



phn
DARLING DOWNS
AND WEST MORETON

An Australian Government Initiative

Activity Work Plan **Core, General** **Practice Support,** **After-Hours**

2018 - 2019



Local Integrated
Primary Health Care



1. Contents

<i>Strategic Vision</i>	<i>3</i>
<i>Core Flexible Funding Activities</i>	<i>7</i>
CF_6.1_201819 – Services Supporting People with Chronic Disease	7
CF_8.1_201819 – Initiatives to Support Aged and/ or Palliative Care	10
CF_9.1_201819 – Population Health with a Focus on Vulnerable and Marginalised People	13
CF_12.1_201819 – Health Service Navigation and Care Coordination	15
CF_18.0_201819 – Access and Equity Opportunities Across the Region	17
CF_19.0_201819 – Service Integration and Preventing Inappropriate Hospital Presentations	19
CF_20.0_201819 – Prevention and Early Development Initiatives for Young People	21
CF_21.0_201819 – Closing the Gap Initiatives	24
CF_22.0_201819_ Workforce Development	26
<i>Core Operational Activities (Health Systems Improvement and General Practice Support)</i>	<i>28</i>
GPS_2.1_201819 – Primary Care Engagement, Education, Support & Training Development	28
HSI_6.0_201819 – Primary Care Engagement – System Integration & Stakeholder Engagement	30
<i>After Hours Strategic Vision</i>	<i>32</i>
<i>Core After Hours Activities</i>	<i>32</i>
AH_3.1_201819 - After Hours Outreach	32
AH_4.1_201819 After Hours Palliative Care	34
AH_5.1a_201718 – Home Outreach Care – After Hours	35
AH_5.1b_201718 – Home Outreach Care (RACF) – After Hours	36
AH_6.1_201819 - After Hours – Outreach Palliative Care	39
AH_7.1_201819 – After Hours -Mental Health After Hours Outreach	40
AH_10.1_201819 - After Hours Care – Rural Diabetes Care	41



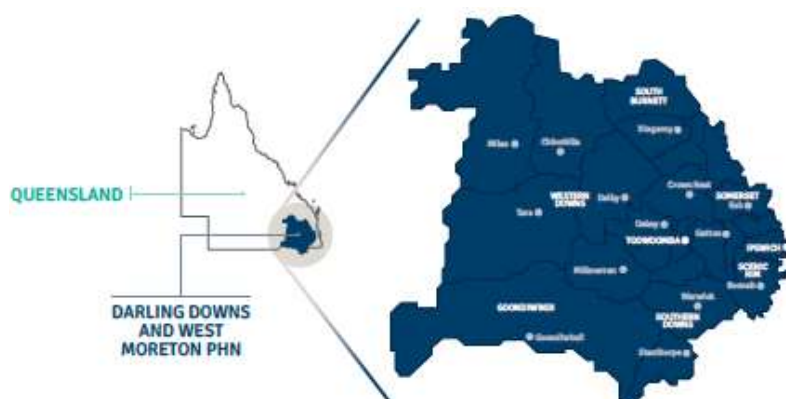
2. Strategic Vision

OUR ROLE

The role of the Darling Downs and West Moreton PHN is to better understand the health needs of the Darling Downs and West Moreton communities and support equitable delivery of primary health care services ensuring that all people living in our region, especially marginalised or vulnerable groups, have access to a responsive, integrated and high quality primary health system.

The Darling Downs and West Moreton PHN covers more than 95,500 km² across 10 local government areas and encompasses the major communities of Ipswich and Toowoomba, plus the surrounding rural communities of Lockyer Valley, Boonah (Scenic Rim), Esk (Somerset), South Burnett, Southern Downs, Goondiwindi and the Western Downs.

Fig 1 DDWMPHN SERVICE AREA



OUR STRATEGY

The DDWMPHN aims to ensure that all people living in our region, particularly marginalised and vulnerable groups, have access to responsive, integrated and high quality primary health services.

Following the transition from Medicare Local to the DDWMPHN, 2017 was a year to realise opportunities for further embedding governance process such as realignment of the Board and Clinical Councils, and enhancement of sub-committees including the Mental Health Sub-Committee. The Mental Health Sub-Committee consists of mental health expertise from a variety of disciplines including Aboriginal and Torres Strait Islander representation and helps to ensure alignment to the mental health strategic vision to support the improvement of outcomes for people with, or at risk of, mental illness and/ or suicide.



OVERARCHING STRATEGIES 2017 – 2020

Our charter, as directed by the Federal Government, is to ensure that all people living in our region, especially marginalised or vulnerable groups, have access to responsive, integrated and high quality primary health services.

To view the DDWMHN overarching strategy, please [click here](#).

OUR HEALTH NEEDS ASSESSMENT – PRIORITY AREAS

PREVALENCE OF CHRONIC DISEASE

To improve the outcomes of people burdened with chronic disease, we will focus on transitioning chronic disease management to community level care and reviewing ways to maximise existing services via service integration.

HEALTH AND EQUALITY FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The core needs of these communities are demonstrated in their vulnerability and health outcomes. Particular focus is needed in management of chronic disease, violence, substance misuse, along with health challenges associated with disability, Maternal, Child & Youth mental and physical Health.

HEALTH BEHAVIOURS

All 29 risk factors included in the Australian Burden of Disease Study (2011) combine to contribute to the burden for endocrine disorders, cardiovascular diseases, injuries, kidney and urinary disease and cancer. The joint effect of all the risk factors included in this study accounted for 31% of the total burden of disease and injury in Australia in 2011. This illustrates the potential for health gain through disease and injury prevention by reducing exposure to these risk factors.

INFANT, CHILD DEVELOPMENT AND YOUTH HEALTH

Darling Downs and West Moreton PHN children are more developmentally vulnerable than the Queensland rates across all five domains. Evidence supports that successes, health and emotional well-being have their origins in early childhood. The Darling Downs and West Moreton PHN will seek opportunities and partnerships to promote optimal early childhood development and health outcomes.

PRIMARY MENTAL HEALTH CARE

The stepped care model will be implemented in 2018 and is aimed at improving service alignment and access for people experiencing mental health issues across a spectrum of concerns. Interventions and programs to support moderate to severe mental health issues including suicide prevention and opportunities to reduce self-harm hospitalisations will be instigated. The Darling Downs and West Moreton PHN has invested in a regional Suicide Prevention Plan which will be utilised to inform next steps and will be published in late 2018.



VULNERABLE, MARGINALISED AND HARD TO REACH

The DDWMPHN values the elderly and people living with disabilities and aims to support their care via appropriate primary care and community management. Improving the integration and coordination between other services, commonwealth and state programs in the Aged Care and Disability sectors is a key focus. Further vulnerable groups include patients, families and health professionals managing end of life care, the culturally and linguistically diverse, refugees, and socio-economically disadvantaged.

DRUG AND ALCOHOL USE

Evidence supports that addressing substance misuse will improve the long-term outcomes for individual, reduce hospital admissions, and improve social outcomes for our community. The Darling Downs and West Moreton PHN will seek to create an appropriately resourced system integrated with other health and community services.

ACCESS AND EQUITY

The population of the Darling Downs and West Moreton PHN region as a whole is experiencing greater disadvantage in comparison to the corresponding rate for Queensland. Research indicates people living with disadvantage are impacted by access and equity barriers. The Darling Downs and West Moreton PHN will focus on improving access and equity by partnerships, alliances and service integration activities aim at removing unfair and avoidable barriers that compromise health and well-being.

WORKFORCE CAPACITY AND WELL-BEING

The Darling Downs and West Moreton PHN is currently working closely with Health Workforce Queensland to assess need and holistic strategies to support the health professionals across our region. To address workforce gaps, retention and well-being across our region, will require thoughtful and integrated models of care to meet the demand.



