Gold Coast Primary Health Network
NEEDS ASSESSMENTS 2020
OPPORTUNITIES, PRIORITIES AND OPTIONS

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

This could include options and priorities that:

- *may be considered in the development of the Activity Work Plan, and supported by PHN flexible funding*
- *may be undertaken using programme-specific funding; and*
- *may be led or undertaken by another agency.*

Additional rows may be added as required.

phn GOLD COAST

An Australian Government Initiative

GENERAL POPULATION HEALTH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
General Practice and Primary Care • Support for general practices participating in Practice Incentive Program Quality Improvement (PIP QI) incentive submitting data through the CAT Plus or Primary Sense through specified improvement measures or any other area that meets the need of the practice population. • Growth in general practice and general practitioners • Gold Coast rates for potentially preventable hospitalisations above the National rate in 2017/18. • Additional support for general practices patient consent arrangements in relation to PIP QI • Established use of secure messaging in Australia, however, a range of systems are currently used with a lack of service compatibility between systems. This means systems, potentially are not able to	**General practice support** • Continuation of support in adoption of a Clinical Audit tool with Practice Data being submitted to GCPHN. • Information, resources and education (delivery of clinician and patient resources) provided though face to face, telephone, electronic bulletins, email networks • Practices enrolled in PIP QI are provided with quarterly reports which include a practice profile and analysis of their clinical data identifying key trends and areas where improvements could be made in clinical outcomes or practice processes. • Continue to improve data quality through ensuring effective data entry, data cleaning and quality assurance processes. • Maintain building a data repository (increasing those submitting data) and accuracy (through data cleaning and data entry activities) to inform current and future GCPHN activities such as needs assessment and service development.	• General practice is supported in the adoption of evidence based best practice methods and meaningful use of digital systems to inform quality improvement, promoting the uptake of practice accreditation and ensuring timely provision of information, resources and or education to support changes in programs and policy that impact on general practice. • General practice adoption of evidence based best practice methods to achieve high performing primary care in the Gold Coast. This aims to improve the quality of care through supporting continuous quality improvement methodologies and utilisation of health information management and other building blocks of high performing primary care to inform quality improvements in health care, specifically, the collection and use of clinical data.	GCPHN

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

communicate with each other limiting clinical care coordination, operational and administrative efficiency
• Support required to General Practices to adopt and utilise telehealth as part of the COVID-19 pandemic response
	• 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.
	• Continue to work with general practices to support pandemic response
	
