Gold Coast. Implement as a business and usual tool. Maintenance of resources, information, and education via GCPHN website. **4. GCPHN Project & Contract Management of CF4 Enhanced Primary Care *(*PMP Clinical Educator – Palliative)** • Transition the project into every day care within RACF's, from the time of admission, to identifying a change in condition, and communicating and documenting relevant information; inclusive of the quality improvement components of the program into business as usual. • Embed quality improvement actions within the facility and local community level inclusive of primary care and the HHS. • Complete joint Research with Griffith University and GCHHS for the evaluation of the Project **5. Advance Care Planning: Indigenous & C.A.L.D.** Improve the effectiveness of Aboriginal and Torres Strait Islander people's journey through the system for those that are affected by palliative illnesses – 'Sorry Business" across Gold Coast communities by: • Dying to Yarn Expo • Indigenous PEPA program GCHHs • Reverse Indigenous PEPA training for mainstream • Implement and sustain the program within Aboriginal Medical Services (AMS) • Adapt "The Advance Project" for A.M.S • Adapt "The Advance Project" for C.A.L.D communities. **6. GCPHN Aged and Palliative Care Leadership Group**

	Provide leadership and co-ordination of the GCPHN Aged and Palliative Care leadership group who oversee the deliverables of the GCPHN/HHS Palliative Care Regional Plan. 7. **Partnering with PEPA Queensland** to support a State Conference to be held on the Gold Coast in June 2021, originally scheduled in June 2020 but re-scheduled due to Covid 19 This component links closely with CF4 Enhanced Primary Care *(*PMP Clinical Educator – Palliative) 2020/21 Greater Choices for At Home Palliative Care (GCFAHPC) Project
Associated Flexible Activity/ies:	CF4 Enhanced Primary Care *(*PMP Clinical Educator – Palliative) 2020/21 Greater Choices for At Home Palliative Care (GCFAHPC) Project
Target population cohort	People with Palliative Care Needs Hospital and Health service
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No
Coverage	Whole of Gold Coast PHN Region (Gold Coast SA4)
Consultation	A local palliative care needs assessment Regional plan was endorsed by Gold Coast Health and GCPHN in 2019. The Palliative Care *Regional Plan was* developed through consultation with key sector stakeholders, including our Gold Coast Health partners, primary care providers, and the carers and representatives of people who have undertaken the palliative care journey in the Gold Coast region. A joint GCPHN and GCH work plan developed as an outcome of the regional plan is overseen by a Palliative Care Leadership group who meet bimonthly to provide advice on the projects and their deliverables. In addition to the joint governance arrangements, a number of specific working groups have been established to progress key pieces of work in the plan. GCPHN will be regularly conducting stakeholder and service user interviews and feedback sessions throughout the year. Consultations will take many different forms, such as: o Consultative Palliative Care Workshops o Public workshops o Champion Palliative Clinical Advisory Workshops PHN advisory councils and other committees

Collaboration	GCPHN has longstanding relationships with palliative care providers including GCH, non-government and private agencies who provide community nursing, allied health, residential care, and general practice which have and will continue to support this project. In addition GCPHN's standard governance committees will be supporting and advising on this work (including our Community Advisory Group, Clinical Council and Primary Care Partnership Council) a Palliative Care leadership was established with representation from the Gold Coast Health Specialist Palliative Care Team, General Practitioners, community palliative care services and consumers. The implementation work will be completed in partnership through the establishment of the; 1. Shared Care – Health Pathway Steering Committee which has been established in partnership between GCH, primary care, broader service providers and the GCPHN. 2. Clinical Champion Palliative Care Working Group established to provide clinical and consumer input into appropriate frameworks, systems and processes for the development and validation of future models of care. The group meets on a regular basis. 3. The Gold Coast Health and GCPHN Integrated Care Alliance leadership group signed off the Regional Palliative Care Plan and Needs Assessment in January 2019 and agreed to provide ongoing support and endorsement for the activities detailed in this plan.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates (including the planning and procurement cycle): Activity start date: 1/11/2020 Activity end date: 30/06/2021 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and approach to market	This project will be delivered by GCPHN and Gold Coast Health staff 1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known

	☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details Activity was undertaken as a Joint development project between Gold Coast Health (HHS) and GCPHN
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications

ACTIVITY TITLE	***HSI* 6 Primary Sense™ Population Health Management and audit tool**
Existing, Modified, or New Activity	Modified Activity HSI 2018.3 Practice based population health management using Primary Sense™
Program Key Priority Area	Population Health
Needs Assessment Priority	**Identified local health needs and service issues**

	• Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza) • My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers • Potential to increase use of data in general practice software to proactively plan care • Frequently current systems (including MBS payments and data) do not support population health approach and care-coordination Pages I7-35 of General Practice and Primary Care Health Needs Assessment • Better systems to support care coordination required. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients • Need for greater focus on prevention, early identification and self-management • High rates of smoking and harmful alcohol intake across the region identification and self-management. Pages I7-35 of General Practice and Primary Care Health Needs Assessment **Possible Options identified in Needs Assessment** Continuous quality Improvement Tier 3 Practice Support • Supported implementation of continuous quality improvement methodologies using practice data to drive improvements and other building blocks of high performing primary care • Collection and use of clinical data to improve the population's health • The General Practice determines priority areas for improvement through review of their clinical data • Development of an action plan utilising a CQI methodology through peer to peer conversations • Develop tailored clinical audit reports to determine baselines measures and monitor improvement over time • Review and monitor progress towards achievements/improvements • Access to decision support tools including cycles of care through GCPHN website. Pages I7-35 of General Practice and Primary Care Health Needs Assessment Population health management Tier 4 Practice Support • Improved management of patient health care in general practice • Reducing unnecessary referrals and admissions to hospital. GCPHN 3 Opportunities, priorities and options Priority Possible Options Expected Outcome Potential Lead • Allocated Practice Support Officer to facilitate improved comprehensive and patient centred care planning • Develop person centred, goal orientated care plans that align with MBS requirements. • Provide education and training in the use of the care plans template which support utilisation of systematic cycles of care requiring recall and reminder where necessary to support improved patient management. • Provide regular data reports to monitor improvement in care management of patients. Pages I7-35 of General Practice and Primary Care Health Needs Assessment

	Primary Sense Continued implementation in 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 supports 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 and other data from practice management systems and applying evidenced based algorithms. Working with GCHHS to utilise the risk scores generated from general practice data to assist with the prioritisation of outpatient waitlists, potentially reduce adverse drug events and so admissions through the 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 • Pages I7-35 of General Practice and Primary Care Health Needs Assessment
Aim of Activity	Primary Sense supports general practices to make timely decisions for better health care for their respective populations by: • integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms • identifying high risk groups for proactive care • relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.

	Primary Sense will enable a practice- based population health management approach to reduce unnecessary hospital use, by • Correctly identify which patient groups are suitable for appropriate evidence - based interventions at a local (GP) and regional (PHN) level • Correctly identify patients at risk of poor outcomes on the Gold Coast • Enabling patients to be more effectively managed in primary care
Description of Activity	Automated de-identified data extraction and analysis of the health profile of the entire practice population - generating actionable reports and medication safety alerts for general practices, analysed population health data for the practice to inform the service response, and for GCPHN commissioning purposes: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts to patients at immediate risk from medication prescribing safety issues Primary Sense has been developed as an evidenced based decision assist tool to help inform timely decisions for better primary healthcare. Primary Sense is compatible with Medical Director and Best Practice software (comprising approximately 90% of the general practice software market in the Gold Coast) Further enhancement of medication safety alerts and reports will continue based on user feedback. System and process enhancements may include • Targeted patient selection and alerts for research project recruitment • Computerised decision support mechanism for better guideline implementation • Audit and feedback for GP trainee education • Automated chart review for GP training and professional development • Linked databases to better understand potentially preventable hospital admissions Further roll out across GCPHN practices during 2020/21 to cover up to 85% of practices
Associated Flexible Activity/ies:	HSI 2019.5 Primary Care Improvement Program GPS 2019.4 Practice Support A. Tier 1 & 2 CF-7 Primary Sense ™ Population Health Management and audit tool
Target population cohort	Total practice population where Primary Sense™ is installed
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?