OUR PERFORMANCE INDICATOR DOMAINS

EFFICIENCY (ACCESSIBILITY)

Primary health care is provided in a timely manner being responsive to individual and community needs

EFFECTIVENESS

Primary health care aligns with and meets the identified needs of consumers and community

APPROPRIATENESS

Patients receive care in accordance with current evidence base and best practice

COORDINATION OF CARE

Primary health care is integrated to ensure patients receive the right care in the right place at the right time

CONTINUITY OF CARE

Patients, especially those at-risk, vulnerable or with complex needs, have access to coherent and uninterrupted care as appropriate to their needs

PATIENT/ CLIENT EXPERIENCE

Patients/ clients experience care that understands their identified need while receiving adequate information for decisions and respect for individuality

QUALITY

Opportunities for improving services are appreciated and evidenced



3. Core Flexible Funding Activities

CF_6.1_201819 – SERVICES SUPPORTING PEOPLE WITH, OR AT-RISK OF DEVELOPING, CHRONIC CONDITIONS	
Previous name: <i>CO_F_6.0_201718 – Wellness Transition – Chronic Disease (Formerly Rural Primary Health Service)</i>	
Program Key Priority Area	Population Health
Needs Assessment Priority Area	<p>DDWMPHN HNA Key Priority Area/s</p> <p>Prevalence of Chronic Disease</p> <p>Health Behaviours</p> <p>C1 (p. 39, HNA, Nov 2017) - Aboriginal and Torres Strait Islander health, including: chronic disease, health challenges associated with disability and high rates on summary measures of disadvantage</p> <p>C4 (p.42, HNA, Nov 2017) - Chronic Disease Prevention, Detection and Management</p> <p>C6 (p. 44, HNA, Nov 2017) - Childhood obesity</p> <p>C9 (p. 46, HNA, Nov 2017) - Adult obesity and physical activity rates</p> <p>C10 (p. 47, HNA, Nov 2017) - Smoking rates and smoking in pregnancy</p>
Aim	<p>This activity aims to reduce the impact of chronic conditions in our community via effective and efficient, goal-oriented, client-centred and evidence-based service delivery for clients who are either at risk of developing or already have a diagnosed chronic condition including:</p> <ul style="list-style-type: none">▪ Programs targeting early intervention and promotion of healthy lifestyle habits▪ Direct clinical interventions provided by a relevant health professional.▪ Target groups identified through the HNA including Aboriginal and Torres Strait Islander people, children and adults, focussing on health promotion and literacy, self-management and non-acute clinical interventions.
Description	<p>PHN funded services under the Rural Primary Health Service (RPHS) have historically delivered services that support clients for direct service delivery based on presentation of complex chronic conditions and management of those conditions. In response to the National Strategic Framework for Chronic Conditions, the PHN will re-align service delivery to include a focus on prevention, early intervention, advanced care coordination and self-management.</p> <p>For continuity of care, services previously contracted under <i>CO_F_6.0_201718 – Wellness Transition – Chronic Disease (Formerly Rural Primary Health Service)</i> will receive extension of contracts to support transition to a multidisciplinary approach.</p> <p>Commissioning processes are informed by significant consultation with the sector and will include a model of care for holistic wrap-around, multidisciplinary services for individuals with high and complex support needs, and those who would benefit</p>



from prevention and early intervention support. Components of the service to be commissioned will include:

- Advanced Care Coordination: for clients with high and complex support needs to maximise health literacy and access to wrap-around services in a timely manner in an appropriate environment
- Self-Management: Targeted self-management programs to improve the ability of clients to effectively manage their condition and reduce deterioration, exacerbation or complication of their chronic conditions which may require an acute response.
- Health promotion: to better manage risk factors associated with chronic conditions and to reduce the likelihood of converting these risk factors to a chronic condition e.g. increase physical activity, healthy eating choices which includes a behavioural change element.
- Direct clinical interventions: provided by commissioned providers to support high and complex clients whose needs exceed those offered through Enhanced Primary Care. It will complement existing service delivery through EPC referrals for Chronic Disease and will not duplicate service.

Services may be delivered by a range of health professionals such as Physiotherapist, Podiatrist, Pharmacist, Exercise Physiologist, Therapy Assistant, Diabetes Educator, Nurse, Occupational Therapist, Dietitian, Respiratory Nurse, or Speech Pathologist.

Activities will be directed across the lifespan in recognition of the impacts to health arising from risk factors prior to birth and throughout childhood and will include a focus on empowering people to self-manage their health. DDWMPHN will partner with key providers to identify evidence-based programmes that target priority populations.

Background and further links to HNA:

In 2005, the World Health Organisation's (WHO) *Preventing Chronic Diseases: A Vital Investment* discussed the prevalence and impact of chronic disease throughout the world. There is a need and ability to achieve rapid health gains through comprehensive and integrated action to address causes of chronic disease and prevent the emergence of future epidemics.

"Small reductions in the exposure of the population to risk factors such as tobacco use, unhealthy diet and physical inactivity lead to population-level reductions in cholesterol, blood pressure, blood glucose and body weight", WHO (2005).

In 2011, the Australian Institute of Health and Welfare (AIHW) estimated that chronic disease was the underlying cause of 90% of Australian deaths, and half of all Australians have one chronic disease with the number and incidence increasing



	<p>with age. Primary care plays an important role in the prevention, detection and management of chronic disease; 31% of the burden of disease is attributable to lifestyle factors highlighting the importance of opportunities for prevention. Factors include smoking, overweight and obesity, alcohol, physical inactivity and high blood pressure. In 2016, Amanda Biggs (on Social Policy, Parliament of Australia) stated:</p> <p><i>"The rise in chronic diseases is putting health budgets under pressure and placing growing numbers of Australians at risk of serious complications and early death. Improving the management of chronic diseases in primary care is urgently needed."</i></p> <p>While the WHO noted increased action in countries such as Australia to decrease the burden of chronic disease, the DDWMPHN is concerned with evidence of high prevalence and risk across our region. This is in accordance with the <i>National Strategic Framework for Chronic Conditions</i> (Australian Health Ministers Advisory Council, 2017) statement:</p> <p><i>"Australia must adopt a consistent and integrated approach to the effective prevention and management of chronic conditions to improve health outcomes for all Australians and to ease the pressure on the health system".</i></p>
Target Population Cohort	<p>Priority populations within the DDWMPHN region including (but not limited to):</p> <ul style="list-style-type: none"> ▪ Aboriginal and Torres Strait Islander people; ▪ People from culturally and linguistically diverse backgrounds; ▪ Older people; ▪ Carers of people with chronic conditions; ▪ People experiencing socio-economic disadvantage; ▪ People living in rural and urban locations; ▪ People with a disability; ▪ People with a mental illness.
Consultation	<p>Extensive consultation has occurred to inform development of these programs. This has included a "Think Tank" with providers and community consultation through the HNA process.</p> <p>Consultation will be ongoing to inform the further development and refinement of these programs. This will occur through community consultation with the Clinical Council, existing service providers and other peak bodies e.g. professional organisations, health organisations</p>
Collaboration	<p>Community collaboration will be integral to the success of this program to embed into local communities and ensure sustainability. Collaboration will occur with the following organisations:</p>



	<ul style="list-style-type: none"> Local Government Hospital and Health Services Professional Bodies such as the Lung Foundation Other key organisations. <p>Collaboration will be ongoing throughout the duration of the program.</p>
Duration	1 st July 2018 to 30 th June 2019

CF_8.1_201819 – INITIATIVES TO SUPPORT OLDER PEOPLE, PEOPLE WITH COMPLEX NEEDS AND/ OR PALLIATIVE CARE

Previous name: *CO_F_8.0_201718 - Aged Care and Chronic Disease*

Program Key Priority Area	Aged Care
Needs Assessment Priority Area	<p>DDWMPHN HNA Key Priority Area/s</p> <p>Vulnerable, Marginalised and Hard to Reach</p> <p>C16 (p. 51, HNA, Nov 2017) - Aged care (with a continuing focus on additional processing and detailed analysis to identify further needs)</p> <p><i>Options 2 and 3:</i></p> <ul style="list-style-type: none"> <i>Facilitate end of life decision making processes with general practitioners</i> <i>Explore opportunities for increased care provision in rural communities.</i>
Aim	Improve quality of life and dignity in the most appropriate setting for people needing support to remain independent and have choice and control around their support needs.
Description	<p><i>For the purposes of this activity, aged/ elderly refers to people aged over 65 years of age, and recognises the majority of Indigenous people do not reach 'old age' with an average age expectancy between 56 and 62 years.</i></p> <p>Imperative to this activity is the ongoing partnership with key stakeholders to understand gaps in support mechanisms to identify opportunities providing or promoting service integration. Support and initiatives are to be provided to assist people remain in their chosen place of residence, improve quality of life, and partner with carers, care agencies and care facilities. The DDWMPHN will:</p> <ul style="list-style-type: none"> Extend current contracted service delivery providing non-acute nursing care in an appropriate setting for older people, people who require support with high and complex needs, and/ or palliation over and above what is currently provided through HACC. This supports people who may otherwise require social or a



preventable acute admission to hospital (this incorporates *CO_F_8.0_201718 - Aged Care and Chronic Disease*) and includes end of life planning between primary care and referring facilities and falls prevention initiatives.

