



Australian Government

**phn**  
DARLING DOWNS  
AND WEST MORETON  
An Australian Government Initiative

# Primary Health Networks Core Funding Operational and Flexible

Activity Work Plan  
2017-18



Local Integrated  
Primary Health Care

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# 1. DDWMPHN Overview

## STRATEGIC VISION:

The Darling Downs and West Moreton PHN region covers the major Queensland communities of Ipswich and Toowoomba, plus the surrounding rural communities of the Lockyer Valley, Boonah (Scenic Rim), Esk (Somerset), South Burnett, Southern Downs, Goondiwindi and the Western Downs (Dalby, Chinchilla, Miles and Tara).

The PHN region covers two Hospital and Health Service areas, ten local government areas (or parts thereof), nine Australian Statistical Geography Standard (ASGS) SA3 statistical areas (or parts thereof) and 64 SA2 statistical areas.



*We exist as a PHN to support primary health professions through reform activity that delivers better health outcomes for the Darling Downs and West Moreton community. We seek to ensure that people in the Darling Downs and West Moreton region enjoy optimal health and wellbeing through accessible to a responsive, integrated and high quality primary health system.*



To achieve our strategic vision, we will:

- Better understand the health needs of the DDWMPHN community through comprehensive, ongoing analysis and planning, in collaboration with the general practice, the primary health sector, Hospital and Health Services, the social sector and the community.
- Achieve best value for money, by considering service gaps and the needs of the community, to work with service providers to augment and/or increase their delivery.
- Optimise genuine collaboration and integration of general practice, hospital and health services, allied and mental health services, and other service providers by focussing on the social determinants of health and wellness.
- Deliver of responsive, focussed practice support to create a regional primary health environment that continues to provide high quality, efficient and accessible health care to individuals and communities in our region.
- Provide useful and appropriate support to ensure primary health professionals are best placed to provide care to patients subsidised through the Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) with a focus on reducing emergency department presentations and avoidable hospital admissions.
- Assist primary health services and the broader community to understand and use digital health systems in order to optimise the secure flow of patient information across the health provider community.
- Commission, and decommission, service delivery through active and genuine co-design, innovation and good governance.

### VISION:

A seamless healthcare system that fulfils the needs of Primary Health Care Providers and the Community.

### PURPOSE:

With a strong focus on primary and integrated health care, we believe that, by bringing the Darling Downs and West Moreton health community together we can significantly improve the health outcomes of our community. We are better when we achieve things together!

### VALUES:



### FOCUS AREAS:



### GOVERNANCE:

In addition to the Board of Directors, the Governance Framework for DDWMPHN includes Clinical Councils, Community Advisory Committees and Mental Health / AOD Sub-Committees for both West Moreton and Darling Down regions, along with an Antimicrobial Taskforce for the Darling Downs region.

## 2. Link to Health Needs Assessment

### HEALTH NEEDS:

- Demographically, the key issues facing the PHN are the high population growth rate and the high proportion of the population that are aged 65 years and over. These factors will significantly impact on future health needs and health service delivery.
- A significant number of the social determinants of health in the PHN are higher than the state levels, and overall, the region is more disadvantaged than other regions in the state.



- Chronic disease prevalence rates in the PHN are all higher than the state averages
- The health behaviours of the population are below the state averages (weight, diet, physical inactivity and smoking). The only health behaviour better than the state average is risky drinking.
- Childhood immunisation rates in the PHN are above the state average, as are all of the cancer screening rates except cervical cancer, which is the lowest in QLD and in Australia.
- There are four communities where there may be a need for additional GP after-hours services: Chinchilla, Millmerran, Crows Nest and Somerset (Lowood, Esk).

### 3. Planned Activities Funded Under Primary Health Networks Core – Flexible - Schedule

#### CO\_F\_1.0\_201718 – REGIONAL PATIENT CARE-COORDINATION FOR CLIENT TRANSPORT

##### Activity Description

**Aim:** To support patients at risk of preventable re-admission to hospital through care coordination and assistance in accessing transport to attend primary health care appointments. Transport deficiencies impact the accessibility to Primary Health Care in regional communities however direct transport provision is outside of the scope of the PHN.

In areas that have limited public transport, such as rural towns, socially isolated and disadvantaged people often struggle to access services. This project will assist people living in rural areas in the DDWMPHN region who are otherwise not able to access private transport to take them to and from medical appointments.

**Activity:** To assist communities in improved accessibility to primary health care, DDWMPHN will enter inter-community relationships (current discussions with the district health service and local council) for low cost, non-urgent medical transport services funding the care coordinator component. Goondiwindi is the chosen pilot area site with an aim of decreasing preventable re-admission to hospital with the view to evaluating the model prior to duplication in other regional areas.



	<p>The care coordinator will facilitate primary health care appointments, case conferencing and assist patients access to transport to attend these appointments.</p> <p>This may include development of a database which identifies available transport, including local volunteer options, coordinated and managed with a hotline/online interface for real time patient coordination and connection to service provision.</p>
<b>Target Population Cohort</b>	Socially isolated and disadvantaged people who have been admitted to hospital and are discharged back into the community requiring additional supports. This will be assist in their access to ongoing care appointments and reducing risk for readmission to hospital.
<b>Consultation</b>	Providers of medical and community transport, HHSs, NGOs, AMSs, regional council, Local Chapter, and Lead GP advisors
<b>Collaboration</b>	HHSs, NGOs, medical and community transport and regional council
<b>Indigenous Specific</b>	No
<b>Duration</b>	1st July 2017 - 30 June 2018 with evaluation in April-May 2018 by an independent organisation to determine the voracity of the service and whether it met the needs of the community
<b>Coverage</b>	Goondiwindi (pilot site)
<b>Commissioning Method</b>	Brokered agreement with HHS and regional council
<b>Approach to Market</b>	<p>Limited tender</p> <p>Following development of an appropriate tender to guide the desired project outcome (Project Development), we anticipate utilising a focussed approach to market, working closely with current providers of services</p>





**CO\_F\_2.0(A)\_201718 - ASSISTING WITH INAPPROPRIATE HOSPITAL PRESENTATIONS:  
CARE ASSISTANT**

**Activity  
Description**

**Aim:**

- To reduce inappropriate presentation to/ wait times in EDs, improve the health literacy of identified groups and enable them to access online health portals for additional support where required.
- To develop the necessary networks, processes and resources for implementation of the activity through consultation and collaboration with appropriate key stakeholders.

**Background:** The Darling Downs and West Moreton Hospital and Health Services have identified increasing Category 4 and 5 presentations at Emergency Departments (ED). There are several reasons for the increase, including limited access to bulk billing GP services and low health literacy amongst certain cohorts e.g. Aboriginal and Torres Strait Islander peoples and disadvantaged and marginalised communities. Disadvantaged people struggle to access care, often due to accessibility and cost factors and are more likely to face issues of chronic disease. They are also likely to delay seeking medical assistance due to cost, making their conditions worse. This is a result of both low health literacy and affordability of health care.

**Activity:** Initial consultation is underway with the HHS' to determine specific issues with presentations in the Category 4 and 5's in ED's including cultural, socioeconomic and health literacy domains.

Working with the HHS', the DDWMPHN will place Care Assistant positions within the Emergency Department of the Toowoomba and Ipswich Hospitals with the aim of facilitating an increased ability of patients to access appropriate health care within the community. Consultations with the HHS', including Aboriginal Community representation, will identify specific cultural considerations to be incorporated into two indigenous-identified positions.