	No
Coverage	The practices have been drawn from various areas within the Gold Coast. This activity plan seeks to support the roll out of Primary Sense to provide geographical coverage for the whole PHN region, but will be dependant of the practice software and willingness to participate
Consultation	**GCPHN staff**. Staff who provide management of the program that supports general practice to use Primary Sense and other clinical audit and QI tools **General Practice Staff** To provide input and feedback as key users of the activity; co-design of enhancements to the activity as part of the review, implementation and Ongoing user support requirements **Gold Coast Health and Hospital Service/Integrated Care Alliance** Provide input and feedback as key users of the activity; co-design of enhancements to the activity as part of the review, implementation and Ongoing data analytics to support integrated care and Clinical QI activities **Peak bodies including RACGP** Consultation with RACGP CEO and Quality Committee members to ensure activity aligns to the standards and best practice guidelines/evidence-based practice **GCPHN Primary Health Care Improvement Committee** With local clinical and non- clinical general practice staff who provide input and advice into the current issues facing general practice, and design and implementation feedback on behalf of General Practice related to Primary Sense and other GCPHN practice support activities **General Practice Gold Coast** Provide ongoing engagement opportunities, communication channels and advice about general practice in the Gold Coast; input into service review, development and evaluation; partner in delivering education and other quality improvement activities **Kalwun Medical Corporation (Gold Coast AMS provider)** Provide ongoing engagement and advice about Aboriginal and Torres Strait Islander People in Primary Sense development activities in the Gold Coast; input into Primary Sense design and development, testing and implementation **Gold Coast Health, national and international specialists, academics**

	Engage with a variety of local, national and international population health service specialist and researchers to access expert advice and input to Co-design, development, evaluation and implementation activities **Quality Improvement Committee –** clinical advisory group
Collaboration	**1.General Practice Gold Coast-**Test practices provide advice and input into the design, development, testing and implementation change management for Primary Sense **2. Gold Coast Health General Practice Liaison Unit -**Engagement of GPLO to provide advice and guidance about integrated care and population health issues between general practice and Gold Coast Health **3. Gold Coast Health/Integrated Care Alliance with Gold Coast Health-**Provide advice and input into referral, care coordination, service integration and clinical handover **4. John Hopkins University-**Linking with the John Hopkins School of Public Health for use of ACG tool and to customise tool for Australian general practice data **5. Bond University-** Linking with the Medical School and Centre for Research Excellence in Evidence Based Primary Care **6. Sydney University-** Linking with Uni to ensure learnings from BEACH study and licence arrangements for use of ICPC2+ International Coding for Primary Care data
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension

	☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details Undertaken in collaboration with General Practice users, GP Peak body representatives, Academic medical representatives and PHN key staff users
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, please provide a description of the proposed decommissioning process and any potential implications
Total Planned Expenditure	Enter the planned expenditure for this Activity in the following table.
Funding from other sources	If applicable, name other organisations contributing funding to the activity (i.e. state/territory government, Local Hospital Network, non-profit organisation).

ACTIVITY TITLE	***HSI* 7 Primary Care Engagement**
Existing, Modified, or New Activity	Modified Activity (2016-18 Activity Work Plan) GPS 2019.3 Practice Support Tier 1 & 2
Program Key Priority Area	Other (please provide details) Practice Support and Digital Health
Needs Assessment Priority	**Identified local health needs and service issues** 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 areas that meets the need of the practice population. • Comparatively high rates of potentially preventable hospitalisations. • My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers. • Potential to increase use of data in general practice software to proactively plan care • Frequently current systems (including MBS payments and data) do not support population health approach and care-coordination • 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 lack of service compatibility between systems. This means systems, potentially are not able to communicate with each other limiting clinical care coordination, operational and administrative efficiency (Page 333, 334 and 335 of 359 of full Needs Assessment submitted) Chronic Disease • Better systems to support care coordination required. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients • Need for greater focus on prevention, early identification and self-management • High rates of smoking and harmful alcohol intake across the region identification and self-management. (Page 340 of 359 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** General practice support: • Support the adoption of a Clinical Audit tool with practice data being submitted to GCPHN • Information, resources and education (delivery of clinician and patient resources) provided though face-to-face, telephone, electronic bulletins, email networks and mail out for areas including: • public health (immunisation and cancer screening)