- Explore the potential to integrate service including Aboriginal and Torres Strait Islander people's palliative care options incorporating cultural sensitivities and appropriateness into current systems, and partner to provide information to the community or initiatives that promote cultural awareness in the care of Aboriginal and Torres Strait Islander older people. This activity is an engagement and integration opportunity and will not be commissioned.
- Consult to identify ongoing initiatives promoting physical and mental health of older Australians.

The DDWMPHN will partner with culturally appropriate services to address the unique needs of Aboriginal and Torres Strait Islander people over the age of 50. Collaboration will consider care coordination, assistance to individuals and families, and the composition of the aged care workforce.

Background:

As per *Shrivastava SRBL, Shrivastava PS, Ramasamy J. Health-care of elderly: Determinants, needs and services. Int J Prev Med 2013;4:1224-5.*

- Gradual improvement in health-care delivery services has increased life expectancy and thus the percentage of the elderly population
- The number of people aged 60 and over will increase to 1.2 billion in 2025 and subsequently to two billion in 2050 with almost 75% of this elderly population living in developing nations, which already have an overburdened health-care delivery system
- These demographic transitions essentially require shifting the global focus to cater to the preventive health-care and medical needs of the elderly population
- An ageing population tends to have a higher prevalence of chronic diseases, physical disabilities, mental illnesses and other co-morbidities
- Health needs cannot be viewed in isolation; a number of factors impact the quality of life:
 - Social concerns (isolation from family)
 - Maltreatment towards the elderly
 - Poor knowledge and awareness of risk factors
 - Food and nutritional requirements
 - Psych-emotional concerns (mental stress)
 - Financial constraints
 - Health-care system factors
- Prevention and control of health problems of the elderly necessitates a multifaceted approach



Target Population Cohort	Older people, people with complex needs and/ or requiring palliative care
Consultation	Consultation undertaken via: <ul style="list-style-type: none">▪ Regional Aged Care and Palliative Care Working Group▪ Clinical Councils▪ Community consultation▪ GP Chapter meetings
Collaboration	Planning, design and implementation will include: <ul style="list-style-type: none">▪ Hospital and Health Services▪ General Practitioners▪ Residential Aged Care Facilities▪ Public and private sector health care providers▪ Outreach health care providers▪ Community care services
Duration	1 st July 2018 to 30 th June 2019



CF_9.1_201819 – POPULATION HEALTH WITH A FOCUS ON VULNERABLE AND MARGINALISED PEOPLE Previous name: <i>CO_F_9.0_201718 – Health Support for Vulnerable and Marginalised People</i>	
Program Key Priority Area	Population Health
Needs Assessment Priority Area	DDWMPHN HNA Key Priority Area/s Vulnerable, Marginalised and Hard to Reach C5 (p. 43, HNA, Nov 2017) – Health needs of people experiencing financial hardship, in particular children C16 (p. 51, HNA, Nov 2017) - Aged care (with a continuing focus on additional processing and detailed analysis to identify further needs) C18 (p. 53, HNA, Nov 2017) – Disability Care
Aim	Support improvements in integration and coordination between services, commonwealth and state programs to assist those who are vulnerable and marginalised.
Description	To provide support to vulnerable, marginalised and hard to reach cohorts, the DDWMPHN will: <ul style="list-style-type: none"> ▪ Extend current contracted service delivery to support refugee health through the current model of care coordination and linkages (CO_F_9.0_201718 – Health Support for Vulnerable and Marginalised People) providing pathways for health assessments and screening, immunisation catch-ups and referrals to health care providers. Recent evaluation of the service has identified opportunities for enhanced service delivery to ensure appropriate ongoing care for people with refugee status through modification of the current model to improve partnerships and pathways. ▪ Continue the current contracted provision of translation and interpreter services for allied health and pharmacy not eligible for government subsidy (CO_F_9.0_201718 – Health Support for Vulnerable and Marginalised People) including a comprehensive evaluation of the efficacy of the service. ▪ Consider recommendations from the 2017-18 research activities to scope and commission activities responding to solutions for refugee health, health needs for people experiencing homelessness, people experiencing domestic violence, and integration and service access for people with disability. Delivery of recommendations in October 2018 will form the basis for scoping of options and will also inform the DDWMPHN HNA.



	<p>Background:</p> <p>Some of the vulnerable, marginalised or at-risk groups in our region include:</p> <ul style="list-style-type: none"> ▪ Aboriginal and Torres Strait Islander people ▪ Socio-economically disadvantaged people ▪ People living in rural areas ▪ People with mental illness ▪ People with a physical and/ or intellectual disability ▪ Those living with the effects of disadvantage as a child ▪ Those affected by discrimination, social exclusion or incarceration ▪ People from cultural or linguistically diverse backgrounds, particularly refugees ▪ Survivors of torture and trauma <p>With the Australian Government's commitment, the Humanitarian Program has seen an increase in refugee settlement across 2017-18, continuing to grow throughout 2018-19:</p> <ul style="list-style-type: none"> ▪ Each year, approximately 1800 refugees settle in Queensland under Australia's Humanitarian Program. ▪ The Darling Downs & West Moreton region is home to more than 10,000 people from migrant and refugee backgrounds from diverse cultural such as Afghanistan, Iraq, Syria, Pakistan, Congo, South Sudan, Rwanda, Liberia, Eritrea, Cuba, Burundi and more ▪ Toowoomba was allocated 760 individuals arriving during the 2017/2018 financial year with 400 of these arriving March – June 2018.
Target Population Cohort	Vulnerable, marginalised and hard to reach cohorts of the DDWMPHN region
Consultation	<ul style="list-style-type: none"> ▪ Consultation with the Regional Clinical Advisory Group for focused outcomes for integrated health service delivery and access of health services. ▪ Engagement with other PHNs to share and expand knowledge and commonalities in supporting people from refugee background.
Collaboration	<ul style="list-style-type: none"> ▪ Queensland Partnership Advisory Group – Settlement Services ▪ DD&WM HHSs ▪ Other stakeholders as identified through research activity response ▪ University of Southern Queensland ▪ Community Advisory Group
Duration	<p>Ongoing to 30th June 2019</p> <p>Research findings will be delivered by October 2018</p>



CF_12.1_201819 – HEALTH SERVICE NAVIGATION AND CARE COORDINATION Previous name: <i>CO_F_12.0_201718 – Care Coordination and Referral Agencies</i>	
Program Key Priority Area	Population Health
Needs Assessment Priority Area	DDWMPHN HNA Key Priority Area/s Access and Equity Primary Mental Health Care MH1 (p.35, HNA, Nov 2017) – Alignment of services to reach people with anxiety, depression and other mental health illnesses within the community C7 (p. 46, HNA, Nov 2017) – Pathways for patients needing to access multiple health services for a condition
Aim	Reduce the complexity of accessing services available at the local level for people with complex support requirements including barriers due to social determinants.
Description	<p>This Activity compliments <i>PMH_MS_10.0_201819 – Primary Mental Health Service Navigation</i> to further develop support systems for people with co-morbidities including chronic disease, substance mis-use and mental illness. Co-morbidities of mental illness, drug and alcohol misuse and chronic conditions compound the level of functioning of an individual and result in the need for a multi-disciplinary approach for support.</p> <p>To maximise outcomes, a coordinated and person-centred approach is required to navigate their journey across the care spectrum. Health service navigation is also aimed at assisting health care providers, including GPs to facilitate appropriate referrals. Service providers will:</p> <ul style="list-style-type: none"> ▪ Facilitate integrated multi-disciplinary services for consumers, carers, GPs, and other key services to provide coordinated wrap-around integrated services. ▪ Prioritise care needs according to clinically identified client risk ▪ Provide clarity to availability of care options and increase knowledge of local access to services ▪ Link clients with required service provision in alignment with goals and clinical needs ▪ Maintain client records to enable shared care models of service delivery where appropriate including a 'one story', integrated/coordinated response including and integrated e-referral system from GP to Provider