The Care Assistant will work collaboratively with ED staff in suggesting alternative avenues for identified category 4 and 5 patients. This will include identifying barriers, including social determinants, to accessing primary health care and providing links and/ or referrals to assist meeting underlying problems (financial, cultural, social, knowledge deficit, transport/ access). Some of this will include direct liaison (seeking availability of service, booking appointments) to community primary health care including bulk billing or low/ no cost general practitioners, allied health care or AMS, supporting access solutions, and providing opportunity for education on telehealth, My Health Record and My Aged Care.



	<p>Each Care Assistant will have a mobile phone, to assist with connection between patient and alternative care, and tablet device, to provide information sharing about available services while assisting the patient, including access to online information and brochures. The ED will provide them with space/desk as needed.</p> <p>Along with trialling a solution for meeting an identified need, this position will assist with data collection on the service. In assisting with tracking the uptake, referral points, ability to refer and peak times of service, the HHS will allow the DDWMPHN to access de-identified data on the users of this service to assist with evaluation of the usage of the program and further tailor community engagement and programs to meet the needs of these groups. It is noted that this model may differ between the DDHHS and WMHHS to suit the services' needs.</p>
<b>Target Population Cohort</b>	People who frequently access ED services focussing on category 4 and 5 type presentations or those seeking other primary care services
<b>Consultation</b>	DD&WM HHSs, Clinical Councils and Lead GP Advisor Departments at the DDHHS including accident and emergency, acute mental health, palliative care, social work, chronic disease allied health outpatients, nursing, GP liaison. Toowoomba and district branch of Queensland Ambulance
<b>Collaboration</b>	Darling Downs Hospital and Health Service; West Moreton Hospital and Health Service; Aboriginal Medical Services; General Practitioners, general practice and other primary health providers
<b>Indigenous Specific</b>	No however does incorporate indigenous specific elements
<b>Duration</b>	Initial 3 x months pilot – July – September 2017 with evaluation/ review to determine effectiveness of resource including actual patient contact/ numbers and times of need. Re-work for continuation to 30 June 2018.
<b>Coverage</b>	Toowoomba and Ipswich Hospitals in the initial pilot
<b>Commissioning Method</b>	No commissioning required. Staff will be employees of the DDWMPHN working within the HHS
<b>Approach to Market</b>	Internal and External



**CO\_F\_2.0(B)\_201718 - ASSISTING WITH INAPPROPRIATE HOSPITAL PRESENTATIONS:  
SPOT ON (SUPPORTING PATIENT OUTCOMES THROUGH ORGANISED NETWORKS)**

<p><b>Activity Description</b></p>	<p><b>Aim:</b></p> <ul style="list-style-type: none"> <li>▪ To reduce inappropriate presentation to EDs, improve the health literacy of identified groups and enable them to access online health portals for additional support where required.</li> <li>▪ To develop the necessary networks, processes and resources for implementation of the activity through consultation and collaboration with appropriate key stakeholders. This will include trialing an intervention strategy to triage and re-route non-emergent care patients from presentation at the emergency department (ED) via ambulance to other appropriate health providers.</li> </ul> <p><b>Background:</b> The Darling Downs and West Moreton Hospital and Health Services have identified increasing Category 4 and 5 presentations at Emergency Departments (ED). There are several reasons for the increase, including limited access to bulk billing GP services and low health literacy amongst certain cohorts e.g. Aboriginal and Torres Strait Islander peoples and disadvantaged and marginalised communities. Disadvantaged people struggle to access care, often due to accessibility and cost factors and are more likely to face issues of chronic disease. They are also likely to delay seeking medical assistance due to cost, making their conditions worse. This is a result of both low health literacy and affordability of health care.</p> <p><b>Activity:</b> Initial consultation is underway with the HHS' to determine specific issues with presentations in the Category 4 and 5's in ED's including cultural, socioeconomic and health literacy domains.</p> <p>This activity is an abridged version of a SPOT ON model in trial with the Sunshine Coast PHN; it will include establishment of an MOU and development of a referral protocol. The memoranda will include triage assessment, listings of participating health providers and the hours available, reporting and follow up treatment summaries. An evaluation report from Sunshine Coast PHN trial will be used to inform the development of the activity where relevant.</p> <p>Queensland Ambulance Service (QAS) will be the key to triage assessment and on-referral to more appropriate primary health providers over transporting to hospital ED for treatment.</p>
<p><b>Target Population Cohort</b></p>	<p>People who frequently access ED services through transportation via ambulance; includes people with wound management requirements, chronic disease, non-acute mental health, Aboriginal and Torres Strait Islander peoples, marginalised and socially isolated people</p>



<b>Consultation</b>	DD&WM HHSs, Clinical Councils and Lead GP Advisor Departments at the DDHHS including accident and emergency, acute mental health, palliative care, social work, chronic disease allied health outpatients, nursing, GP liaison Toowoomba and district branch of Queensland Ambulance
<b>Collaboration</b>	Darling Downs Hospital and Health Service; West Moreton Hospital and Health Service; Aboriginal Medical Services; General Practitioners, QAS, general practice and other primary health providers
<b>Indigenous Specific</b>	No
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	Trial through DDHHS
<b>Commissioning Method</b>	Limited tender
<b>Approach to Market</b>	Internal and External

#### CO\_F\_3.0\_201718 – DELIVERY OF THE MYHEALTH RECORD EXPANSION PROJECT

<b>Activity Description</b>	<p><b>Aim:</b> The activity aims to increase understanding of the health system and processes to support patients in accessing available services and reducing unnecessary presentation to hospital emergency departments. Working with GPs, allied and mental health professionals, we will seek to increase health literacy and understanding of MyHealth and MyAged Care in the Darling Downs and West Moreton region. Focussing on patients with low literacy and or low health literacy, the PHN will provide usable information (through a number of methods) to increase understanding and accessibility to primary health care.</p> <p>This project links to our core function of supporting the implementation and uptake of the MyHealth and MyAged Care initiatives.</p> <p><b>Activity:</b></p> <ul style="list-style-type: none"> <li>▪ The development of an innovative range of local patient information and resources to be made available to primary health care services and their patients.</li> <li>▪ The Digital Health Agency will be funding a Digital Health Expansion project to introduce a wide range of promotions to properly introduce the</li> </ul>
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	<p>new opt-out system to begin in May 2018. DDWMPHN is contributing to a Statewide adoption strategy and will complement this with a local implementation plan. The requirements of the digital health agency mean that the delivery of the expansion project will require staffing.</p> <ul style="list-style-type: none"><li>▪ The project approved for 2016-17 was not fully undertaken by the DDWMPHN due to staffing/resource challenges and a change to the leadership, resulting in a revised strategy across the organisation. This revised proposal has been scoped more comprehensively and discussed with the Clinical Councils and Digital Health portfolio holder. We are confident that, unlike the original proposal, it will succeed.</li></ul>
<b>Target Population Cohort</b>	<p>DDWMPHN region</p> <p>Will also ensure those who are unemployed, have low literacy and health literacy levels, cultural barriers or difficulty in navigating the current primary health care system are effectively engaged and informed regarding digital health</p>
<b>Consultation</b>	<p>GPs, allied and mental health providers will be involved in the scoping of this program using an innovation hub / co-design approach</p>
<b>Collaboration</b>	<p>This program will be rolled out by DDWMPHN, through our Practice Support Team</p>
<b>Indigenous Specific</b>	<p>No</p>
<b>Duration</b>	<p>12 Months to 30 June 2018</p>
<b>Coverage</b>	<p>DDWMPHN region</p>
<b>Commissioning Method</b>	<p>NA</p>
<b>Approach to Market</b>	<p>NA</p>





#### CO\_F\_4.0\_201718 – HOSPITAL AND HEALTH SERVICE GENERAL PRACTICE INTEGRATION

##### Activity Description

**Aim:** To effect on-the-ground change to communication, referral pathways, connectivity, discharge summaries etc. to provide a conduit for direct responsiveness to issues between HHS' and general practice and provide continuous feedback to the PHN regarding needs and issues.