	• e-referrals from primary to secondary/tertiary and nongovernment agencies • transition to 5th Edition Standards of Accreditation • compliance with ePIP and QPIP • 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 process • Continue to improve data quality through ensuring effective data entry, data cleaning and quality assurance process • 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. (Page 333 of 359 of full Needs Assessment submitted) Access to information and resources GCPHN will continue to host. Develop the IT 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 GCHs systems and protocols. • Other clinical and service navigation support information including the emerging the new models of care • Professional resources • Patient facing resources (Page 341 and 342 of 359)
Aim of Activity	The aim is to support general practice in the adoption of evidence based, best practice methodology and meaningful use of digital systems. To also promote quality improvement, the uptake of practice accreditation and to ensure timely provision of information, resources and education to support changes in programs and policy that impact on general practice.
Description of Activity	Supporting general practices to deliver safe, high quality evidence-based care to their communities. Effective engagement and support for practices is critical to achieve the objectives of the General Practice Support Schedule. The Primary Care Liaison model of support ensures the general practice team and the wider community of primary healthcare providers are supported through regular and targeted contact by providing a central point of contact between GCPHN and the local primary health care community.

	The Primary Care Liaison team will assist general practices and the wider community of primary healthcare professionals to access information and resources that promote best practice methods to improve the quality of care provision. Support activities include: • Help desk – to support access to information and resources relevant to delivery of health care in the primary care sector • Promote and support General Practice accreditation • Support the use of digital health technologies including awareness and use of the My Health Record • Disseminating information to promote uptake of Gold Coast PHN programs or those provided in collaboration with other key partners including Gold Coast Health • Informing General Practitioners, general practice team members and other primary healthcare providers of key National, State and local information or changes to key National, State or local information relating to primary health care service provision • Collection of workforce data related to local general practices and primary health care providers to support better understanding of the primary health care services within the Gold Coast region • Support workforce development by offering education and training opportunities aligned to evidence-based guidelines and in line with continuing professional development requirements of General Practitioners, the general practice team and other primary healthcare providers • Proactive and strategic engagement with general practice through bi-annual visits by allocated Primary Care Liaison team member • Proactive and strategic engagement with other primary healthcare providers through visits by Primary Care Liaison team member as required
Associated Flexible Activity/ies	HSI 2019.5 Primary Care Improvement Program HSI 2019.6 Primary Sense™ Population Health Management and audit tool
Target population cohort	Practice defined cohorts of patient's dependant on focus area General Practitioners, Practice Managers, Practice Nurses and Practice Support staff Primary healthcare provides where relevant to program delivery
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No
Coverage	Gold Coast PHN Region (Gold Coast SA4)
Consultation	**GCPHN Staff**- implementation and engagement

	General Practice Staff- implementation and engagement The Australian Digital Health Agency **Peak bodies including RACGP and all relevant accreditation organisations**- Consultation to ensure activity aligns to the standards. **GCPHN Primary Health Care Improvement Committee comprising local general practice staff** - provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities. **Practice staff participating in the implementation of Primary Sense™ clinical audit tool** – implementation and engagement **General Practice Gold Coast (GPGC)** - linkage to ensure consultation and partnership **Queensland Health and Hospital Service, General Practice Liaison Unit (GPGC)**– linkage to ensure consultation and partnership **Bond University and Griffith University** – supporting evidence-based practice **Public Health Unit-** consultation and partnership **My Health for Life-** consultation and partnership **Pen CS-** consultation and partnership
Collaboration	**1.GCPHN Staff**- implementation and engagement **2. General Practice Staff-** implementation and engagement. The Australian Digital Health Agency **3. Peak bodies including RACGP and all relevant accreditation organisations**-Collaboration to ensure activity aligns to the standards. **4. GCPHN Primary Health Care Improvement Committee comprising local general practice staff** - provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities. **5. Practice staff participating in the implementation of Primary Sense™ clinical audit tool** – informing enhancements and user experience **6. General Practice Gold Coast (GPGC)** - linkage to ensure collaboration and partnership **7. Queensland Health and Hospital Service, General Practice Liaison Unit (GPGC)**– linkage to ensure collaboration and partnership

