Aged Care PHN Program

Activity Work Plan - 2025/26 - 2028/29

phn
DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

Local Integrated Primary Health Care

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1. Commissioning Early Intervention Initiatives

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aged Care

AIM OF ACTIVITY

The aim of this activity is to support senior Australians to live at home for as long as possible through the commissioning of early intervention activities and models of care for chronic disease management that support healthy ageing and reduces pressure on local health services. This activity also supports the empowering of GPs and other primary health care workers through training, tools and resources which contribute to improved health and care outcomes for older people.

DESCRIPTION OF ACTIVITY

The commissioned services provide early intervention initiatives that promote healthy ageing and the ongoing management of chronic conditions and are:

- Informed by the PHN's Health Needs Assessment.
- Designed to meet the specific needs of senior Australians in the Darling Downs and West Moreton region with a specific focus on Aboriginal and Torres Strait Islander communities and other priority populations including those who are culturally and linguistically diverse and those living in regional and remote areas

Our PHN will also:

- Monitor and evaluate existing programs to ensure that the services are effective and efficient and meet the needs of the community.
- Foster encouraging partnerships, and collaborative approaches between multidisciplinary teams and primary care providers.
- Provide Healthy Ageing Support to assist older people within the eligible cohort to coordinate and access the care and services they may require, to help them to remain living at home and in their community.
- Assist older people to retain functional capability in their usual activities of daily living, enabling them to live as independently as possible, for as long as possible, in their own homes and communities.
- Create meaningful social participation that connects people to family, friends, and community.
- Strengthen culturally appropriate health pathways to ensure at-home and primary/community services meet the cultural needs of Aboriginal and Torres Strait Islander peoples and other priority population groups in our region.
- Provide necessary, appropriate, easy to understand and accurate information in health management, available services, and resource accessibility.

This activity will also include workforce education on how to connect senior Australians with necessary psycho social, health, social and welfare supports and the availability of the above commissioned services initiatives.

The PHN supports the commissioned services by:

- Monitoring processes and supporting quality improvements activities to meet reporting requirements.
- Supporting the integration of the program into the local aged care network.
- Supporting continuous improvement of the program.
- Identifying and addressing opportunities to enhance integration between the health, aged care and other systems at the local level.
- Increasing the awareness of the program among General Practitioners and primary health care providers, by developing and embedding local referral pathways within the Health Pathways sites and ensure contracted providers directly undertake adequate promotion of their services to community referrers and intermediaries.

NEEDS ASSESSMENT PRIORITES

Joint Regional Needs Assessment 2025/28

PRIORITY
Priority populations
Care across the lifespan

ACTIVITY CONSULTATION AND COLLABORATION

Collaboration

A Community of Practice has been established for contracted service providers, along with other aged care providers that support continuous improvement through collaboration, information sharing and solution focused ways of working together. The Joint Regional Older Person Strategy – Stronger for Life 2025/30 was developed in partnership with the Regional Health Collaborative that was established to enable governance and practical collaborative partnerships on joint strategic priorities in the region. Governance includes chief executive representation from:

- Darling Downs and West Moreton PHN
- Australian Government
- West Moreton Health
- Darling Downs Health
- Queensland Ambulance Service
- Queensland Government
- Health Consumers Queensland
- Kambu Aboriginal and Torres Strait Islander Health
- CRAICCHS Community Controlled Health Services
- Goolburri Aboriginal Health Advancement Company
- Carbal Medical Services
- Goondir Health Services.

2. Aged Care On Site Pharmacist Measure

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aged Care

AIM OF ACTIVITY

This program provides funding for PHNs to assist residential aged care homes (RACHs) to engage aged care onsite pharmacists in a clinical role improve the medication management for residents.

ACOP activities aim to:

- Increase uptake of aged care onsite pharmacists by RACHs
- Improve access to aged care onsite pharmacists in RACHs
- Identify eligible pharmacists available to work onsite in RACHs
- Ensure pharmacists seeking to participate in the ACOP measure meet eligibility requirements.

DESCRIPTION OF ACTIVITY

The Darling Downs and West Moreton will facilitate the successful implementation of the Aged Care On-Site Pharmacist Measure across Residential Aged Care Homes (RACHs) in our region. Our PHN will begin by identifying eligible pharmacists available to provide services to RACHs and ensure that they meet the eligibility criteria to participate in the program.

The PHN will coordinate the provision of clear and detailed information about the initiative to RACHs within the region, in accordance with guidance issued by the Department of Health and Aged Care.

These activities may include:

- Conducting an assessment of Residential Aged Care Homes (RACH) and Pharmacies in the region to evaluate current service arrangements, identify existing gaps, and explore opportunities to optimise resource utilisation to effectively address unmet needs.
- Provision of summary information about eligible pharmacists that have expressed interest in the program, ensuring they are well-informed about the initiative and its benefits.
- Managing and responding to requests from RACHs seeking to engage eligible Pharmacists, acting as a liaison to connect RACHs with suitable candidates.

These activities will enable the utilisation of the available resources to be accessed in a way that addresses the unique needs of RACH's and pharmacists in our region, ensuring a more efficient, targeted and sustainable approach to matching.