The GPLOs will work within the PHN Clinical Excellence team and assist with the HealthPathways project as well as preparing GP workforce for HealthCare Homes, when appropriate.

##### **Activity:**

- a) **General Practice Liaison Officers** funded through the DDWMPHN and placed in the Darling Downs and West Moreton HHSs with a focus on linking hospitals directly with General Practices across the region.
- b) **Case Conferencing Officer** funded via DDWMPHN to manage integrated care and case conferencing between West Moreton and Darling Downs HHS' and General Practitioners across the region. This Case Conferencing Officer would manage care planning between GPs, Palliative Care Specialists and patient/family/carers for people with end stage heart failure or non-malignant lung disease to improve and increase palliative care in the community and reduce Emergency Department presentations and hospitalisations.

This activity is based on a pilot study funded by DDWMPHN of case conferences between the patient's GP and specialist staff to facilitate care planning for people with end stage heart failure or non-malignant lung disease in West Moreton.

This pilot showed that a single case conference involving the patient's heart or lung failure team is associated with significant reductions in service utilisation, apparently by improving case coordination, enhancing symptom management and assessing and managing carer needs. Results of the study have been published and are located at Mitchell et al. BMC Palliative Care 2014, 13:24 <http://www.biomedcentral.com/1472-684X/13/24>

Case conferencing care planning would require 1 x FTE per annum to coordinate and manage case conferences. The conferencing system has already been created and the pilot shows significant advantages for patients, their families and/or carers and the health system. The case conference process was developed in conjunction with WMHHS Heart Failure and Lung Health teams and palliative care staff over a six-month period. The outcomes of this process were a document for nurses to



	<p>provide a preliminary report of key palliative care issues for discussion, and a reporting document/care plan.</p> <p>Heart or Lung Failure Case Conference Pilot Results: Twenty-three case conferences involving 21 GPs were conducted between November 2011 and November 2012. One GP refused to participate. Ten patients died, three at home. Of 82 management recommendations made, 55 (67%) were enacted. ED admissions fell from 13.9 per annum (pa) to 2.1 (difference 11.8, 95% CI 2.2-21.3, <math>p = 0.001</math>); ED admissions leading to discharge home from 3.9 to 0.4 pa (difference 3.5, 95% CI -0.4-7.5, <math>p = 0.05</math>); hospital admissions from 11.4 to 3.5 pa (difference 7.9, 95% CI 2.2-13.7, <math>p = 0.002</math>); and length of stay from 7.0 to 3.7 days (difference 3.4, 95% CI 0.9-5.8, <math>p = 0.007</math>). Participating health professionals were enthusiastic about the process.</p>
<b>Target Population Cohort</b>	People in rural and metropolitan areas who require an acute care response and continuity of care during their admission and post discharge
<b>Consultation</b>	Darling Downs and West Moreton Hospital and Health Services, general practice and Clinical Council
<b>Collaboration</b>	Darling Downs and West Moreton Hospital and Health Services, primary health professionals and other social service providers, as required
<b>Indigenous Specific</b>	No
<b>Duration</b>	12 x Months to 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	NA
<b>Approach to Market</b>	NA



#### CO\_F\_5.0\_201718 - ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY MIDWIFE

<b>Activity Description</b>	<p><b>Aim:</b> This programme is solely focussed on the needs of young women who identify as Aboriginal and Torres Strait Islander, and their children to connect with care throughout the phases of pregnancy and post-partum care.</p> <p>We know that young Aboriginal and Torres Strait Islander women often do not seek care during their pregnancies and after the birth of their babies. They often struggle to access services, putting their health, and that of their baby, at risk. In particular, young women in Toowoomba and Ipswich are not regularly attending appointments with maternity care before and after the birth of their baby.</p> <p><b>Activity:</b> A pilot programme will be implemented to engage a community midwife, through a local AMS or provider to be available to connect with young women during anti-natal, peri-natal and post-partum phases, their families, support networks, their GP and the Darling Downs Hospital and Health Service maternity service. A case management model will be implemented to ensure that other service providers are engaged where relevant, such as housing and child protection agencies. If successful, the provider will submit a plan to implement a longer-term programme with ability for DDWMPHN to implement in other communities e.g. Cherbourg, Goondiwindi, Tara.</p>
<b>Target Population Cohort</b>	Aboriginal and Torres Strait Islander women and their children
<b>Consultation</b>	AMSs, HHSs general medical and maternity departments, Community Advisory Council and Lead GP advisor
<b>Collaboration</b>	AMS's, HHSs
<b>Indigenous Specific</b>	Yes
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	Toowoomba and surrounding region
<b>Commissioning Method</b>	External
<b>Approach to Market</b>	<p>Closed EOI directed to regional AMS's after outcomes of pilot</p> <p>A review will be commissioned through a review provider panel in the final quarter of the project</p>



CO_F_6.0_201718 – WELLNESS TRANSITION – CHRONIC DISEASE (FORMERLY RURAL PRIMARY HEALTH SERVICE)	
<b>Activity Description</b>	<p><b>Aim:</b> To accommodate continuity of service delivery for clients receiving support under this program as it transitions to the Wellness model and provide a funding allocation for service delivery under Wellness for allied health service provision.</p> <p><b>Activity:</b> Ongoing funding for this activity accounting for transition and implementation of the Wellbeing model of service delivery. Whilst this activity will transition to a new model of service delivery it will continue to be funded through Core flex funding to complement the Mental Health Wellness Program. An increased budget has been allowed to provide an increased capacity of services with access extended from a rural focus to include Toowoomba and Ipswich communities with this need validated through the Clinical Council.</p> <p><i>DDWMPHN will retain all responsibility for commissioning and contract management functions of providers of all mental health services. This work will be informed by CCaRA (Care Coordination and Referral Agencies (CCaRA – see CO_F_12.0_201718 - Care Coordination and Referral Agencies) including reporting data informed by the e-referral process and knowledge at the local level.</i></p>
<b>Target Population Cohort</b>	People who reside in rural communities within DD&WM region who require allied and other health professional support
<b>Consultation</b>	Extensive communication strategies have been implemented to support the transition and implementation for allied health, other key stakeholders, local state and federal members of government
<b>Collaboration</b>	NA
<b>Indigenous Specific</b>	No
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	External
<b>Approach to Market</b>	Open tender



CO_F_7.0_201718 – RESPOND AND ADDRESS / SIGNIFICANT ADVERSE EVENTS RESPONSE	
<b>Activity Description</b>	<p><b>Aim:</b> To assist community to respond and address events with impact on community as they arise and reduce the impact of incidents causing trauma in communities, responding at the local level with supports that do not seek to duplicate. Activities complement what is available and enhance the flexibility of the response to build community resilience and cohesiveness and are identified in response to clear and immediate needs within priorities areas.</p> <p><b>Action:</b></p> <ul style="list-style-type: none"> <li>▪ Respond to community need, with suggested activities submitted to department of health for approval</li> <li>▪ Develop and implement strategies when the need arises to respond to significant adverse events as guided by the affected community, government departments and key stakeholders.</li> </ul> <p>Initial consultation has been achieved through the emergency services reference group (including QFRS, QAS and HHS') with recognised support of the DDWMPHN preparedness to respond. Discussions with LGAs within the region have also occurred with resultant endorsement of DDWMPHN's preparedness to respond to identified need.</p> <p><b>Current proposed activity:</b> <i>Dalby State School Fire Response – Boost capacity of current PHN mental health providers in Dalby for counselling services as required</i></p>
<b>Target Population Cohort</b>	Varied
<b>Consultation</b>	As required
<b>Collaboration</b>	As required
<b>Indigenous Specific</b>	No
<b>Duration</b>	2017/ 2018
<b>Coverage</b>	As required
<b>Commissioning Method</b>	As required
<b>Approach to Market</b>	As required