	Primary Care Improvement
	• This program will continue to move beyond basic practice support and encompasses practice support activities as well as a wider program based on evidence based best practice methods to achieve high performing primary care. It includes activities to achieve better quality of care through continuous quality improvement methodologies, using health information to drive improvements and other building blocks of high performing primary care to inform continuous improvement in primary health care, including but not limited to the collection and use of clinical data to improve the population's health. This also links with Primary Sense in section below. By identifying the most appropriate tools to assist GPs and general practice to analyse general practice data to assist with proactive planned care of patients with the overall aim of managing patient health care in general practice while reducing unnecessary referrals and admissions to hospital.
		• Clinical and social expected outcomes of secure exchange of clinical information through secure messaging
		  • Facilities access to clinical information to improve patient care
		  • Reduced time managing paper-based correspondence
		  • Improved communication between health care providers as part of an end-to-end clinical workflow
		  • Improved privacy and security of patient information
			GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	COVID-19 • Workforce support • PPE distribution • Promote information and Professional resources and Patient facing resources • Support roll out of vaccine if appropriate	• Achieving increased access to contemporary evidence-based resources and localised service and referral information • Increase direct links to local service provider information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways. • General Practices and Pharmacy ae equipped with PPE	GCPHN
General Practice and Primary Care • Clinical handover, particularly to General Practice on discharge from hospitals remains a significant issue • Comparatively high rates of potentially preventable hospitalisations • Access to Information about services and resources to support general practice in key areas required • Potential to increase use of data in general practice software to proactively plan care • Current systems (including MBS payments and data) do not support	**Integrated Care Alliance** • Continue to support the implementation of new integrated models of care. • Preliminary work to develop models of care have been completed for a range of disease conditions. The models and implementation requirements are currently being scoped. • A major body of work for GCPHN involves the implementation of shared care frameworks and pathways to enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work. This will include the electronic infrastructure to support	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.	GCPHN with Gold Coast Health (GCH)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
population health approach and care-coordination	the implementation of the new models of care. **Primary Sense** Continue refinement and implementation in practices of automated pseudonymised data extraction and analysis of the health profile of the entire practice population - generating actionable optimal care reports and medication safety alerts for general practices, analysed population health data for the practice to inform the service response, and for GCPHN needs assessment and other commissioning purposes: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts to patients at immediate risk from medication prescribing safety issues • Public Health Surveillance, dashboard updates every five minutes with condition/ symptoms of interest such as influenza/influenzas symptoms.	Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms. • Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time by the right person. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. • Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	GCPHN with key stakeholders
General Practice and Primary Care • While categories 4 and 5 ED presentations have remained stable, there has been growth in higher acuity categories, increasing demand on ED services	**Emergency Alternatives** • Continue promotion of after-hours doctor's services, online and telephone services to improve awareness of options and help people make appropriate and informed decisions. Activities include:	• Contribute to prevention of increasing numbers of Emergency Department presentations • Reduce the burden in Emergency Departments by reducing the number of unnecessary or inappropriate presentations	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Access to Information about services and resources to support general practice in key areas required.	• Collateral development and distribution, including magnets, brochures and posters. To be distributed through general practice and GCH emergency department. • Online advertising, social media and radio advertising • Usual GCPHN and GCH publications • Tonic advertising at pharmacy • Advertising through GCUH screens in foyer and emergency waiting areas.		
General Practice and Primary Care • Access to information about services and resources to support general practice in key areas required	**Access to information and resources** • Promote information and resources that supports referrals and access to appropriate services. See also Access to Information and Resources. • GCPHN to support Gold Coast Health implementation of Health Pathways and promote uptake and use 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 • Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources This activity links closely with practice support activities and other program activities.	• Achieving increased access to contemporary evidence-based resources and localised service and referral information • Increase direct links to local service provider information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways.	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
After-hours • Increasing rates of non-urgent general practice after-hours services among people aged 80 years and over • Ageing population indicates more people accessing after-hours general practice services • Gold Coast rate for potentially preventable hospitalisations above the national rate in 2017-18 • Focus on preventive health interventions and early disease management in primary care and community-based settings to prevent potentially preventable hospitalisation • While categories four and five Emergency Department presentations have remained stable, there has been growth in higher acuity categories, increasing demand on ED services.	**Primary Sense** • Continue refinement and implementation in practices of automated de-identified data extraction and analysis of the health profile of the entire practice population - generating actionable reports and medication safety alerts for general practices, analysed population health data for the practice to inform the service response, and for GCPHN commissioning purposes: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts to patients at immediate risk from medication prescribing safety issues • Public Health Surveillance, dashboard updates every five minutes with condition/ symptoms of interest such as influenza/influenzas symptoms.	Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms. • Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time by the right person. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. • Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	GCPHN with stakeholders
	Access to information and resources (gcphn.org.au) • Promote information and resources that supports referrals and access to appropriate services. See also Access to Information and Resources. • GCPHN to support Gold Coast Health implementation of Health Pathways and promote uptake and use	• Direct links to local service providers information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	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 • Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources This activity links closely with practice support activities and other program activities. **Safe spaces (PCCS)** • Continue to fund after-hours drop-in service for primary mental health care services for people with severe and complex mental illness in the form of community based safe space. **Emergency Alternatives** • Continue promotion of after-hours doctor's services, online and telephone services to improve awareness of options and help people make appropriate and informed decisions. GCPHN anticipate this will continue to assist reduce the burden in Emergency departments by reducing the number of unnecessary or inappropriate presentations. Activities include: • Collateral development and distribution, including magnets, brochures and posters. To be distributed through general practice and GCH emergency department. • Online advertising, social media and radio advertising • Usual GCPHN and GCH publications	• Support for people to proactively manage their mental health by allowing access through a drop-in arrangement when the person identifies symptoms of becoming unwell and their primary care provider is not accessible • Increase awareness of the community about other services and options available to the community, when to use them and when it is appropriate to go to an emergency department • Reduce the burden in Emergency Departments by reducing the number of unnecessary or inappropriate presentations.	GCPHN GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Tonic advertising at pharmacy • Advertising through GCUH screens in foyer and emergency waiting areas.		
Cancer • High rates of melanoma across the region. • Higher rates of colorectal cancer and breast cancer but lower rates of screening compared to national rates. • Low community awareness of eligibility for screening in Gold Coast region	**Public Awareness/Campaign - Cancer** • Maintain public awareness campaigns promoting screening and skin checks through usual communication channels including information and resources on website (gcphn.org.au), GCPHN publications, social and traditional media, targeting particular hot spot areas. **General Practice Support – Quality Improvement** • Quality improvement activities in general practice support to include prevention as potential focus area including recall / reminder of potentially eligible patients for screening options through Health Assessments and skin checks.	• Increase in awareness and uptake of screening services for breast, bowl and cervical screening. • Increased skin cancer and prostate cancer checks.	GCPHN GCPHN
Immunisation • Lower rates of children fully immunised in Gold Coast particularly Hinterland, Surfers Paradise and Mudgeeraba-Tallebudgera. • Lower rates of HPV vaccination in Gold Coast compared to the national figure. • COVID-19 requires ongoing monitoring an activity, which may include support for vaccination program, if one developed	**Public Awareness – Immunisation** • Continue public awareness campaigns promoting early childhood, HPV and influenza vaccinations through usual communications channels including information and resources on website (gcphn.org.au), GCPHN publications, social and traditional media, targeting particular hot spot areas (including areas with overall high percentage of children fully immunised but also high number of children not fully immunised- Ormeau-Oxenford and Nerang.	• Increase in awareness and uptake of vaccinations.	GCPHN GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	General Practice Support – Quality Improvement • Quality improvement activities in general practice support to include prevention as potential focus area including recall / reminder of potentially eligible patients for vaccinations • Training and planning to facilitate potential of COVID-19 vaccination program (cold chain, storing, priority groups for ordering vaccine) etc.		
Family and Domestic Violence • Clear health pathways within Primary Care for domestic and family violence victims and perpetrators • Lack of accommodation and safe spaces for women and children • Some health professionals do not understand dynamics of Domestic Violence making things difficult for victim and to other providers • The psychosocial support needs of those experiencing domestic and family are currently under-supported • The impacts of family and domestic violence on child development • Often health services only become aware and get involved in DV situations when there is a crisis	**Access to Information and resources** • Promote information and resources that supports referrals and access to appropriate services. See also Access to Information and Resources. • Potential to explore training to support general practice staff with family and domestic violence.	• Direct links to local service providers information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways	GCPHN with partners GCH
Persistent Pain • High rates of musculoskeletal conditions in Southport, Gold Coast North, Ormeau-Oxenford and Coolangatta. • Ageing population means more musculoskeletal conditions projected	**Continuation of Turning Pain into Gain** (Persistent Pain) program with the following service components included: • Patient self-management education program	• Improved self-management of pain.	Contractor