	Background: Chronic disease prevalence has been highlighted through the DDWMPHN HNA (Nov 2017) recognising the often-complex nature with a long and persistent duration which may be slow to progress. The presence of chronic disease may increase the complexity and care access difficulties for people experiencing mental illness, substance abuse or who are vulnerable and/ or marginalised
Target Population Cohort	All marginalised and vulnerable people requiring access to support, relative to needs and well-being
Consultation	Significant consultation has occurred with: <ul style="list-style-type: none">▪ Community▪ Consumers▪ Carers▪ Clinical Council▪ Mental Health Sub-Committee and Mental Health Working Group.▪ The approach has also been proposed to the Qld MHAOD joint PHNs to seek validation.
Collaboration	Service model has been designed with representatives from ABT Associates, HHS, GPs, clinical mental health providers including Psychiatry, mental health nursing, psychology, consumer advocate and consumers.
Duration	1 st July 2018 – 30 th June 2019



CF_18.0_201819 – ACCESS AND EQUITY OPPORTUNITIES ACROSS THE REGION Incorporates: <i>CO_F_1.0_201718 – Regional Patient Care-Coordination for Client Transport</i> <i>CO_F_11.0_201718 - Transition for Ineligible Wellness Services</i>	
Program Key Priority Area	Population Health
Needs Assessment Priority Area	DDWMPHN HNA Key Priority Area/s Access and Equity C5 (p. 43, HNA, Nov 2017) - Health needs of people experiencing financial hardship, in particular children C11 (p. 49, HNA, Nov 2017) - Access to health services not available locally, including transportation to health care
Aim	To improve access to services and resources needed to increase or maintain health status and achieve equity of health outcomes for people who experience health disadvantage for a range of reasons.
Description	<p>Difficulties in accessing primary health care may result in delays to early intervention or ongoing treatment, increased morbidity, increased need for hospitalisation and potentially premature deaths.</p> <p>DDWMPHN will provide a variety of activities designed to effectively and sustainably address health inequities, particularly for the most disadvantaged and marginalised groups of people in our region. DDWMPHN will redress health disadvantage through service integration and system reform activities together with provision of transport, care coordination, telehealth and outreach services that provide opportunity for people and communities to access the healthcare services they need.</p> <p>In accordance with DDWMPHN Health Needs Assessment these activities may include:</p> <ul style="list-style-type: none"> Continued coordination of low cost, non-urgent health transport services in rural areas of need with a volunteer network and service mapping at the local level in a continuation of <i>CO_F_1.0_201718 – Regional Patient Care-Coordination for Client Transport</i>. This provides improved accessibility to primary health care for the Goondiwindi community facilitating primary health care appointments, case conferencing and client access to transport for these appointments. Support existing contractors to explore options locally for telehealth and virtual health initiatives with a view to reducing the need for transport.



Target Population Cohort	People and communities across the DDWMPHN region who experience health disadvantage
Consultation	A range of consultation has taken place regarding service access and equity of health outcomes with hospital and health services, general practitioners, communities and service providers to understand the most effective and efficient methods of improving health access and health status for marginalised and disadvantaged people
Collaboration	<ul style="list-style-type: none"> ▪ DDHHS: Integrating the pilot alternative response to PTSS from Goondiwindi to Toowoomba ▪ Goondiwindi Regional Council: Facilitation of access to the vehicle for transport ▪ Care Goondiwindi: Transport for health and pharmaceutical access at the local level ▪ General Practitioners ▪ Health care providers
Duration	1 st July 2018 – 30 th June 2019



CF_19.0_201819 – SERVICE INTEGRATION AND PREVENTING POTENTIALLY PREVENTABLE HOSPITAL PRESENTATIONS

Program Key Priority Area	Population Health
Needs Assessment Priority Area	<p>DDWMPHN HNA Key Priority Area/s</p> <p>Access and Equity</p> <p>Health behaviours</p> <p>C4 (p. 42, HNA, Nov 2017) – Chronic disease prevention, detection and management</p> <p>C7 (p. 46, HNA, Nov 2017) – Pathways for patients needing to access multiple health services for a condition</p>
Aim	Partner to initiate service integration opportunities which provide alternative health care avenues decreasing inappropriate hospital presentations.
Description	<p>In easing pressure on Emergency Departments, providing alternative, low-cost, accessible primary health care solutions continues to be a challenge.</p> <p>Service integration and partnership is integral in delivering a continuous healthcare system that allows for appropriate ongoing care.</p> <p>The DDWMPHN will:</p> <ul style="list-style-type: none"> Complete the Care Assistant in Emergency Department's trial activity (<i>CO_F_2.0(a)_201718 - Assisting with Inappropriate Hospital Presentations: Care Assistant</i>) and respond to recommendations provided through the evaluation. This activity involved the placement of 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. People who are triaged as suitable to visit a General Practitioner are assisted in understanding the most appropriate primary health care service for their needs including location and methods of access. Complete the SPOTON Activity trial (<i>CO_F_2.0(b)_201718 - Assisting with Inappropriate Hospital Presentations: SPOTON (Supporting Patient Outcomes Through Organised Networks)</i>) and respond to recommendations provided through evaluation. This activity was adapted from the Sunshine Coast PHNs Model which includes a referral protocol to minimise inappropriate presentations to EDs.



	<ul style="list-style-type: none"> Continue funding General Practice Liaison Officers to link hospitals directly with General Practices across the region (<i>CO_F_4.0_201718 – Hospital and Health Service General Practice Integration</i>) Provide support and linkages for community awareness campaigns for primary healthcare such as medicine safety
Target Population Cohort	People with lower priority clinical conditions who may inappropriately access Hospitals and Emergency Departments for primary health care
Consultation	<p>Consultation has occurred with DDHHS, WMHHS, QAS, General Practitioners and the SPOTON pilot site PHN.</p> <p>Ongoing consultation will occur with both HHSs, General Practitioners, Specialists, Allied Health providers and other health care service providers.</p>
Collaboration	<p>Design:</p> <ul style="list-style-type: none"> Queensland Ambulance Service Hospital and Health Services Streamliners Clinical Councils <p>Implementation:</p> <ul style="list-style-type: none"> Queensland Ambulance Service Hospital and Health Services Clinical specialists Allied health providers Other health care service providers
Duration	<p>Ongoing to 30th June 2019</p> <p>SPOTON will be completed by 31st December 2018</p> <p>Care Assistant Activity will be completed by 31st December 2018</p>



CF_20.0_201819 – PREVENTION AND EARLY DEVELOPMENT INITIATIVES FOR CHILDREN AND YOUNG PEOPLE

Incorporates: *CO_F_5.0_201718 - Aboriginal and Torres Strait Islander Community Midwife*

Program Key Priority Area	Population Health
Needs Assessment Priority Area	<p>DDWMPHN HNA Key Priority Area/s Infant, Child Development and Youth Health</p> <p>C2 (p. 40, HNA, Nov 2017) – Aboriginal and Torres Strait Islander Child and Maternal Health</p> <p>C4 (p. 42, HNA, Nov 2017) – Chronic disease prevention, detection and management</p> <p>C5 (p. 43, HNA, Nov 2017) – Health needs of people experiencing financial hardship, in particular children</p> <p>C6 (p. 44, HNA, Nov 2017) – Childhood obesity</p> <p>C10 (p. 47, HNA, Nov 2017) – Smoking rates and smoking in pregnancy</p> <p>C19 (p. 54, HNA, Nov 2017) – Lifelong immunisation</p>
Aim	Reduce the risk for vulnerable children and young people by partnering for integrated models of care that target those at-risk and provide health and wellbeing support and wrap around services.
Description	<p>This activity will focus on leveraging current alliances and networks including key stakeholders supporting children and young people who are at risk of adverse health and wellbeing outcomes while:</p> <ul style="list-style-type: none"> ▪ Considering enhancements to current mechanisms supporting the health of vulnerable children and young people including those who have had exposure to domestic and family violence, trauma, social and economic disadvantage, developmental deficits and fractured family connections. ▪ Partnering to create the ability for primary care providers to understand referral pathways to non-government organisations ▪ Identifying gaps in referral pathways and partnering to develop a response <p>The activity will include:</p> <ul style="list-style-type: none"> ▪ Completing the care coordination pilot for antenatal, perinatal and post-partum support. This will include evaluation and consideration for program extension and replication within the DDWMPHN region (CO_F_5.0_201718 - Aboriginal and Torres Strait Islander Community Midwife) ▪ Sexual and reproductive health initiatives



- Exploring opportunities to support, initiate or implement a First 1000 Days program or concepts with a possibility for extension to additional vulnerable groups and through to 2000 days (see background information).