#### CO\_F\_8.0\_201718 - AGED CARE AND CHRONIC DISEASE

<b>Activity Description</b>	<p><b>Aim:</b> DDWMPHN Aged Care Working Group identified three priority areas of need. These are aimed at implementing strategies to reduce admissions to hospital and RACFs for older people and those with chronic disease so that they can maintain their independence and reside in their own homes for longer, reducing social admissions for hospitals and RACFs, and for ensuring vital information is shared at admission and discharge points to acute care facilities.</p> <p><b>Activity:</b></p> <ul style="list-style-type: none"><li>▪ Yellow Envelope: Implement and continue the Aged Care carry over activity for the Yellow Envelope – a mechanism for sharing vital patient information through admission and discharge to acute care facilities.</li><li>▪ Care Coordination Model: Supporting people with complex significant and complex support needs in care coordination to ensure access to appropriate existing services</li><li>▪ Outreach Care: Design and implement a response for non-acute nursing care in the home over and above what is currently provided through HACC, facilitating care at home for people who otherwise may require social admission to hospital.</li></ul>
<b>Target Population Cohort</b>	Older people and people with complex chronic disease care requirements
<b>Consultation</b>	Aged Care Working Group, Lead GP advisor, DD&WM HHSs, Toowoomba and Ipswich Hospices, RACFs, Home and Community Care providers
<b>Collaboration</b>	HHSs, RACFs, Hospices, GPs, NGOs
<b>Indigenous Specific</b>	No
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	External
<b>Approach to Market</b>	Open tender and limited tender where identified



CO_F_9.0_201718 – HEALTH SUPPORT FOR VULNERABLE AND MARGINALISED PEOPLE	
<b>Activity Description</b>	<p><b>Aim:</b> Ensure that health services are accessible for people with refugee status including services from GPs, allied health including chronic disease and immunisation.</p> <p><b>Activity:</b></p> <ul style="list-style-type: none"> <li>Continuation of the Refugee Health Nurse activity and immunisation catch up</li> <li>Translation and interpreter services for allied health and pharmacy not eligible for government subsidy.</li> </ul>
<b>Target Population Cohort</b>	Vulnerable members of community - refugee peoples
<b>Consultation</b>	Clinical Council, Lead GP Advisor, DDWM PHUs, HHSs, Settlement services
<b>Collaboration</b>	Settlement services, PHUs, NGOs
<b>Indigenous Specific</b>	No
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	External
<b>Approach to Market</b>	Open tender and limited tender where identified



**CO\_F\_10.0\_201718 - QUALITY USE OF MEDICINES  
AND ANTI-MICROBIAL STEWARDSHIP**

**Activity  
Description**

**Aim:**

- To encourage general practice and the broader community to think about over-prescribing for antimicrobials including antibiotics; build reliable audit and data capture mechanisms to inform future focus of AMS strategies in areas where prescribing rates are highest.
- Through consultation, consider exploration of the impact of high-risk medications such as opioid prescribing in the DDWMHN. Appropriate opioid prescribing may be further impacted by the removal of over the counter availability of low-dose codeine in February 2018.

**Activity:**

These priorities have been raised through the joint Clinical Councils and the DDHHS Public Health Unit as over-prescribing and inappropriate prescribing has been noted broadly within the region. This activity will align with the NPS models as appropriate and be linked to providing education.

- a) Specific review and consultation project on the appropriate links, CPD points and clinical education possible through collaborative delivery with NPS, along with DDWMPHN extent of concern with at-risk medications.
- b) Raise community awareness and develop education and resources supporting Antimicrobial Stewardship to assist best practice and prescribing habits in the primary health sector including clinical audit tools that complement current data capture mechanisms.
- c) Participate in the development and then implement across the DDWMPHN region, the NPS Medicine Wise Choosing Wisely Australia Consumer Engagement and Activation Project. This project seeks to improve health literacy of patients and consumers regarding medicines and medication usage. DDWMPHN will participate with other PHNs in the development of a health literacy framework and set of principles that underpin this medication health literacy project. Tools and strategies will also be developed and implemented.
- d) Consider the extension of the AMS work to include high-risk medications such as opioids based on the consultation



<b>Target Population Cohort</b>	Those who are susceptible to viral and infectious disease including children, the elderly and those with compromised immunity
<b>Consultation</b>	Clinical Council, Lead GP Advisor, DDWM PHUs, PenCAT/Pat CAT
<b>Collaboration</b>	PHUs, PenCAT/PatCAT key Antimicrobial Stewardship stakeholders
<b>Indigenous Specific</b>	No
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	Internal and external
<b>Approach to Market</b>	Limited tender



#### CO\_F\_11.0\_201718 - TRANSITION FOR INELIGIBLE WELLNESS SERVICES

<b>Activity Description</b>	<p><b>Aim:</b> To continue service provision and continuity of care with providers that do not fall within the remit of chronic disease. This extension will allow for continuity of care for their current clients and provide an appropriate transition time should funding not continue beyond June 2018 based on the DDWMPHN Health Needs Assessment.</p> <p><b>Activity:</b> Provide extensions of contracts for providers who were previously funded under RHPS and do not meet the Wellness program guidelines where their funding allocation has been wrapped up into outputs for Wellness. These programmes include:</p> <ul style="list-style-type: none"><li>▪ Palliative Care - Toowoomba Hospice</li><li>▪ True Relationships – teenage sexual health</li><li>▪ Perinatal/ Midwife/ Lactation (Mums and Bubs)</li><li>▪ Counselling services</li><li>▪ Speech Language Pathology (children)</li></ul> <p>Through the Wellness transition, RHPS services were offered a 6 months transition; they will be offered 6 months with a further 6 months for continuity while a review of the service delivery model is undertaken. This will go through to end of the funding cycle of 30/6/2018.</p>
<b>Target Population Cohort</b>	People requiring end of life support, allied health and sexual health
<b>Consultation</b>	NGOs and funded providers, Clinical Council and Lead GP advisors where appropriate
<b>Collaboration</b>	Current service providers
<b>Indigenous Specific</b>	No
<b>Duration</b>	12 x months up to 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	NA
<b>Approach to Market</b>	NA





#### CO\_F\_12.0\_201718 – CARE COORDINATION AND REFERRAL AGENCIES

##### Activity Description

**Aim:** To assist in the continuity of care for clients accessing the Wellness program through coordination of care by providing support and monitoring of referral processes for those with high and complex care requirements that call for a multi-disciplinary response.

**Activity:** Develop and implement through Care Coordination and Referral Agencies (CCaRA) a model of care that includes supporting providers and general practice to embed processes and adopt a holistic approach to service delivery.

Criteria for patient participation:

- those who have not made an appointment with the Service Provider they have been referred to
- those with 3 or more reasons for referral
- those whose GP has identified are at significant risk and have a clinical care plan

Care Coordinators will:

- support GP's and practice staff in referral pathways and processes
- support users of the e-referral tool as required
- monitor the e-referral tool to identify and contact high-risk clients who include:
  - those who have not made an appointment with the referred Service Provider
  - those with 3 or reasons for referral
  - those whose GP has identified are at significant risk
- assist a client's movement through the stepped care model
- connect clients with the most appropriate service

To maximise their effectiveness, Care Coordinators must hold, or be enrolled in, a minimum of a Certificate IV in Mental Health or other appropriate qualifications as workforce permits.