	8. Bond University and Griffith University – supporting evidence-based practice **9. Primary Care Training Providers I.e. Pharmacy Guild, Pharmaceutical Society of Australia, General Practice Gold Coast, National Prescribing Service, Australian Primary Health Care Nurses Association, Gold Coast Medical Association, Royal Australian College of General Practitioners, Local Universities -** Linkage to ensure collaboration and avoid duplication of training events.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Ongoing business as usual activity Any other relevant milestones? NA
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process?

	No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, please provide a description of the proposed decommissioning process and any potential implications No

ACTIVITY TITLE	**GPS1 Primary Care Improvement Program**
Existing, Modified, or New Activity	Modified Activity Modified (inclusion of innovation activity from 2019/2020 to reflect commencement of the Practice Incentive Program Quality Improvement (PIP QI) Incentive.
Program Key Priority Area	Population Health
Needs Assessment Priority	**Identified local health needs and service issues** 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 measure or any other areas that meets the need of the practice population • Comparatively high rates of potentially preventable hospitalisations, with particular growth • My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers • Potential to increase use of data in general practice software to proactively plan care • Frequently current systems (including MBS payments and data) do not support population health approach and care-coordination • 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 limiting clinical care coordination, operational and administrative efficiency (Page 333 of 359 of full Needs Assessment submitted) Chronic Disease • Better systems to support care coordination required. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients • Need for greater focus on prevention, early identification and self-management • High rates of smoking and harmful alcohol intake across the region identification and self-management. (Page 340 of 359 of full Needs Assessment submitted) **Possible Options identified in Needs Assessment** Primary Care improvement through:

	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. 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. (Page 334 of 359 of full Needs Assessment submitted) General Practice support and Primary Care improvement through: Continuation of support in adoption of Clinical Audit tool with general practice data being submitted to GCPHN • Information, resources and education (delivery of clinician and patient resources) provided through face to face, telephone, electronic bulletins, and 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 process • Continue to improve data quality through ensuring effective data entry, data cleaning, and quality assurance process • 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 assessments and service development • 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 (Page 333 of 359 full Needs Assessment submitted) Primary Sense • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care • Highlights patients at risk of chronic disease to target proactive health assessment (Page 335 of 359 of full Needs Assessment submitted)
Aim of Activity	To support general practices and other primary healthcare providers as relevant, to implement data informed CQI activities using an evidence-based model of improvement through:

	• supporting health practitioners and their teams to deliver data informed, high quality and safe health care to their communities on the Gold Coast • support the integration of CQI including Clinical Audits into general practice workflow • to progress CQI from GCPHN led to practice led • support practices to meet the requirements of the PIP QI Incentive Payment • integrate Digital Health requirements into all activities to support sustainable business systems and processes
Description of Activity	This program of work moves beyond general practice engagement activities by supporting the implementation of a wider program based on evidence-based best practice methods to achieve high performing primary care. Based on Bodenheimer's 10 Building Blocks of High Performing Primary Care and utilising the Quadruple Aim to measure outcomes the Primary Care Improvement Program will focus on supporting General Practitioners, other members of the general practice team and primary healthcare providers where relevant to identify and implement CQI activities based on the needs of the practice population. Below list shows how the 10 domains (building blocks) of High Performing Primary Care and the approach/actions/activities GCPHN will use to support general practices to achieve each of the 10 domains listed below. **1. Engaged leadership** • Promote engagement of practice/organisation leaders to support a team-based approach to improvement initiatives • Promote the creation of a practice wide vision to enable engagement of the whole team in the process of change **2. Data-driven improvement** • Promote the use of data analytic tools to effectively inform the health care needs of the practice population • Enhance primary care prevention by identifying patients at risk of developing chronic disease • Improve care provision to patients with chronic disease/s • Optimise patient care by identifying patients most at risk of poor health outcomes **3. Empanelment (patient registration)** • Promote linking of a patient to a primary GP to better support coordination of care **4. Team-based care** • Promote a team-based approach to care provision with each team member working to the top of their scope of practice **5. The Patient-team partnership** • Promote the patient as a member of the care team to support the patients expanded role in shared decision-making and effective self-management **6. Population management**