Background:

The HNA quantitative and qualitative data analysis has prompted further Clinical Council consultation to explore the state of infant, child and youth primary health care delivery across the region. While there is recognition for individual programs and the scope of various organisations (e.g. healthcare, education, childcare), barriers were identified in the ability for service linkage to provide an integrated and holistic approach to the care of infants, children and youth through their development. Deficits in knowledge and integrated pathways have been highlighted as providing discrete approaches to a multi-faceted need.

First 1000 Days:

- Internationally the movement has focused on reducing under-nutrition from before conception to the child's second birthday, with early life interventions reducing human economic burden of communicable diseases and the risk of developing some non-communicable and chronic diseases, along with improving educational achievement and learning potential.
- An Australian model was developed through a long engagement process and includes an Indigenous-led holistic and ecological framework focusing on comprehensive primary health care with a case management approach style
- The Centre for Community and Child Health's evidence paper The First Thousand Days (The Royal Children's Hospital, Melbourne, 2017) discusses the multitude of factors affecting a child's development while citing evidence that the changes made during the first 1000 days can have lifelong effects such as chronic disease risk through 'programming' organs, tissues or body systems structures or functions. Also highlighted is the need to maintain support and provide appropriate intervention beyond the first 1000 days for those who have experienced a potentially compromised beginning to life. This involves maintaining positive conditions for families and children throughout childhood and adolescence such as:

For children:

- o Positive family relations
- o Social support
- o Safety (both physical and social)
- o Healthy environments
- o Optimal nutrition
- o Exposure to natural environments



	<p><i>For families:</i></p> <ul style="list-style-type: none"> o Supportive social networks o Secure housing o Secure employment/ finances o Healthy home environments o Safe community environments o Ready access to family-friendly services and facilities
Target Population Cohort	Children and young people
Consultation	<ul style="list-style-type: none"> ▪ Regional Clinical Councils ▪ Education Queensland and Department of Child Safety ▪ Youth and Women
Collaboration	Opportunities for collaboration with Department of Child Safety, Youth and Women
Duration	Continuing to – 30 th June 2019



CF_21.0_201819 – CLOSING THE GAP INITIATIVES	
Program Key Priority Area	Aboriginal and Torres Strait Islander Health
Needs Assessment Priority Area	<p>DDWMPHN HNA Key Priority Area/s Health and Equity for Aboriginal and Torres Strait Islander People</p> <p>C1 (p. 39, HNA, Nov 2017) – Aboriginal and Torres Strait Islander health including: chronic disease, health challenges associated with disability and high rates on summary measures of disadvantage</p> <p>C2 (p. 40, HNA, Nov 2017) – Aboriginal and Torres Strait Islander Child and Maternal Health</p> <p>C3 (p. 41, HNA, Nov 2017) – Liaison with Aboriginal and Torres Strait Islander Elders to identify ongoing needs</p>
Aim	<p>Ten years after the establishment of the Closing the Gap Framework in 2008, improvements have been made to the lives of Aboriginal and Torres Strait Islander people. As noted by the Prime Minister in his 2018 <i>Closing the Gap Report</i>, a key lesson learned has been in understanding that effective programs and services need to be designed, developed and implemented in partnership with Aboriginal and Torres Strait Islander people.</p> <p>The aim of this activity is to partner and liaison with Aboriginal and Torres Strait Islander elders and communities to identify support for initiatives to progress the health-related Closing the Gap targets.</p>
Description	<p>The DDWMPHN will continue to build strong relationships to empower Aboriginal and Torres Strait Islander Health Services, Organisations and Communities to develop strategies that improve the social and emotional wellbeing of individuals, families and communities. Particular focus is needed in:</p> <ul style="list-style-type: none"> ▪ Improving access to primary health services for Aboriginal and Torres Strait Islander people, ▪ Improving the capacity of primary healthcare providers to deliver culturally competent and culturally safe care, and ▪ Improving the patient journey between tertiary and primary care. <p>To improve understanding and develop solutions for the management of chronic conditions and health challenges associated with disability, maternal, child and youth mental and physical health, violence and substance misuse, the DDWMPHN will:</p> <ul style="list-style-type: none"> ▪ Continue the current Cultural Development Program aimed at increasing social and emotional wellbeing, increasing youth support, providing access to traditional and contemporary healing practices and increasing access to



	<p>culturally and clinically appropriate primary mental health care. Evaluation of outcomes will guide any ongoing modifications.</p> <ul style="list-style-type: none"> ▪ Review opportunities that provide culturally appropriate approaches to primary healthcare and impacts to social and emotional well-being ▪ Liaise with Aboriginal and Torres Strait Islander Elders, organisations and communities to identify opportunities for service improvement ▪ Assist in service linkages that promote the attainment of Closing the Gap health outcomes ▪ Link with <i>CF_24.0_201819_Workforce Development</i> to identify opportunities incorporating increased cultural competence of health care workers and health care training for Aboriginal and Torres Strait Islander people. ▪ Investigate avenues to assist improving access to primary healthcare services and health outcomes for Aboriginal and Torres Strait Islander people through preventative screening, health assessments and immunisations. ▪ Increase opportunities for elevating the healthcare experience and engaging with Aboriginal and Torres Strait Islander people ▪ Increase access through mainstream primary health care facilities via cultural upskilling and competency assessment across community organisations and mainstream health facilities.
Target Population Cohort	Aboriginal and Torres Strait Islander people
Consultation	<ul style="list-style-type: none"> ▪ Consultation is ongoing with: ▪ Aboriginal Medical Services ▪ Community Organisations ▪ Hospital and Health Services ▪ Community ▪ Aboriginal and Torres Strait Islander Elders ▪ Consumers ▪ Mainstream General Practitioners
Collaboration	<ul style="list-style-type: none"> ▪ Mainstream General Practitioners ▪ Aboriginal Medical Services ▪ Community organisations
Duration	Ongoing to 30 th June 2019



CF_22.0_201819_WORKFORCE DEVELOPMENT	
Program Key Priority Area	Workforce
Needs Assessment Priority Area	<p>DDWMPHN HNA Key Priority Area/s</p> <p>Workforce Capacity and Well-Being</p> <p>C15 (p. 50, HNA, Nov 2017) – Analysis of primary care workforce characteristics (depth and diversity)</p>
Aim	DDWMPHN will continue to partner with key organisations to assess need and holistic strategies for support of health professionals across the region. This activity will assist in identifying workforce gaps, retention and well-being across the region and provide linkages and partnerships for integrated models of care to ensure demand is met.
Description	<p>Through this activity, DDWMPHN will create alliances with key organisations such as Health Workforce Queensland (HWQ), CheckUP and Hospital and Health Services (HHSs). Following the release of the HWQ 2018 Workforce Needs Assessment, an increased understanding and analysis of the health workforce landscape will be available to guide the direction of these alliances in developing evidence based and effective models of service delivery for the region. The focus of this priority will be to ensure activities are implemented to support:</p> <ol style="list-style-type: none"> 1. Access: improving access and continuity of access to essential primary health care 2. Quality of access: building health workforce capability 3. Future planning: growing the sustainability of the health workforce. <p>The above alliances will assist in identifying areas of need to implement:</p> <ul style="list-style-type: none"> ▪ Coordination and provision of health specific conferences aimed at building workforce capability ▪ Scholarship program focussing on GPs and Allied Health upskilling to build capacity and capability at a local level throughout the region. This will focus on areas of workforce shortage or poor access to specialised primary health care ▪ Other education supports to enhance existing service delivery models and introduce new models of care to ensure the sustainability of primary health care across the region <p>See also: <i>CF_8.1_201819 – Initiatives to Support Aged and/ or Palliative Care</i></p>