*DDWMPHN will retain all responsibility for commissioning and contract management functions of providers of all mental health services. This work will be informed by CCaRA including reporting data informed by the e-referral process and knowledge at the local level.*



	Expected capacity of each Care Coordinator:		
	<b>LGA</b>	<b>FTE per LGA</b>	<b>Client Case Load per FTE</b>
	<b>South Burnett</b>	1.6	1614
	<b>Somerset</b>	1.2	1611
	<b>Southern Downs</b>	1.8	1622
	<b>Ipswich Regional</b>	2.6	1618
	<b>Lockyer Valley</b>	1.2	1596
	<b>Goondiwindi</b>	0.8	1649
	<b>Western Downs</b>	1.1	1625
	<b>Toowoomba Regional</b>	1.4	1613
	<b>Scenic Rim</b>	0.4	1626
	<b>Total</b>	<b>12</b>	<b>14574</b>
<b>Target Population Cohort</b>	People with differing levels of mental illness and chronic disease who require complex case coordination		
<b>Consultation</b>	The need for a care coordination model was identified in 2016 by general practitioners, existing providers in the ATAPS, RPHS, MHSRHA, and MHNIP programs. This has been validated by the DDWMPHN Clinical Councils and Mental Health Subcommittees, who have also endorsed a specific model developed from that in use by headspace in the region. In 2017, a further extensive round of consultation was conducted with general practitioners (through Chapter meetings) and existing providers (face-to-face, one-on-one), as well as the vast majority of Commonwealth and State MPs, and mayors/LGA CEOs across the region. This further round of consultation provided strong support for the care coordination model, especially from elected officials.		
<b>Collaboration</b>	Service providers identified through the Wellness tender		
<b>Indigenous Specific</b>	No		



<b>Duration</b>	12 x months up to 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	External identified through the Wellness tender
<b>Approach to Market</b>	NA

CO_F_13.0_201718 - CORE FLEX (CF) 2015/16 TO 30 JUNE 2017	
<b>Activity Description</b>	<p><b>CFActivity10:</b> Health Workforce: Review and expansion of the scope of practice of professionals to support capability and capacity to provide more care locally. <i>Project continuing with service integration work between HHS' and GPs for building capacity to provide more care locally</i></p> <p><b>CFActivity11:</b> Investigate a potential business model for multidisciplinary primary care provider models of chronic and complex disease management where the GP is at the centre of care. <i>Project continuing with review of models of care within the practice support and Clinical Excellence team, focussing on readiness for workforce planning to respond to health reform; in particular, rural practices and sole practitioners will be supported to enable them to be ready for potential changes to funding.</i></p> <p><b>CFActivity12:</b> Model and trial an inter-professional learning opportunities program for all primary providers e.g.: clinical placements, rural placements and mentoring in aged care/mental health/general practice. <i>Project continuing with providing opportunities for GPs or primary health professionals to attend clinical placements with HHS' to enhance skills and service integration improving care in the community and reducing unnecessary hospitalisations regionally</i></p> <p><b>CFActivity13:</b> Primary Health Care summits, connect primary care provider and community leaders to brainstorm/inform approaches to local health issues. <i>Project continuing with plans for a Primary Health Care Summit</i></p>
<b>Target Population Cohort</b>	People who are at risk of social isolation, who are aged or at risk of poor health outcomes including but not limited to those who are socially disadvantaged and marginalised with low socio-economic status and people from CALD and aboriginal and Torres Strait Islander descent
<b>Consultation</b>	NA
<b>Collaboration</b>	NA



<b>Indigenous Specific</b>	No
<b>Duration</b>	Activities 10-13 to 30th June 2018
<b>Coverage</b>	NA
<b>Commissioning Method</b>	NA
<b>Approach to Market</b>	NA

#### CO\_F\_14.0\_201718 – IDENTIFY BARRIERS AND DEVELOP SOLUTIONS FOR REFUGEE HEALTH

<b>Activity Description</b>	<p>This activity will create local solutions to the barriers faced by our refugee community in accessing health care. Initially, issues will be recognised and mapped by working closely with our community and key stakeholders to create a situation analysis which will form the basis of co-design activities for the development of innovation solutions. It is envisioned that the situation analysis will further inform the Needs Assessment, support existing Refugee, Mental Health, After Hours and HealthPathways programs and enable collaborative implementation of health focused solutions in the future.</p> <p>A tender process will be engaged to commission the data collection, situation analysis and academic review components of this activity. Community engagement and co-design activities will be conducted by the DDWMPHN.</p> <p>A policy review conducted by the Primary Health Care Research and Information Service identified the refugee and asylum seeker community as a primary health care disadvantaged group. The review suggested the main barriers for the cohort accessing primary health care as:</p> <ul style="list-style-type: none"><li>▪ cost of care not covered by Medicare</li><li>▪ reluctance to use services due to previous negative experience, and</li><li>▪ poor communication with primary health care providers (language, culture and lack of information) (2011), <a href="#">Disparities in Primary Health Care Utilisation</a>, accessed 31<sup>st</sup> January, 2017</li></ul> <p>The <a href="#">Refugee Council of Australia</a>, in addition, identified the following key health concerns for refugees:</p> <ul style="list-style-type: none"><li>▪ accessing health services</li><li>▪ use of interpreters</li><li>▪ mental health</li><li>▪ sexual and reproductive health</li><li>▪ food and nutrition</li></ul>
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This primary health care disadvantaged group is also increasing in our region:

*"Currently, Queensland accepts 1,650 refugees annually, about 12 per cent of the national intake. But over the next five years, the national intake will increase by 5,000, and it is expected that an extra 500 refugees per year will settle in Queensland. In addition, the Premier has also offered to settle up to 3,500 refugees in Queensland that have been displaced by the conflict in Syria."* (Media Statement by Hon. Cameron Dick (2016). [online] available at: [Queensland Casts Focus on Refugee Health and Wellbeing](#) [date accessed 31 January 2017].

Four locations have been identified as part of this intake, including Toowoomba in the Darling Downs. Logan and Brisbane have also been identified and both border the West Moreton region.

Refugees arrive in Australia having come from traumatic experiences into a new country with little to no language skills in some circumstances. We also know that living in the rural and remote areas of our region can provide additional barriers due to a lack of access to transport and availability of health care services in those areas (Refugee Health & Wellbeing Strategic Framework for Queensland 2016).

There is no current ABS data on the refugee population as it is still using results from the 2011 Census data. We do however have data on the following arrivals:

*Ipswich -*

Arrivals Nov 2016 - Jan 2017: 12

Arrivals Aug 2016 – Oct 2016: 28

Arrivals Feb 2016 – July 2016: No data supplied

Arrivals Nov 2015 – Jan 2016: 16

*Toowoomba*

Arrivals Feb 2017: 41

Arrivals July 16 – Jan 17: 138

**Strategic Alignment**

Primary Health Networks

This activity will align with the Primary Health Networks Programme in that it will aim to identify solutions that will increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, who in this activity are our vulnerable refugee cohort.