Opportunities, priorities and options			
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• Pain management frequently focusses on medication • High levels of opioid dispensing across region compared to national rate, particularly Southport • Need for more awareness and support for prevention and self-management • Focus on multidisciplinary and coordinated care	• Individual patient assessment including support to navigate service providers and recommendations to patient's GP • Access to additional allied health services where required • GP and allied health services education • Peer to peer support group lead by previous participants • Refresher workshops for participants at 6 months, 9 months, and 12 months' post program • Evaluation using validated tools		
Chronic Disease • Better systems to support care coordination. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients. • Need for greater focus on prevention, early identification, and self-management. • High rates of smoking and harmful alcohol intake across the region.	**Integrated Care Alliance** • GCPHN to support Gold Coast Health implementation of Health Pathways and promote uptake and use • to support the implementation of new integrated models of care. • Preliminary work to develop models of care have been completed for a range of disease conditions. The models and implementation requirements are currently being scoped. **Primary Sense** • Continue refinement and implementation in practices of automated de-identified data extraction and analysis of the health profile of the entire practice population - generating actionable reports and medication safety alerts for general practices, analysed population health data for the practice to inform the service response, and for GCPHN commissioning purposes: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care	Create a single integrated healthcare system for the Gold Coast by: • Improving the coordination of care to endure consumers receive the right care at the right place by the right person • Increasing effectiveness and efficiency of health services for consumers • Engaging and supporting clinicians to facilitate improvements in our health system. Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms. • Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so	GCPHN with GCH GCPHN with key stakeholders including RACGP