Target Population Cohort	DDWMPHN health workforce, particularly those servicing rural areas
Consultation	<ul style="list-style-type: none">▪ Health Workforce Queensland▪ Check Up▪ Hospital and Health Services▪ General Practices▪ Other healthcare providers
Collaboration	<ul style="list-style-type: none">▪ Hospital and Health Services▪ General Practices▪ Other healthcare providers
Duration	1 st July 2018 – 30 th June 2019



4. Core Operational Activities

(Health Systems Improvement and General Practice Support)

GPS_2.1_201819 – PRIMARY CARE ENGAGEMENT – GENERAL PRACTICE SUPPORT

Previous Name: *CO_O_2.0_201718 - Education and Support Training and Development Suite*

Incorporates: *CO_F_3.0_201718 – Delivery of the My Health Record Expansion Project*

CO_O_3.0_201718 - General Practice Data Quality and Continuous Improvement Project

Program Key Priority Area	General Practice Support
Aim	<p>This activity aims to provide the required PHN support to general practice by:</p> <ul style="list-style-type: none">▪ Adopting best practice methods to support general practice to improve the quality of care▪ Promoting and improving the uptake of practice accreditation▪ Assisting practices in the understanding and meaningful use of digital health systems in order to streamline the flow of relevant patient information across the local health provider community <p>Developing health information management systems to inform quality improvement in health care, specifically, the collection and use of clinical data within practices</p>
Description	<p>DDWMPHN's Primary Care and Engagement Team will achieve these aims through:</p> <ol style="list-style-type: none">1. Delivery of a comprehensive suite of education and training to general practitioners, practice nurses and allied health professionals in response to identified needs. This will be fulfilled through various forms such as grand rounds, practice support engagement, workshops, webinars, upskilling, forums and other formal education modes.2. Providing support and information to assist compliance with the RACGP Standards for General Practice (5th Edition) while promoting the benefits of practice accreditation3. Providing support for community awareness campaigns for primary healthcare such as increasing immunisations and reducing communicable diseases.4. Promoting and supporting the use of CAT Plus tools with resulting improvements to management and care of high risk patients and patients with chronic disease, and business performance.5. Assisting in the understanding of health information management systems and health data to support quality improvement in primary health care.6. Providing ongoing support and updates for MBS billing



Supporting the Primary Health Care Sector	Providing support and education through the Primary Care Engagement Team will continue to allow general practitioners, practice nurses, practice managers and allied health professionals access to up to date and current best practice education, information and resources.
Collaboration	<ul style="list-style-type: none"> ▪ General Practice – Education, Practice Support (Accreditation, CAT Plus Tools, MBS Billing) and health information data ▪ Allied Health Professionals – Education and health information data ▪ DDHHS, WMHHS – Service Integration, education and health information data ▪ Private Hospitals and Specialists in DDWMPHN region – Service Integration, education and health information data ▪ External education providers – Education
Duration	Continued activity through to 30 th June 2019
Expected Outcome	<ol style="list-style-type: none"> 1. Up to date knowledge base improving effectiveness of general practitioners in meeting the needs of their communities 2. Accredited general practices providing assurances of compliance with health standards 3. Partnership in community education to improve efficiencies in health care 4. Effective healthcare resulting from increased care planning and maintenance of cycles of care 5. Improved client experience of quality health care 6. Effective and seamless general practice business performance related to appropriate billing



HSI_6.0_201819 – PRIMARY CARE ENGAGEMENT – SYSTEM INTEGRATION AND STAKEHOLDER ENGAGEMENT

Incorporates elements of: *CO_F_3.0_201718 – Delivery of the My Health Record Expansion Project*

Program Key Priority Area	General Practice Support
Aim	<p>Provide support to health system integration and stakeholder engagement to:</p> <ul style="list-style-type: none"> ▪ Enhance patient outcomes ▪ Identify and design solutions to address relevant health issues ▪ Address and improve integrated care pathways and the delivery of coordinated, effective and efficient care ▪ Consult with relevant stakeholders ▪ Support the integration of the health system to improve outcomes related to the six national priority areas ▪ Support broad primary health care improvement
Description	<p>Core Flexible activities provide descriptions of the use of the Health Needs Assessment to inform activities and the engagement of stakeholders while partnering for improved system integration. This activity encompasses the role of the Primary Care and Engagement Team in health system integration.</p> <ol style="list-style-type: none"> 1. Supporting the Nurse Navigator – GP Practice relationship model across the region 2. Ongoing delivery of the GP Clinical Placement Program to increase skills and capacity within the community while improving service integration 3. Promoting service linkage and referral paths, especially for at-risk and vulnerable and marginalised groups. 4. Collaborating with the region's Public Health Units to review key areas of health concern that are resulting in potentially preventable hospital admissions and develop recommendations for action 5. Delivery of a PHN Primary Health Care Summit 6. Maintain membership of the Toowoomba and Surat Basin Enterprise to ensure linkages within the community and early notification of change that may impact the community. Through this DDWMPHN will partner to deliver a regional Health Conference 7. Maintain membership with The Advisory Board to ensure up to date information regarding best practice and innovative models of care for complex health issues in primary care. Scheduled meetings, research reviews and model of care solution focussed workshops will be conducted to assist in implementation of projects aimed at delivery of coordinated, effective and efficient care. 8. Ongoing engagement and consultation through an online platform that enables exploration of research/ pilots from diverse locations, provision of links to



	<p>innovation sites, sharing of co-design opportunities, opening of consultation topics, and advising of health and workforce needs.</p> <p>9. Ongoing commitment to the Digital Health Expansion Project through the local implementation plan and contract with the Digital Health Agency</p> <p>10. Supporting Grand Rounds and Clinical Team learnings to improve workforce capability while increasing integration of health care opportunities</p>
Supporting the Primary Health Care Sector	<ul style="list-style-type: none"> As digital health becomes embedded into health care delivery, providing general practitioners, practice nurses, practice managers and allied health professionals access with the most current and up to date information (My Health Record, referral criteria and services available) continues to improve care to positively impact patient outcomes. Providing linkages for partnership opportunities, access to new or innovative primary care delivery options and increased knowledge and/ or skill base, encourages a collaborative primary health care sector with a continuum of care approach.
Collaboration	<ul style="list-style-type: none"> General Practice – Education, Project collaboration with Clinical Editors Allied Health Professionals – Education DDHHS, WMHHS – Service Integration with project collaboration, education Private Hospitals and Specialists in DDWMPHN region – Service Integration with project collaboration, education Community – Education
Duration	Continued activity through to 30 th June 2019
Expected Outcome	<ol style="list-style-type: none"> The actions in this activity are aimed at ensuring patients receive the right care in the right place at the right time by improving efficiencies and effectiveness in primary health care through: ensuring best practice identifying and understanding the needs of at risk, vulnerable and marginalised groups, incorporating appropriate health care and referral pathways improving the digital health experience and analysing deficits in service delivery



5. After Hours Strategic Vision

The DDWMPHN retains an After-Hours focus in 2018-19 that provides increased access to primary health care for people whose health condition cannot wait for treatment until regular services are available in the in-hours timeframe. This care is not a substitute for primary health care that should occur in the in-hours timeframe.

Service provision within this Activity Work Plan has resulted from extensive consultation, collaboration and negotiation with regional communities which has highlighted needs related to decreased availability and access for vulnerable and at-risk population groups. Aims of service provision align with increasing access, improving service integration and providing the right care, at the right time in the right place. Activity delivery targets identified community need which addresses gaps in after-hours service provision.