	<p><b><u>Primary Health Care Advisory Report</u></b> This activity will work with the recommendations of the Primary Health Care Advisory Report particularly around Key Recommendation 5: Enhance regional planning</p> <p><b><u>DDWMPHN</u></b> This activity will support numerous DDWMPHN programs, those primarily being our Refugee Health, Mental Health, After Hours and HealthPathways programs.</p> <p>The data collection for this activity will also directly address a current gap in our Needs Assessment whilst informing future Needs Assessments.</p> <p><b>Scalability</b> The solutions developed from this project will be able to be shared across PHNs. The identification of common barriers will not only inform the DDWMPHN's future projects around this cohort but will provide a resource for planning in other PHNs. Our data collection and the methods engaged will assist other PHNs in assessing how they will gather data and what methods work and/or do not work for engaging this specific cohort.</p> <p><b>Anticipated Outcomes</b></p> <ol style="list-style-type: none"><li>1. Mapping of current health care pathways for refugees.</li><li>2. Identification of barriers to accessing health care and why these occur.</li><li>3. Informing future DDWMPHN Needs Assessments, future program delivery and prioritisation.</li><li>4. Production of an academic review assessing the outcomes of the activity from a clinical perspective.</li><li>5. Increased community and stakeholder engagement, further development of relationships.</li><li>6. Clearly identified solutions to address barriers to accessing health care.</li><li>7. Future planning and funding provision around any suitable solutions identified.</li></ol> <p><b>Measurement</b></p> <ol style="list-style-type: none"><li>1. The development and outline of concepts/solutions.</li><li>2. Future DDWMPHN activities will look to these solutions for consideration and implementation were suitable. Collaboration and partnership activities with other key stakeholders will also form a component of this.</li></ol>
<b>Target Population Cohort</b>	The DDWMPHN refugee community will be the primary beneficiary of this activity along with the primary health care spectrum in assessing barriers and identifying potential solutions for future consideration
<b>Consultation</b>	Entire PHN region

<b>Collaboration</b>	Key stakeholders for situation analysis and co-design activities: <ul style="list-style-type: none"> <li>▪ Darling Downs HHS – Kobi House</li> <li>▪ Public Health Unit</li> <li>▪ West Moreton HHS</li> <li>▪ MDA</li> <li>▪ Toowoomba Refugee and Migrant Support (TRAMS)</li> <li>▪ General practices in the Darling Downs &amp; West Moreton regions</li> <li>▪ Regional Councils</li> <li>▪ Mater Integrated Refugee Health Service</li> <li>▪ Other organisations that may be involved once settlement has occurred: e.g. Salvation Army</li> </ul>	
	WHEN	WHAT
	April 2017	Conduct tender process for data collection component
	July 2017	Tender awarded and engaged to begin data collection
	July to October 2017	Data collection completion
	November 2017	Situation Analysis Report Submitted
	December to January/February 2018	Promotion of the Situation Analysis and marketing of co-design workshops
	March to April 2018	Co-design workshops to develop solutions to barriers
	May 2018	Solutions collated into a report for future consideration/implementation.
	June 2018	Activity Completion.
<b>Indigenous Specific</b>	No	
<b>Duration</b>	To 30 June 2018	
<b>Coverage</b>	DDWMPHN region	
<b>Commissioning Method</b>	External	
<b>Approach to Market</b>	Open tender	



**CO\_F\_15.0\_201718 – IDENTIFY BARRIERS AND DEVELOP SOLUTIONS FOR HOMELESSNESS  
HEALTH**

**Activity  
Description**

This activity will create local solutions to the barriers faced by our homeless community in accessing health care. Initially, issues will be recognised and mapped by working closely with our community and key stakeholders to create a situation analysis which will form the basis of co-design activities for the development of innovation solutions. It is envisioned that the situation analysis will further inform our Needs Assessment, support our existing Mental Health, After Hours and HealthPathways programs and enable us to collaboratively implement health focused solutions in the future.

A tender process will be engaged to commission the data collection and situation collection, situation analysis and academic review components of this activity. Community engagement and co-design activities will be conducted by the DDWMPHN.

A policy review conducted by the Primary Health Care Research and Information Service identified homeless people as a primary health care disadvantaged group with the main barriers to accessing primary health care for the cohort as:

- inflexible models of service delivery;
- practical barriers such as transport and stigmatisation; and
- poor relationships with health care providers (2011). [online] available at: [Disparities in Primary Health Care Utilisation](#) [date accessed 31 January 2017].

In 2011, the Australian of Bureau Statistics reported, sourced from the Homelessness Australia website, that 105,237 people in Australia are homeless of which 25% (or 26,744) are Aboriginal and Torres Strait Islander Australians and 30% are born overseas (Homelessness Australia, 2011). [online] available at: [Homelessness Australia](#) [date accessed 31 January 2017].

Homelessness Australia also report that homeless people stay in a range of alternative options including improvised dwellings, tents or sleeping out, supported accommodation for the homeless, staying temporarily with other households, boarding houses, other temporary lodging, and “severely” overcrowded dwellings. This activity will enable us to work with key stakeholders to establish what is occurring in the Darling Downs & West Moreton regions, where people are accessing shelter and health care.



### **Strategic Alignment**

#### Primary Health Networks

This activity will align with the Primary Health Networks Programme in that it will aim to identify solutions that will increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, who in this activity are our vulnerable homeless cohort.

#### Primary Health Care Advisory Report

This activity will work with the recommendations of the Primary Health Care Advisory Report particularly around: Key Recommendation 5: Enhance regional planning

#### DDWMPHN

This activity will support numerous DDWMPHN programs, those primarily being our Mental Health, After Hours and HealthPathways programs.

The data collection for this activity will also directly address a current gap in our Needs Assessment and inform future Needs Assessments.

### **Scalability**

The solutions developed from this project will be able to be shared across PHNs. The identification of common barriers will not only inform the DDWMPHN's future projects around this cohort but will provide a resource for planning in other PHNs. Our data collection and the methods engaged will assist other PHNs in assessing how they will gather data and what methods work and/or do not work for engaging this specific cohort.

### **Anticipated Outcomes**

1. Mapping of current health care pathways for those who are homeless.
2. Identification of barriers to accessing health care and why these occur.
3. Informing future DDWMPHN Needs Assessments, future program delivery and prioritisation.
4. Production of an academic review assessing the outcomes of the activity from a clinical perspective.
5. Increased community and stakeholder engagement, further development of relationships.
6. Clearly identified solutions to address barriers to accessing health care.
7. Future planning, collaboration and funding provision around any suitable solutions identified.



	<b>Measurement</b> <ol style="list-style-type: none"> <li>1. Engagement will be measured through the input of key stakeholders in our co-design activities.</li> <li>2. The development and outline of concepts/solutions.</li> <li>3. Future DDWMPHN activities will look to these solutions for consideration and implementation were suitable. Collaboration and partnership activities with other key stakeholders will also form a component of this.</li> </ol>
<b>Target Population Cohort</b>	Our homeless community will be the primary beneficiary of this activity and along with the primary health care spectrum in assessing barriers and identifying potential solutions for future consideration
<b>Consultation</b>	Entire PHN region
<b>Collaboration</b>	<p>Key stakeholders for situation analysis and co-design activities</p> <ul style="list-style-type: none"> <li>▪ Base Services Toowoomba</li> <li>▪ Toowoomba Council</li> <li>▪ Ipswich Council</li> <li>▪ Ozcare</li> <li>▪ Lifeline Darling Downs &amp; South West Queensland</li> <li>▪ Toowoomba &amp; District Youth Service</li> <li>▪ Mission Australia</li> <li>▪ Young Women's Christian Association (YWCA)</li> <li>▪ Department of Communities, Child Safety &amp; Disability Services</li> <li>▪ Salvation Army</li> <li>▪ Drug Arm</li> <li>▪ Goodna Youth Accommodation Service</li> <li>▪ Young People Booval Community Service</li> <li>▪ Ipswich Homelessness Early Intervention Service</li> <li>▪ Australian Red Cross Queensland Early Intervention</li> <li>▪ ICYS - Ipswich Community Youth Service</li> <li>▪ Young People Ipswich Accommodation Project</li> <li>▪ Ipswich Independent Youth Service</li> <li>▪ Crisis Supported Accommodation for Aboriginal &amp; Torres Strait Islander Young Men</li> <li>▪ Laidley Crisis Care and Accommodation</li> <li>▪ Toowoomba &amp; Ipswich General Practices</li> <li>▪ Department of Housing &amp; Public Works (Housing &amp; Homelessness Services)</li> </ul>