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts to patients at immediate risk from medication prescribing safety issues Public Health Surveillance, dashboard updates every five minutes with condition/ symptoms of interest such as influenza/influenzas symptoms. **Access to Information and resources** **Access to information and resources** • Promote information and resources that supports referrals and access to appropriate services. See also Access to Information and Resources. • GCPHN to support Gold Coast Health implementation of Health Pathways and promote uptake and use 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 • Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources This activity links closely with practice support activities and other program activities.	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. Improvement in health outcomes in the community.	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	Work cooperatively with National Health Service Directory to ensure most effective information sharing. This activity links closely with practice support activities and other program activities **Population health management** • Using the learnings from previous Comprehensive over 75 Complex Care Planning, continue to support implementation of comprehensive proactive management of complex and at-risk patients through a quality improvement model in general practice. **General Practice Support – Quality Improvement** • Quality improvement activities in general practice support to include prevention as potential focus area including recall / reminder of potentially eligible patients for health checks and referral to lifestyle modification programs. **Chronic disease care model** • Support the implementation of chronic disease care model proposed by Government aimed at improving the health outcomes of patients aged 70 and over and those with a chronic condition in Primary Care.		GCPHN GCPHN
Aged Care • High numbers of preventable hospital admissions for older adults are recorded for chronic obstructive pulmonary disease, urinary tract infections, congestive cardiac failure and cellulitis	**Enhanced Primary Care in RACFs** • New contract in negotiations with GCHHS to extend the model of support for RACF staff and general practitioners to increase care coordination, provide a multidisciplinary approach to managing RACF residents with palliative and end of life care needs	• Development of strong partnerships with community palliative care supports and services and GPs • Implementation and adoption of clinical guidelines and protocols focused on key best practices for generalist primary palliative care within RACFs	GCPHN with partners Gold Coast Health / other Contractor

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Lack of established clinical coordination tools and processes that result in fragmentation of the local health system in patient centred care – management and problematic after-hours management • Low use of advanced care directives-Plans and deficits in confidence and capacity of staff to provide adequate and/or quality palliative care. • Residents in residential aged care presenting with increasing complexity of care, including dementia behaviour management, mental health, palliative and end of life care. • Transient and lower skilled workforce in RACF • Lack of role clarity and access to the relevant information to support 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.	• Opportunity to develop and trial a shared care model for palliative care that could be extended more broadly to non-RACF residents in the future **After hours advice and support** • Provide a point for RACF clinical staff to communicate with expert clinical staff to provide advice and guidance to facilitate an alternative to hospital transfer for acute, subacute and outpatient services, facilitate early and proactive planning of transfers between GCHHS and RACFs	• Engagement of RACF Staff in training to increase role appropriate competence in primary palliative care skills • Enhanced clinical competency of professionals within RACF in primary palliative care management • Increased awareness of palliative care clinical management and its integration into patient centred care • Decrease in avoidable admissions to Emergency Department • Increase in number of Advance Care Plans and upload to My Health Record.	
Palliative Care • Maintaining the role of GPs in coordinating care for palliative patients is important to clinicians, consumers and carers but this is difficult because: • Some GPs and other primary care providers may not regularly provide palliative care influencing levels of knowledge and confidence • Low levels of uptake and awareness of existing palliative care-related training and information resources	• The plan for 20-21 is to develop and promote an Advance Care Plan toolkit for general practices to implement QI activity to increase the awareness of Advance Care planning, initiation of conversations for all age groups and completion of the required documentation	• Improved practical advice and support for families • Improved awareness by health, community and aged care providers regarding family access to bereavement support • Improved health, community and aged care provider understanding of end-of-life care, and appropriate referrals to specialist palliative care • The generalist healthcare workforce supported and mentored to increase capacity, knowledge and skills • Workforce better equipped to support an ageing population	GCPHN through Greater Choices for At Home Palliative Care with Gold Coast Health and other key stakeholders HHS CNC's HHS Aboriginal Liaison Health Workers Kalwun Health Services Cura Multicultural