6. Core After Hours Activities

AH_3.1_201819 - AFTER HOURS OUTREACH	
Previous Name: <i>CO_AH_3.0_201718 - After Hours Outreach</i>	
Needs Assessment Priority Area	DDWMPHN HNA Key Priority Area Health Behaviours Infant, Child Development and Youth Health MH1 (p. 35, HNA, Nov 2017) – Alignment of services to reach people with anxiety, depression and other mental health illnesses within the community C2 (p. 40, HNA, Nov 2017) – Aboriginal and Torres Strait Islander Child and Maternal Health C5 (p. 43, HNA, Nov 2017) – Health needs of people experiencing financial hardship, in particular children C17 (p. 53, HNA, Nov 2017) – After hours care
Aim	<ul style="list-style-type: none">▪ Increase the awareness of children, youth, and young adults of appropriate local health care and community services▪ Provide accidental counselling and referral to local services in a non-threatening setting▪ Improve access to health care
Description	This activity provides early intervention, harm minimisation, crime prevention, and referral and support to children, youth, and young adults at times of high stress and anxiety. The service is delivered in the Toowoomba CBD by appropriately trained staff between 6pm and 11pm Thursday nights and includes: <ul style="list-style-type: none">▪ Health promotion and local health service awareness▪ Incidental counselling



	<ul style="list-style-type: none"> ▪ Suicide prevention ▪ Referral to appropriate health and community services <p>This activity will achieve:</p> <ul style="list-style-type: none"> ▪ Improved awareness of locally available health services ▪ Engagement and involvement of other service providers in diversionary activities ▪ Direct counselling to address poor health behaviours ▪ Suicide counselling ▪ Onward referrals to services when need is identified.
Target Population Cohort	Children, youth, and young adults including those who identify as Indigenous, Torres Strait Islander, or Culturally and Linguistically Diverse
Consultation	<ul style="list-style-type: none"> ▪ Stakeholder groups and service providers ▪ This includes those who are currently providing services to the target population cohort which contains homeless, vulnerable, and disadvantaged groups.
Collaboration	<p>Advice and Expert Guidance</p> <ul style="list-style-type: none"> ▪ Clinical Councils <p>Local community perspective</p> <ul style="list-style-type: none"> ▪ Community Advisory Committees <p>Linked Services</p> <ul style="list-style-type: none"> ▪ Toowoomba Youth Service ▪ Headspace ▪ Beyond Blue ▪ Kids Helpline ▪ DV Connect ▪ Lifeline ▪ Workplace Wellness Inc ▪ MDA and TRAMS migrant services ▪ Toowoomba Together Inc ▪ Toowoomba Regional Safer Partnerships ▪ Toowoomba Youth Network ▪ Toowoomba Regional Council ▪ Red Cross ▪ Ozcare
Duration	Activity extended to 30 th June 2019 with ongoing evaluation against performance indicators guiding future direction



AH_4.1_201819 AFTER HOURS PALLIATIVE CARE Previous name: <i>CO_AH_4.0_201718 - After Hours Care – Palliative Care</i>	
Needs Assessment Priority Area	DDWMPHN HNA Key Priority Area Access and Equity C5 (p. 43, HNA, Nov 2017) – Health needs of people experiencing financial hardship, in particular children C16 (p. 51, HNA, Nov 2017) - Aged care (with a continuing focus on additional processing and detailed analysis to identify further needs) – focusing on palliative care options C17 (p. 53, HNA, Nov 2017) – After hours care
Aim	To provide appropriate and available access to no-cost General Practitioner (GP) led palliative care in a community-funded holistic hospice setting in the after-hours period, reducing the potential for an admission to an acute care facility.
Description	Within the PHN region there is a limited capacity of no-cost residential end-of-life care services. Community hospices provide support for palliative care patients and their families with placement made through the patient's primary care provider. This activity will contribute to the after-hours provision of palliative care nursing, ensuring a continuity of service for community members who are unable to fund such care themselves.
Target Population Cohort	Community members with end-of-life needs
Consultation	<ul style="list-style-type: none"> ▪ Clinical Council ▪ Lead General Practitioners
Collaboration	Current palliative care service providers to ensure continuity of service, prevent duplication, and prevent gaps in service
Duration	Activity extended to 30 th June 2019 with ongoing evaluation against performance indicators guiding future direction



AH_5.1A_201718 – HOME OUTREACH CARE – AFTER HOURS

Previous name: *CO_AH_5.0_201718 – Home Outreach Care – After Hours*

Compliments: *CF_8.1_201819 – Initiatives to Support Older People, People with Complex Needs and/ or Palliative Care*

Needs Assessment Priority Area	<p>DDWMPHN HNA Key Priority Area</p> <p>Vulnerable, Marginalised and Hard to Reach</p> <p>Access and Equity</p> <p>C11 (p. 48, HNA, Nov 2017) – Access to health services not available locally, including transportation to health care (with a focus on improving access)</p> <p>C16 (p. 51, HNA, Nov 2017) - Aged care (with a continuing focus on additional processing and detailed analysis to identify further needs) – focusing on palliative care options</p> <p>C17 (p. 53, HNA, Nov 2017) – After hours care</p>
Aim	To provide increased access to in-home after-hours nursing care for people wishing to reside in their own home longer through an appropriate plan of care
Description	<p>Complementing <i>CF_8.1_201819 – Initiatives to Support Older People, People with Complex Needs and/ or Palliative Care</i>, provision of planned unplanned nursing care (e.g. breakthrough pain for palliative care, wound breakdown for clients receiving home dressings). Care will be provided after hours for treatment that can be addressed by a registered nurse rather than requiring the client to leave their home and access hospital care. Appropriate Primary Care Provider Care Plans will be provided to the service to ensure client continuity of care and nurse familiarisation with illness state.</p> <p>The 2017-18 activity was a trial approved to October 2018 with ongoing monitoring and evaluation of service provision to determine continuation and extension throughout region. A combination of monitoring and community consultation has identified specific needs within the region's community and the ability of this activity to meet recognised gaps. Therefore, this activity will be extended throughout 2018-19.</p>
Target Population Cohort	People with complex care requirements in home, including older people, those with chronic disease and those with palliation needs
Consultation	<p>Consultation has occurred and will continue with:</p> <ul style="list-style-type: none"> ▪ Aged Care Working Group and Palliative care working group ▪ Lead GP advisor ▪ DD&WM HHSs ▪ Toowoomba and Ipswich Hospices ▪ RACFs ▪ Home and Community Care providers



Collaboration	<ul style="list-style-type: none"> ▪ HHSs ▪ Hospices ▪ GPs ▪ NGOs
Duration	Activity extended to 30 th June 2019 with ongoing evaluation against performance indicators guiding future direction

AH_5.1B_201718 – HOME OUTREACH CARE (RACF) – AFTER HOURS

Previous name: *CO_AH_5.0_201718 – Home Outreach Care – After Hours*

Compliments: *CF_8.1_201819 – Initiatives to Support Older People, People with Complex Needs and/ or Palliative Care*

Needs Assessment Priority Area	<p>DDWMPHN HNA Key Priority Area</p> <p>Vulnerable, Marginalised and Hard to Reach</p> <p>Access and Equity</p> <p>C16 (p. 51, HNA, Nov 2017) - Aged care (with a continuing focus on additional processing and detailed analysis to identify further needs)</p> <p>C17 (p. 53, HNA, Nov 2017) – After hours care</p>
Aim	<p>Background:</p> <p>Consultation within the 2017-18 Activity <i>CO_AH_5.0_201718 – Home Outreach Care – After Hours</i> provided opportunity for expansion into an aligning outreach model to increase capacity and capability for care of residents in RACFs to decrease potential Emergency Department presentations in the after-hours timeframe. This portion of the activity was commenced in 2017-18 utilising approved increased activity funding apportioned from <i>CO_AH_8.0_201718 - After Hours Respond and Address Projects</i> and is separated as a co-activity for 2018-19 to assist in DDWMPHN management.</p> <p>This Activity will support the Federal Government's Aged Care commitment within the 2018-19 budget in implementing the Aged Care Quality Standards with a stronger focus on consumer outcomes.</p> <p>Aim:</p> <p>To provide increased access to in-home (RACF) after-hours care from the most appropriate health service provider and that it is delivered in the right place at the right time. This will be achieved through implementing sustainable strategies to</p>