	WHEN	WHAT
	April 2017	Conduct tender process for data collection component
	July 2017	Tender awarded and engaged to begin data collection
	July to October 2017	Data collection completion
	November 2017	Situation Analysis Report Submitted
	December to January/February 2018	Promotion of the Situation Analysis and marketing of co-design workshops
	March to April 2018	Co-design workshops to develop solutions to barriers
	May 2018	Solutions collated into a report for future consideration/implementation.
	June 2018	Activity Completion.
<b>Indigenous Specific</b>	No	
<b>Duration</b>	To 30 June 2018	
<b>Coverage</b>	DDWMPHN region	
<b>Commissioning Method</b>	NA	
<b>Approach to Market</b>	Open tender	



## CO\_F\_16.0\_201718 – IDENTIFY BARRIERS AND DEVELOP SOLUTIONS FOR DOMESTIC VIOLENCE VICTIMS' HEALTH

### Activity Description

This activity will create local solutions to the barriers faced by victims of domestic violence in accessing health care. Initially, issues will be recognised and mapped by working closely with our community and key stakeholders organisations to create a situation analysis which will form the basis of co-design activities for the development of innovation solutions. It is envisioned that the situation analysis will further inform our Needs Assessment, support our existing Mental Health, After Hours and HealthPathways programs and enable us to collaboratively implement health focused solutions in the future. A tender process will be engaged to commission the data collection, situation analysis and academic review components of this activity. Community engagement and co-design activities will be conducted by the DDWMPHN.

A policy review conducted by the Primary Health Care Research and Information Service identified victims of domestic violence as a primary health care disadvantaged group with the main barriers to accessing primary health care for the cohort being

- A lack of disclosure to PHC professionals;
- short consult times that do not enable issues to be addressed;
- lack of privacy in some settings;
- lack of skills and experience of primary health care providers; and
- reluctance of primary health care providers to suggest screening or raise the issue of domestic violence (2011). [online] available at: [Disparities in Primary Health Care Utilisation](#) [date accessed 31 January 2017].

The health care impacts on domestic violence victims are significant, can be acute and chronic, can continue after the relationship has ended and can be psychologically and physically damaging (Domestic Violence Prevention Centre (2004). [online] available at: [Domestic Violence Prevention Centre](#) [date accessed 1 February 2017].

### Strategic Alignment

#### Primary Health Networks

This activity will align with the Primary Health Networks Programme in that it will aim to identify solutions that will increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, who in this activity are victims of domestic violence.





#### Primary Health Care Advisory Report

This activity will work with the recommendations of the Primary Health Care Advisory Report particularly around Key Recommendation 5: Enhance regional planning

#### DDWMPHN

This activity will support numerous DDWMPHN programs, those primarily being our Mental Health, Alcohol and Other Drugs, After Hours and HealthPathways programs.

The data collection for this activity will also directly address a current gap in our Needs Assessment and inform future Needs Assessments.

#### **Scalability**

The solutions developed from this project will be able to be shared across PHNs. The identification of common barriers will not only inform the DDWMPHN's future projects around this cohort but will provide a resource for planning in other PHNs. Our data collection and the methods engaged will assist other PHNs in assessing how they will gather data and what methods work and/or do not work.

#### **Anticipated Outcomes**

1. Mapping of current health care pathways for those who are victims of domestic violence.
2. Identification of barriers to accessing health care and why these occur.
3. Informing future DDWMPHN Needs Assessments, future program delivery and prioritisation.
4. Production of an academic review assessing the outcomes of the activity from a clinical perspective.
5. Increased community and stakeholder engagement, further development of relationships.
6. Clearly identified solutions to address barriers to accessing health care.
7. Future planning, collaboration and funding provision around any suitable solutions identified.

#### **Measurements**

1. Our engagement will be measured through the input of key stakeholders during our co-design activities.
2. The development and outline of concepts/solutions.
3. Future DDWMPHN activities will look to these solutions for consideration and implementation were suitable. Collaboration and partnership activities with other key stakeholders will also form a component of this.



	WHEN	WHAT
	April 2017	Conduct tender process for data collection component
	July 2017	Tender awarded and engaged to begin data collection
	July to October 2017	Data collection completion
	November 2017	Situation Analysis Report Submitted
	December to January/February 2018	Promotion of the Situation Analysis and marketing of co-design workshops
	March to April 2018	Co-design workshops to develop solutions to barriers
	May 2018	Solutions collated into a report for future consideration/implementation.
	June 2018	Activity Completion.
<b>Target Population Cohort</b>	Victims of domestic violence will be the primary beneficiary of this activity with engagement and co-design activities aimed at key stakeholders, along with the primary health care spectrum in assessing barriers and identifying potential solutions for future consideration	
<b>Consultation</b>	PHN region	
<b>Collaboration</b>	Key stakeholders for situation analysis and co-design activities <ul style="list-style-type: none"> <li>Domestic Violence Action Centre (DVAC)</li> <li>DV Connect</li> <li>Toowoomba Domestic &amp; Family Violence Prevention Service</li> <li>Various shelters including Ipswich Women's Shelter</li> <li>Darling Downs &amp; West Moreton General Practices</li> </ul>	
<b>Indigenous Specific</b>	No	
<b>Duration</b>	To 30 June 2018	
<b>Coverage</b>	DDWMPHN region	
<b>Commissioning Method</b>	NA	
<b>Approach to Market</b>	Open tender	



CO_F_17.0_201718 - FLEXIBLE FUNDING SUBMISSIONS	
<b>Activity Description</b>	<p><b>Aim:</b> To adhere to transparent decision making and probity for evaluations of funding unsolicited applications made from outside the PHN with a focus on unmet need, and not to duplicate where services are currently on the ground.</p> <p><b>Activity:</b> Formalise assessment process and implement a strategy to evaluate submissions for non-core business funding applications made to the PHN. The Commissioning and Performance Oversight Committee (CPOC) with membership consisting of the PHN Executive and Leadership Team assess submissions based on procurement and tender policy and procedures. The Clinical Council will be engaged for relevant clinical evidence-based advice.</p>
<b>Target Population Cohort</b>	People who reside in rural communities within DD&WM region who require allied and other health professional support
<b>Consultation</b>	Extensive communication strategies have been implemented to support the transition and implementation for allied health, other key stakeholders, local state and federal members of government
<b>Collaboration</b>	NA
<b>Indigenous Specific</b>	No
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	External
<b>Approach to Market</b>	Open tender

## 4. Planned Activities Funded Under Primary Health Networks Core – Operational - Schedule

CO_O_1.0_201718 – DRUG AND ALCOHOL REGIONAL SERVICE EVALUATION AND CO-DESIGN	
<b>Activity Description</b>	<p><b>Aim:</b> Determine the efficacy of current drug and alcohol treatment services delivered in the region through funded, informal and mainstream services. Based on the evaluation report and through co-design, ensure services are appropriate, not duplicated and meet the population demand for each area identified.</p> <p><b>Activity:</b> <i>(As per the Standard Funding Agreements this evaluation is being undertaken under the Core Flexible Schedule rather than Drug and Alcohol Treatment Services).</i></p> <p>Commission an evaluation for services being offered across the region for drug and alcohol support to identify where there are duplications in service delivery models, identifying what is working and where there are barriers to service access and support. Undertake a co-design activity including consumers and carers, service providers and other key stakeholders to shape a tailor-made model at the local level for communities with high representation of drug and alcohol related issues.</p>
<b>Target Population Cohort</b>	People with drug and or alcohol related issues
<b>Consultation</b>	Contracted and non-contracted service providers and informal and mainstream services, DDWMPHN Community advisory groups, people with lived experience with alcohol and drug issues and their carers. Other government departments as required
<b>Collaboration</b>	Drug and alcohol service providers, other government departments and LGAs
<b>Indigenous Specific</b>	No
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	External
<b>Approach to Market</b>	Limited