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Care coordination involving a person's different care providers and family is seen as important but can be difficult due to funding arrangements and lack of dedicated resources to operationally support • GPs experience challenges in making palliative care-related attendances particularly in the after-hours period due a range of factors including MBS payments, capacity, limited access to information on current treatment/medications and for RACFs there are also issues with accessing facilities, coordination with onsite nursing staff and communication with deputising services. • Fatigue and burnout for families supporting loved ones at home is a significant issue, particularly those with limited practical and social support • There is low uptake, awareness and confidence reported for advance care planning amongst both service providers and community members. • Effectiveness of local palliative care services in an inpatient setting typically exceeds patient outcome benchmarks but achieving similar outcomes in the community setting is challenging due to limited resourcing. • Limited funding is available to support community services to provide after-hours in-home care, offer respite nursing support or purchase appropriate equipment to enable palliative care to be provide in a patient's home (including residents of RACFs)		• Improved public understanding of end-of-life and palliative care uptake of ACP	

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Families report difficulty with understanding and navigating the palliative journey of loved ones including equipment requirements			

PRIMARY MENTAL HEALTH CARE (including suicide prevention)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Low intensity mental health services • Flexible evidence-based services are required and could include the review and possible adaptation of existing funded groups and alternative service models. • Promotion of low intensity services to General Practice to support complementary use with other primary health interventions. • Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services. • Demographic data collection on people experiencing or at risk of developing mild mental illness	**Group programs** • Review of commissioned psychological group programs aimed at people with mild mental health issues from underserviced groups as listed under target population cohort. **New Access** • Continue to review New Access program, with a focus on the northern growth corridor of the Gold Coast, which commenced 1st January 2018 **Public Awareness** • Continuation of public awareness campaign promoting increased referrals across the stepped care continuum in particular low intensity mental health services. **Access to information and resources** • Promote information and resources that supports referrals and access to appropriate evidence based electronic (digital) mental health services. See also Access to Information and Resources above General Population Health section.	Improve targeting of evidence based psychological interventions and models of service to most appropriately support people with, or at risk of, mild mental illness. Enhance the capacity and effectiveness of the funded organisations, General Practice, and the broader sector to meet the needs of their client group.	Contracted providers Beyond blue GCPHN GCPHN
National Psychosocial Services Short-term, non-clinical, recovery-focussed psychosocial support services for people of all ages	**Coordinated of services** • Maintain work with existing contracted provider delivering non-clinical Psychosocial services for people with severe mental illness to implement the provision of psychosocial support for people with severe mental illness.	Improve targeting of evidence based Psychosocial interventions and models of service to support people most appropriately with, or at risk of, mild mental illness.	Contracted provider

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

Ensure effective engagement with key vulnerable groups
 	
Local workforce comprised of peer support workers, life coaches and support workers able to provide client-centred, trauma-informed, culturally appropriate, and recovery-orientated support in both outreach and centre-based settings
 	
Promotion of psychosocial services to General Practice and other stakeholders to support complementary use with other primary health interventions
 	
Efficient referral pathways to increase accessibility to new psychosocial services
	• Commission short-term, non-clinical, recovery-focused psychosocial support services to address the most frequently identified areas of unmet psychosocial need:
	  • Obtaining employment/volunteering opportunities
	  • Managing physical health issues
	  • Engaging in a fulfilling social life
	  • Participating in daytime activities
	  • Ensure effective engagement with key vulnerable groups:
	  • Culturally and linguistically diverse (CALD) backgrounds
	  • Those who identify as lesbian, gay, bisexual, transgender, Intersex, queer, asexual, pansexual and others (LGBTIQAP+)
	  • Identify as Aboriginal and/or Torres Strait Islander
	
	Public Awareness
	• Continue public awareness campaign promoting increased referrals across the stepped care continuum in psychosocial support services.
	
	Access to information and resources
	• Promote information and resources that supports referrals and access to appropriate to evidence based electronic (digital) mental health services.
	• GCPHN to support Gold Coast Health implementation of Health Pathways and promote uptake and use
	• See also Access to Information and Resources.
			GPCHN and contracted provider
			
			GCPHN

Mental Health - Suicide Prevention	**Expanded Horizons**	At risk LGBTIQAP+ youth are supported to access culturally safe supports and build connections with like-minded peers.	GCPHN with Wesley Mission Queensland