	<p>support the integration of after hours' care delivered to RACF residents by addressing the following:</p> <ul style="list-style-type: none"> ▪ Decision making frameworks within care pathways reducing the need for people residing in RACFs to access Emergency Departments in the after hours' period ▪ Access to increased care needs including wound management and palliation. ▪ Efficiencies of coordination of care delivery for escalating needs of RACF residents in the after-hours period ▪ Integration of services to provide timely and appropriate care <p>This activity will create alliances with key stakeholders to improve the integration of after hours' service delivery with close involvement of residents' general practitioners' which is central to the implementation of changes to after hours' care pathways for RACF residents. A person-centred framework will be utilised throughout all phases and will involve residents' choices of GP for planning and implementation decisions. The activity will specifically address sustainability of strategies, tools, and resources initiated, beyond the allocated timespan of funding provided by DDWMPHN.</p>
Description	<p>Directed towards people living in residential aged care, this activity provides a collaborative framework:</p> <ul style="list-style-type: none"> ▪ Extending existing services improving access to after-hours care, and ▪ Providing enhanced decision-making frameworks/ tools within care pathways to guide appropriate care. <p>The activity involves the development of decision support tools and care pathways for utilisation within RACFs to provide timely and appropriate access to medical and/or nursing support and care for people experiencing a change in health status in the after-hours timeframe. Pathways will involve care support delivered by residents' General Practitioners, Nurse Navigators, and Hospital and Health Services. The strategy will support:</p> <ul style="list-style-type: none"> ▪ Keeping older people well in their homes, ▪ Reducing potentially preventable hospital presentations and admissions, ▪ Preservation of the older person's choice for treatment, ▪ Promoting uptake of the My Health Record, ▪ Utilisation of Statement of Choices to document wishes for level of care and preferred environment for the care to be provided, and ▪ Utilisation of the Yellow Envelope for unavoidable transfers to hospital. <p>Service elements integral to this activity include:</p> <ul style="list-style-type: none"> ▪ Stakeholder engagement (RACFs, HHS, EDs, GPs) ▪ Development of decision support tools and care pathways



	<ul style="list-style-type: none"> ▪ Appropriate access to an Acute Geriatric Evaluation Service ▪ Support of RACF staff including advice and education
Target Population Cohort	Residents of Residential Aged Care Facilities
Consultation	<p>Already undertaken:</p> <ul style="list-style-type: none"> ▪ Clinical Council ▪ Community Advisory Committees ▪ Lead GPs with special interest in aged care ▪ HHSs ▪ RACFs
Collaboration	<ul style="list-style-type: none"> ▪ HHSs whose geographic areas of responsibility correspond with the PHN – as successful tenderers for this activity these organisations are implementing the project and include geriatric, emergency, and other services as deemed appropriate. ▪ All RACFs within the PHN geographic area (public and private) ▪ Queensland Ambulance Service as a key service provider ▪ General practices that are providing care to RACF residents ▪ PHN practice support, digital health, and aged care teams as deemed appropriate
Duration	Activity extended to 30 th June 2019 with ongoing evaluation against performance indicators guiding future direction



AH_6.1_201819 - AFTER HOURS – OUTREACH PALLIATIVE CARE Previous name: <i>CO_AH_6.0_201718 - After Hours – Outreach Palliative Care</i>	
Needs Assessment Priority Area	DDWMPHN HNA Key Priority Area Vulnerable, Marginalised and Hard to Reach C16 (p. 51, HNA, Nov 2017) - Aged care <ul style="list-style-type: none"> Palliative care provision (option 2) Opportunities for increased care provision in rural communities (option 4) C17 (p. 53, HNA, Nov 2017) – After hours care
Aim	To increase access to after-hours primary health care for palliative care needs that arise/ require attention in the after-hours period for people in the South Burnett.
Description	<p>The continuation of this activity will provide outreach, after-hours, palliative, nursing care led by patients' GPs for people residing within the Kingaroy district. This will reduce the need for people to leave their home to access palliative care.</p> <p>GPs and patients will have access to an after-hours Palliative Care Registered Nurse allowing an agile and responsive service to meet patients' needs.</p> <p>The palliative care nurse has an office base used for administrative tasks only given the service provides care in the home. The service provider is responsible for ensuring safe working conditions as per the Workplace Health and Safety Act 2009 and Awards associated with the position.</p>
Target Population Cohort	Individuals who have exhausted their allocation of services through MBS or private Funding and require palliative nursing care while residing in their home in the Kingaroy catchment area
Consultation	Already undertaken: <ul style="list-style-type: none"> Kingaroy Chapter General practice Kingaroy Hospital
Collaboration	Kingaroy Hospital
Duration	Activity extended to 30 th June 2019 with ongoing evaluation against performance indicators guiding future direction



AH_7.1_201819 – AFTER HOURS -MENTAL HEALTH AFTER HOURS OUTREACH

Previous name: *CO_AH_7.0_201718 – After hours – Primary Mental Health Care*

Needs Assessment Priority Area	<p>DDWMPHN HNA Key Priority Area</p> <p>Primary Mental Health Care</p> <p>C17 (p. 53, HNA, Nov 2017) – After hours care</p> <p>MH1 (p. 35, HNA, Nov 2017) – Alignment of services to reach people with anxiety, depression and other mental health illnesses within the community</p>
Aim	<p>The aim of this activity is to support people with, or at risk of, mental illness in the after hours' period who would normally present to the emergency department or other services. ED and other services are unsuitable to provide support to this cohort to reduce the broader impacts of mental illness on relationships, education, employment, and housing security, particularly amongst adolescents, young adults and the Aboriginal and Torres Strait Islander Community.</p>
Description	<p>The service delivers targeted responses to people experiencing situational crises presenting after-hours. They are triaged as not requiring hospital-based acute care. The activity includes:</p> <ul style="list-style-type: none"> ▪ De-escalation of persons in distressed psychological states ▪ Referral facilitation to appropriate after-hours services ▪ Provision of an alternative service to assist in decreasing unnecessary hospital presentations. ▪ Provision of face-to-face psychological support to address immediate short-term needs.
Target Population Cohort	<ul style="list-style-type: none"> ▪ Adolescents ▪ Young adults ▪ Aboriginal and Torres Strait Islander Community
Consultation	<p>Already undertaken:</p> <ul style="list-style-type: none"> ▪ Clinical Council ▪ Community Advisory Committee ▪ Ipswich Hospital Emergency Department ▪ WMHHS ▪ Crisis accommodation ▪ Domestic violence agencies ▪ Pharmacies ▪ General practice
Collaboration	<ul style="list-style-type: none"> ▪ WMHHS ▪ Queensland Ambulance Service as key referrer



	<ul style="list-style-type: none"> General practices Queensland Police Service as a key referrer
Duration	Ongoing to 30 th October 2018

AH_10.1_201819 - After Hours Care – Rural Diabetes Care Previous Name: <i>CO_AH_10.0_201718 - After Hours Care – Rural Diabetes Care</i>	
Needs Assessment Priority Area	DDWMPHN HNA Key Priority Area Access and Equity C4 (p. 42, 2017) – Chronic Disease Prevention, Detection and Management C11 (p. 48, 2017) – Access to health services not available locally, including transportation to health care C17 (p. 53, HNA, Nov 2017) – After hours care MH1 (p. 35, HNA, Nov 2017) – Alignment of services to reach people with anxiety, depression and other mental health illnesses within the community
Aim	To provide access to After Hours Diabetes telephone support to people with diabetes across the rural communities of Darling Downs and West Moreton region.
Description	<p>This activity was altered in February 2018 to provide telephone consultations to people living in rural areas with time sensitive advice regarding issues such as accidents with administration of insulin.</p> <p>Changes were based on needs of rural communities and service provider feedback indicating increased support provided by this service assisted in preventing hospitalisations and presentations to emergency departments. Current program re-evaluation of the amended service delivery has identified that the model is not providing emergent service for diabetes management.</p> <p>This activity will be decommissioned from after-hours with further diabetes opportunities to be commissioned within <i>CF_6.1_201819 – Services Supporting People with Chronic Disease</i></p>
Target Population Cohort	People with diabetes living in rural areas of the DDWMPHN region
Consultation	Undertaken and will continue with: <ul style="list-style-type: none"> NGOs and funded providers



	<ul style="list-style-type: none">▪ Clinical Council▪ Lead GP advisors where appropriate
Collaboration	Current service providers for planning and evaluation of service model
Duration	Continuation through to 30 th June 2019 Evaluation in October 2018 will determine any refinements required for the service



phn

DARLING DOWNS
AND WEST MORETON

An Australian Government Initiative

Head Office

Level 1, 162 Hume Street (PO Box 81),
Toowoomba QLD 4350

P (07) 4615 0900 **F** (07) 4615 0999

E info@ddwmpnh.com.au **www.ddwmpnh.com.au** ABN 51 605 975 602

West Moreton

Ipswich Corporate Centre, 6th Floor,
16 East Street, Ipswich QLD 4305

P (07) 3202 4433 **F** (07) 3202 4411



Local Integrated
Primary Health Care