#### CO\_O\_2.0\_201718 - EDUCATION AND SUPPORT TRAINING AND DEVELOPMENT SUITE

<b>Activity Description</b>	<p>Ongoing education and support – training and development that addresses the needs as identified in preliminary needs assessment and ongoing needs and gaps analysis.</p> <p>Due to limited resources and internal re-organisation within the DDWMPHN, this project was not undertaken in 2016-17. This updated proposal is in response to departmental feedback to strengthen approved projects rather than replace completely. The DDWMPHN proposes that the activity is re-approved and implemented in the 2017-18 year as relevant resources and experience is now available within the organisation to undertake the work successfully.</p> <p>This activity will deliver a comprehensive suite of education sessions to general practitioners, practice nurses and allied health professionals in response to identified education and training needs. This training includes mental health skills training, infection control, working with Aboriginal &amp; Torres Strait Islander patients, working with Culturally and Linguistically Diverse patients; Doctors Health and Wellbeing; Paediatrics, Wound Care, Chronic Disease Management, Pain Management, Immunisation and other Public Health Unit updates, Managing Medical Emergencies.</p> <p><b>Expected Outcome:</b></p> <ul style="list-style-type: none"><li>▪ Increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.</li><li>▪ Improve coordination of care to ensure patients receive the right care in the right place at the right time</li></ul>
<b>Target Population Cohort</b>	The DDWMPHN will provide practice support and education to general practice, allied health and mental health professionals through ensuring access to education, particularly for those in rural areas
<b>Collaboration</b>	GPs, mental health and other allied health professionals
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	DDWMPHN region



CO_O_3.0_201718 - GENERAL PRACTICE DATA QUALITY AND CONTINUOUS IMPROVEMENT PROJECT	
<b>Activity Description</b>	<ul style="list-style-type: none"> <li>Promote the use of the CAT Plus suite of tools in general practice, allowing practices to better cleanse their data, better identify and manage the care of patients with chronic disease or at risk of developing chronic disease, and improve their business performance (increase accuracy of Medicare item claims).</li> <li>Collect and aggregate de-identified practice data into regional reports for needs assessment purposes and to provide feedback to individual practices.</li> <li>Provide support and deliver training to general practice in the use of the CAT Plus suite of tools.</li> </ul> <p><b>Expected Outcome:</b> Increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.</p> <ul style="list-style-type: none"> <li>Improve the % of practices across the region that use CAT Plus from 17/156 (16%) to 120/156 (75%)</li> <li>Improve the % of practices that use TOPBAR from 0 (0%) to 80/156 (50%);</li> <li>Improve the % of practices that are providing de-identified data for aggregation and benchmarking from 0 to 80/156 (50%)</li> </ul>
<b>Collaboration</b>	This is an internally driven support project
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	DDWMPHN region



CO_O_4.0_201718 - CORE OPERATIONAL (CO) 2015/16 TO 30 JUNE 2017 (CARRY OVER)	
<b>Activity Description</b>	<p><b>COActivity4:</b> Server and software upgrade (Ongoing review in place for 2017-18)</p> <p><b>COActivity10:</b> Intranet dashboard incorporating the measurement and assessment framework (outlined in the Core work plan). Internal electronic system monitoring progress across program deliverables and budget. Development of an overarching measurement and assessment framework for the PHN to utilise when developing outcomes and activities based measurement when assessing application for funding</p>
<b>Target Population Cohort</b>	Providing support to all people in the right place at the right time
<b>Consultation</b>	NA
<b>Collaboration</b>	NA
<b>Indigenous Specific</b>	No
<b>Duration</b>	To 30 June 2018
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	NA
<b>Approach to Market</b>	NA





## CO\_O\_5.0\_201718 – HEALTH NEEDS ASSESSMENT REDEVELOPMENT

### Activity Description

**Aim:** To compile an evidence-based Health Needs Assessment to guide the development and implementation of DDWMPHN annual plans which address patient needs, service availability and gaps for the Darling Downs and West Moreton region.

**Activity:** Redevelop the Health Needs Assessment (HNA) to identify the health and healthcare needs of the DDWMPHN region with the assistance of strategic partners ensuring effective stakeholder engagement and expertise in epidemiology, health economics and data collection/analysis. Existing data and evidence will be utilised wherever possible. A reference group will oversee the development of the HNA and provide recommendations to Clinical Council.

#### *Overview of Approach*

The approach we intend to take aligns with the Department's Needs assessment guide ("NAG"), and involves four phases:

- a research phase, supported by a local academic partner, and incorporating data analysis, literature review, and the qualitative analysis of data collected in the consultation phase (NAG pp7-8, 11-17),
- a consultation phase, supported by a stakeholder engagement partner, currently planned to incorporate 15 public events in 12 local communities, as well as consultations with health professionals, providers, funders and other stakeholders (NAG pp8-10),
- a validation phase, including feedback closure for consulted communities and interest groups, the use of an online feedback platform, and the involvement of our Clinical Councils and Community Advisory Committees (NAG pp18-19), and
- an assessment and design phase, incorporating online solutioning on the Mindhive ([www.mindhive.org](http://www.mindhive.org)) platform, co-design activity, and the initiation of longer term community-based health innovation approaches (NAG p22).

#### *Outputs*

The DDWMPHN intends to provide the Department with two specific outputs:

- a presentation of new priorities identified by the consultation phase that impact on 2017/18 AWP, along with proposed changes or additions to programs – this will be provided in mid-late August 2017, and underpin the data requirements of the July-December 2017 Six Month Report, and



- the 2017 Needs Assessment – this will be provided as required by our contract with the Department in November 2017, following completion of the assessment and design phase.

These outputs will allow current AWP's to be adjusted as necessary to meet the region's needs, and guide the development of 2018/19 AWP's, which will commence in October 2017, assuring their timely delivery to the Department.

Organisation	Responsibilities
<b>DDWMPHN</b>	<ul style="list-style-type: none"><li>• Commissions Consultant and the University Partner.</li><li>• Establish HNA Reference Group for project guidance.</li><li>• Accountable for the development of the HNA document and adherence to DoH guidelines.</li><li>• Establishes Project Board for project governance.</li></ul>
<b>Consultant</b>	<ul style="list-style-type: none"><li>• Guides the work of the University Partner to ensure that the HNA is robust, addresses any real or perceived gaps in focus, underlying data, methodology and final content.</li><li>• In partnership with the DDWMPHN, completes community &amp; stakeholder consultation.</li><li>• Responsible for development of the HNA document and adherence to DoH guidelines.</li></ul>
<b>University Partner</b>	<ul style="list-style-type: none"><li>• Completes data analysis (bulk of the HNA redevelopment).</li><li>• Assessment of potential options and strategies through literature and systematic review.</li><li>• Provides expertise in the fields of health economics and epidemiology.</li></ul>



<b>Target Population Cohort</b>	Darling Downs & West Moreton PHN
<b>Consultation</b>	Community, health professionals, providers, funders and other stakeholders
<b>Collaboration</b>	Strategic partners
<b>Indigenous Specific</b>	No
<b>Duration</b>	1 June – 30 October 2017
<b>Coverage</b>	DDWMPHN region
<b>Commissioning Method</b>	External
<b>Approach to Market</b>	Limited tender. Following development of an appropriate tender to guide the desired project outcome (Project Development), we anticipate utilising a focussed approach to market, working closely with current providers of services



**Australian Government**

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