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• PHN funded suicide prevention psychological services are well utilised, but opportunity exists to better target those most at risk. • Workforce education and support is required for general practice and mental health services to ensure consistent approaches to risk assessment and safety planning. • Partnership with Gold Coast Health to ensure care planning and discharge process are inclusive for all participants • Clear referral pathways and supported connections to appropriate community supports	• Continue funding group programs specifically for LGBTIQAP+ youth, residing on the Gold Coast. **Psychological Services Program (PSP)** • Continue provision of psychological services through the underserviced response. Additionally, GPs can refer through to Better Access. **The Way Back Support Service** • The Way Back Support Service (The Way Back) is a low to high intensity non-clinical psychosocial support and transition service for people who may have recently attempted suicide or are at risk of suicide and have presented to either Robina Hospital or Gold Coast University Hospital . **Joint Regional Plan** • Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drugs Services in the Gold Coast region.	Improve targeting of evidence based psychological interventions and models of service to most appropriately support people at risk of suicide. The Way Back will improve access to high-quality aftercare to support at risk individuals to stay safe; connect individuals to community-based services; connect individuals with support networks including families, friends and careers; and reduce distress and improve wellbeing. The Joint Regional Plan aligns future needs assessment and service planning while also identifying key pieces of work in the short term that developed new ways of working together to improve outcomes with existing resources. The Joint Regional Plan aims to lay the groundwork for collaborative action by: • Developing a better shared understanding of current service system • Identifying specific opportunities for the future service system • Establishing joint governance structures to leverage in the future	GCPHN with contracted providers GCPHN, GCH, (with support from Beyond Blue) and Wesley Mission
Mental Health – underserviced Data, research and consultation with service users, service providers and community members identified the	**Psychological Services Program (PSP)**	• Psychological services are provided for each target group. • Improve targeting of evidence based psychological interventions and models of service to support people most	Contracted providers

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
following groups as high risk / underserviced on the Gold Coast: • People who are currently homeless, or are at risk of homelessness • Culturally and Linguistically Diverse people (CALD) • People who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+) • Women experiencing perinatal depression • Aboriginal and Torres Strait Islander people • Children (aged 0-12) who have, or are at risk of developing a mental, childhood behavioural or emotional disorder (including a specific focus on children in care) • People who self-harm or who are at increased risk of suicide.	• Continue to commission PSP targeting identified underserviced groups • Review model to further refine and target most at risk clients. • See also Suicide prevention, Children and Young People and Aboriginal and Torres Strait Islander Mental Health, and Severe and Complex.	appropriately with, or at risk of, mild and moderate mental illness.	
Mental health – children and youth • Wrap around support for youth through outreach opportunities and flexible service entry points. • Early intervention and therapeutic services for children aged 0 to 14 across with a focus on the northern growth corridor. • Limited services in the northern part of the region where there are large child and youth populations and significant demand for Mental Health (MH) services for this cohort, including services for Aboriginal and Torres Strait Islander Children. • Education, training and support to engage schools and broader education	**headspace** • In accordance with Department of Health funding agreement, continue to commission the two headspaces on the Gold Coast **Psychological Services Program (PSP)** • Continue to fund PSP services for children and review considering children in care as a particular focussed target group. **Northern Gold Coast** • Maintain exploring opportunities to increase service delivery options for children in Northern Gold Coast area.	• Increased access to care for young people (aged 12-18) who are at significant risk or have severe mental illness. Improved mental health for clients.	headspace contracted providers GCPHN with potential providers

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
workforce in early identification and intervention. • Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs. Addressing these issues is hampered by: • Long wait times for assessment and treatment in the public system • Costs of private services • Issues with transfer of information • Limited knowledge and adherence to guidelines	**Youth Enhanced Initiative** • Continue funding Lighthouse service which prioritises care for young people (12-18) who are at significant risk or have severe mental health.		GCPHN with Lives Lived Well
Mental Health - Severe and Complex • Coordinated shared care planning that is available across primary care, community and the hospital and health service. • Clear and efficient health pathways to better support severe and complex patients through Primary Care, community and the hospital and health service. • Increased opportunities to support greater engagement in service delivery by peer workers and people with a lived experience. • Centralised intake across the stepped care model to ensure people receive the appropriate support and referral based on their needs. • Develop efficient pathways to support person centered transfer of care between acute and primary services	**Coordinated services** • Continue to monitor and review Plus Social program targeting people with severe and complex mental health conditions and offering access through after-hours drop-in-centre to further refine support provided to clients. Review and refine intake and referral process to support access from Primary care. **Public Awareness** • Public awareness campaign promoting increased referrals across the stepped care continuum in particular for severe and complex. **Access to Information and resources** • Promote information and resources that supports referrals and access to mental	• Increased access to services for people with severe and complex mental health issues. Improved mental health for clients	Contracted provider