	• Promote the use of a risk stratification tool to stratify the needs of the practice population **7. Continuity of care** • Promote proactive planned care approaches according to patient need • Promote the use of data analytic tools to identify gaps in care for patients with a chronic disease and at risk of poor health outcomes • Promote the application of current and consistent clinical guidelines **8. Prompt access to care** • Promote improved access to care through implementation of a proactive planned approach to service delivery **9. Comprehensiveness and care-coordination** • Promote improved coordination of care with other health and social care providers to meet the patients' needs • Promote effective use of digital health systems including the My Health Record to support effective communication between the GP and other healthcare providers **10. Template of the future** Each practice that enrols in this program has an allocated GCPHN General Practitioner (GP) Clinical Lead and Project Officer – Primary Care Improvement who support practice staff to identify their quality improvement (QI) goals and activities. The GCPHN GP and PO provide peer to peer support to increase the practice team's confidence and abilities to independently lead QI initiatives.
Associated Flexible Activity/ies:	HSI 7 Primary Care Engagement HSI 6 Primary Sense™ Population Health Management and audit tool
Target population cohort	Practice defined cohorts of patients dependent on general practice population profile General Practitioners, Practice Managers, Practice Nurses, practice support staff
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? The activity aims to include Aboriginal and Torres Strait Islander people as an optional focus Yes, the aim of the activity is to increase the number of Aboriginal and Torres Strait Islander people with an annual health assessment completed in mainstream general practice. Utilising a clinical audit tool under a quality improvement model general practice staff will be supported to identify Aboriginal or Torres Strait Islander peoples who have not had an annual health assessment completed.
Coverage	Gold Coast PHN Region (Gold Coast SA4)

Consultation	**GCPHN Staff**- implementation and engagement **General Practice Staff**- implementation and engagement **Peak bodies including RACGP and all relevant accreditation organisations**- Consultation to ensure activity aligns to the standards. **The Australian Digital Health Agency** **GCPHN Primary Health Care Improvement Committee comprising local general practice staff** - provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities. **Practice staff participating in the trial phase of the implementation of Primary Sense™ clinical audit tool** -- implementation and engagement **General Practice Gold Coast (GPGC)** - linkage to ensure consultation and partnership **Queensland Health and Hospital Service, General Practice Liaison Unit (GPGC)**– linkage to ensure consultation and partnership **State and National Universities**- exploring potential research collaboration opportunities relating to quality improvement **ACG Johns Hopkins ACG Risk Stratification tool support team:** supporting evidence-based practice and data quality
Collaboration	**1.GCPHN Staff**- implementation and engagement **2. General Practice Staff-** implementation and engagement **3. Peak bodies including RACGP and all relevant accreditation organisations**-Collaboration to ensure activity aligns to the standards. 4.**The Australian Digital Health Agency** **5. GCPHN Primary Health Care Improvement Committee comprising local general practice staff** - provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities. **6. Practice staff participating in the implementation of Primary Sense™ clinical audit tool** – informing enhancements and user experience **7. General Practice Gold Coast (GPGC)** - linkage to ensure collaboration and partnership **8. Queensland Health and Hospital Service, General Practice Liaison Unit (GPGC)**– linkage to ensure collaboration and partnership

	9. Bond University and Griffith University – supporting evidence-based practice **10. ACG Johns Hopkins ACG Risk Stratification tool support team:** supporting evidence-based practice and data quality *List and describe the role of each stakeholder that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services.*
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones? NA
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes

	3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No 4a. Co-design or Co-commissioning details No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, please provide a description of the proposed decommissioning process and any potential implications N/A