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
(general practice, allied health and community services). • Transition to NDIS creates uncertainty for providers in their sustainability to provide services to individuals that are not NDIS eligible.	health services. See also Access to Information and Resources. • GCPHN to support Gold Coast Health implementation of Health Pathways and promote uptake and use **Youth Enhanced Initiative** • (See above, Mental health- Children and Youth)		

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Alcohol and Other Drug • Increased detoxification, pre-treatment, residential rehabilitation and aftercare services • Flexible outreach treatment services with a focus on vulnerable target groups including young people. • Promotion of alcohol and other drug treatment services to support early identification • Provision of training and resources including referral pathways, for General Practice to support patients with substance use issues including ice • Enhance collaborative between mainstream and Aboriginal and Torres Strait Islander workforce to support increased access to treatment.	**AOD Mainstream** • Continue to monitor and evaluate effectiveness of services which commenced 1 January 2017 (AOD Mainstream) to deliver innovative responses to increase existing treatment sector capacity (focused in Northern Gold Coast) in the following areas: •Early Treatment Support • Post Treatment Support • Continue to explore outcomes focussed activities and improved data collection.	• Timely access to services to capture clients wanting to address their drug use and maximize the effectiveness of the intervention	GCPHN with Lives Lived Well

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• 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.	**AOD Youth Outreach** • Continuation of monitoring and evaluating effectiveness of services to deliver innovative outreach AOD intervention services to young people. • Review services with a view to driving continuous quality improvement and alignment with State and Commonwealth government investment. **Access to Information and resources** • Promote information and resources that supports referrals and access to appropriate services. **Training and Education** • Training and education as part of workforce and sector support including demand management, commission general management, commissioning general practice training, sector capacity building and general practice referral pathways (links with workforce) **Capacity building** • Capacity building activities with current PHN funded provider. Monitor and evaluate effectiveness of services and identify opportunities for driving continuous quality improvement and alignment with State Commonwealth government services.	• Increased access for young people to AOD services. • Enhance the capacity and effectiveness of the funded organisations, General Practice and the broader alcohol and other drugs (AOD) treatment sector and their ability to meet the needs of their client group. • Increased capacity of local Indigenous service providers	GCPHN with Lives Lived Well GCPHN Key stakeholders with GCPHN support GCPHN with subcontractor Kalwun

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Mental Health overarching stepped Care approach	**Joint Regional Plan** • Implementation of the Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drugs Services in the Gold Coast region. **Public Awareness** • Continuation with public awareness campaign promoting increased referrals across the stepped care continuum. **Access to Information and resources** • Promote information and resources that supports referrals and access to mental health services. See also Access to Information and Resources. • GCPHN to support Gold Coast Health implementation of Health Pathways and promote uptake and use **Centralised information intake and triage** • For GCPHN funded services to support more appropriate referral	The Joint Regional Plan aligns future needs assessment and service planning while also identifying key pieces of work in the short term that developed new ways of working together to improve outcomes with existing resources. The Joint Regional Plan aims to lay the groundwork for collaborative action by: • Developing a better shared understanding of current service system • Identifying specific opportunities for the future service system • Establishing joint governance structures to leverage in the future	GCPHN GCPHN with GCH Contracted provider

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	of clients according to their needs across the stepped care continuum. Including review and implementation of the intake assessment and referral mental health services guidance. **Education and training** • Continue training and education as part of workforce and sector support including demand management, commissioning general practice training, sector capacity building and general practice referral pathways (links with workforce).		
Aboriginal and Torres Strait Islander - Mental Health and Suicide	See Aboriginal and Torres Strait Islander Health and Alcohol and other drugs section below		

INDIGENOUS HEALTH (including Indigenous chronic disease)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Aboriginal and Torres Strait Islander Health • Cultural competency affects access to services for Aboriginal and Torres Strait Islander people • Need to focus on chronic disease early identification and self-management • Gaps remain in terms of life expectancy and many contributing factors • High number of Aboriginal and Torres Strait Islander people with diabetes, COPD and smoking in the region • Low number of Aboriginal and Torres Strait Islander health assessment (MBS item 715)	• Continue current arrangements with Kalwun Health Services including employment of IHPO mainstream to deliver cultural competency training (See also workforce). Review current curriculum content to ensure appropriateness and contemporary and establish systematic process to ensure currency in training. • Implant processes to more effectively monitor cultural competency training for local service providers particularly those funded by GCPHN. • Primary Care improvement team to implement rate and number of Indigenous health assessment completed in PIP QI reports including a benchmark against the Gold Coast rate **Integrated Team Care** • Continue current Integrated Team Care arrangements with IUIH (Department of Health stipulated contracting IUIH to deliver the Care Coordination and Supplementary Services (CCSS) component through Brisbane North PHN as lead commissioner) and Kalwun Health Services locally. Continue to increase awareness of services for Aboriginal and Torres Strait Islander people **Primary Sense** • Continue refinement and implementation in practices of automated de-identified data extraction and analysis of the health profile of the entire practice population - generating actionable reports and medication safety alerts for general practices, analysed population health data for the practice to inform the service response, and for GCPHN commissioning purposes: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review	• Increased number of Aboriginal and Torres Strait Islander health assessments by culturally competent trained workforce; improved coordination of care, supporting mainstream service providers to provide culturally appropriate services. • Improve health equity for Aboriginal and Torres Strait Islander people through culturally appropriate mainstream primary care, provide assistance to Aboriginal and Torres Strait Islander People to obtain primary health care as required, and provide care coordination services to eligible people with chronic disease who require coordinated, multidisciplinary care. Improve service users' capacity to self-manage conditions/health. Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms. • Identifying high risk groups for proactive care.	Kalwun with support from GCPHN GCPHN in partnership with IUIH (Via Brisbane North PHN) and Kalwun Health Services and mainstream primary care services. GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Alerts to patients at immediate risk from medication prescribing safety issues • Public Health Surveillance, dashboard updates every five minutes with condition/ symptoms of interest such as influenza/influenzas symptoms.	• Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time by the right person. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. • Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	
Aboriginal and Torres Strait Islander - Mental Health and Suicide • Access and awareness of appropriate services. • Mainstream services that are culturally appropriate and safe • Holistic service response aligned social and emotional wellbeing framework for Indigenous clients, including mental health, suicide prevention, and alcohol and other drugs	**Access to information and resources** • Promote information and resources that supports referrals and access to appropriate services. See also Access to Information and Resources. • GCPHN to support Gold Coast Health implementation of Health Pathways and promote uptake and use • See cultural competency section above **Coordinated Mental Health Alcohol and other Drug suicide prevention services** • Continue to monitor and evaluate effectiveness of services which commenced 1st January 2017 to deliver holistic service response for Aboriginal and Torres Strait Islander clients and identify opportunities for driving continuous quality improvement and alignment with State government services.	• Facilitate local relationships and partner with mainstream and Aboriginal and Torres Strait Islander services for the delivery of primary care services. • Improve health equity for Aboriginal and Torres Strait Islander people by addressing access issues. • See cultural competency section above • Higher rates of successful engagement with Aboriginal and Torres Strait Islander clients and more effective treatment.	GCPHN in partnership with local service providers. Kalwun with support from GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Aboriginal and Torres Strait Islander- Alcohol and Other Drug • Small Aboriginal and Torres Strait Islander workforce which limits the capacity of providers to work with clients who require treatment. Cultural competency of mainstream alcohol and other drugs treatment services requires improvement to confidently, safely and effectively work with Aboriginal and Torres Strait Islander people.	**Aboriginal and Torres Strait Islander service capacity building** • Capacity building activities with current PHN funded provider.	• Increased capacity of local Aboriginal and Torres Strait Islander service providers.	GCPHN with subcontractor Kalwun

Gold Coast Primary Health Network
Primary Care Gold Coast (ABN 47152953092), trading as the Gold Coast Primary Health Network.

Level 1, 14 Edgewater Court, Robina 4226 | PO Box 3576 Robina Town Centre QLD 4230
P: 07 5635 2455 | F: 07 5635 2466 | E: info@gcphn.com.au | www.healthygc.com.au

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Gold Coast Primary Health Network gratefully acknowledges the financial and other support from the Australian Government Department of Health

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GOLD COAST

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