Additionally, our PHN will:

- Work with neighbouring Primary Health Networks and peak bodies such as the Pharmaceutical Society of Australia to further assist our PHN to identify eligible pharmacists who may be available to support RACH's in the DDWM region.
- Utilise Clinical, Operational and Wrap-around Offerings that recognises place-based care solutions occur in various health settings, including aged care homes, and support connection of aged care onsite pharmacists for provision of medication management within RACH. provide participating RACHs with a list of eligible Pharmacists seeking employment under the initiative, helping to streamline the process of matching pharmacists with eligible RACH's and vice versa. The PHN will also support RACHs in successfully engaging Pharmacists, ensuring that the integration of these professionals into on-site roles are as seamless as possible.
- Utilise our established networks across our region to facilitate communication and collaboration between RACHs, their on-site Pharmacists, the residents' General Practitioners, and other relevant healthcare professionals to ensure better coordination of healthcare services and enhance the quality of care provided to residents.

NEEDS ASSESSMENT PRIORITES

Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

The PHN has completed extensive consultation via face-to-face workshops, online focus groups, and broader stakeholder engagement mechanisms across our region to determine the need and requirements for Aged Care Onsite Pharmacist services.

Utilising a collaborative approach with our health and care partners, we are exploring what supports are currently in place, identifying service gaps and gathering insights on how an ACOP could strengthen care for residents of aged care homes.

Recommendations and collated information captured through the Needs Assessments help inform future planning and program development that ensures any proposed support is specifically co-designed and tailored for/with RACHs and aligned to our Joint Regional Older Person's Strategy – Stronger for Life, key pillar of "Living Well in Supported Living" where all older people living in assisted living or residential aged care receive the quality care and support they need and deserve to continue to live and age well.

3. Support RACH to Increase Availability and Use of Telehealth Care for RACH residents

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aged Care

AIM OF ACTIVITY

This activity aims to assist Residential Aged Care Homes (RACHs) to have access to appropriate telehealth facilities and equipment to enable their residents to virtually consult with their primary health care professionals, specialists and other clinicians.

DESCRIPTION OF ACTIVITY

The Darling Downs and West Moreton PHN invited RACHs in the region to participate in a digital capacity and capability assessment to determine gaps in RACH workforce and telehealth capacity. This enabled our PHN to develop targeted solutions as to what resources and training would be required to better enable the RACHs to provide their residents with telehealth services to access their primary health care professionals.

This activity continues to build on this initial assessment and use its findings by:

- Supporting the participating RACH's use the information gained from the individual and customised audit report relevant to their facility to increase their understanding of what is necessary to improve the facility's digital capacity and capability to improve telehealth access for their aged care residents.
- Promoting the use of enablers of digital health (such as My Health Record).
- Consulting with jurisdictional authorities to ensure these initiatives complement, and do not duplicate, efforts underway by State and Territory Governments to improve technological interoperability between the aged care and health systems.
- Providing training to participating RACH staff to support them to have the capabilities to assist their residents in accessing virtual consultation services.
- Implementing an evaluation process will complete this activity.

NEEDS ASSESSMENT PRIORITES

Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Care across the lifespan

4. After Hours Access in Residential Aged Care Homes

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aged Care

AIM OF ACTIVITY

The aim of the After Hours Access in Residential Aged Care Facilities (RACHs) activity is:

- To increase the number of RACHs with formal after-hours plans
- To increase knowledge and understanding of participating RACH staff regarding after-hours health care options and processes for RACH residents
- To support the development of facility-wide after-hours care plans
- Support engagement between the RACHs and their resident's GPs (and other health professionals), as part of after-hours plan development
- To improve digital health record documentation following an episode of after-hours care.

DESCRIPTION OF ACTIVITY

This activity provides guidance to assist participating RACHs to develop and implement after-hours action plans which support their residents to access the most appropriate medical services out-of-hours. This includes educating participating RACH staff in out-of-hours health care options and processes for residents and supporting participating RACHs to implement procedures that ensure residents' digital medical records remain up to date.

Our PHN also supports engagement between RACHs and their residents' GPs (and other relevant health professionals) as part of the development of their after-hours action plans.

These activities will be achieved by:

• Undertaking extensive stakeholder consultation.

• Creating a detailed engagement and communications plan.

• Scoping the existing after-hours services currently in place at RACHs, then reviewing the key issues and themes.

• Disseminating a diagnostic report for the RACHs as to their current after-hours service providers, key issues and themes.

• Educating RACH staff on after-hours plans, after-hours health care options and processes for residents

• Developing an after-hours framework/plan for RACHs.

• Developing a suite of resources which will include after-hours plan templates and guidelines

• Providing individual support for participating RACHs to develop and implement plans and resource tools

• Undertaking a post implementation evaluation process.

Through use of a Needs Assessment, the PHN has identified those RACHs who require additional support in the after-hours period, including connection to a medical deputising service or clinically-led telemedicine service.

The Needs Assessment informs ongoing planning and development of after-hours care plans, ensuring clinical guidelines are adhered to and clear identification of escalation pathways for residents experiencing more complex health issues. After-hours Care Plans support RACH clinical staff to make sound care decisions and contribute to ensuring the reduction of avoidable hospital admissions and/or emergency department presentations.

NEEDS ASSESSMENT PRIORITES

Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Care across the lifespan

5. Care Finder Program

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aged Care

AIM OF ACTIVITY

The aim of this activity is to establish and maintain a network of care finders to provide specialist and intensive assistance to help older people within the target population to navigate and access aged care services and connect with other relevant supports in the community.

These activities will:

a) Improve outcomes for older people in the care finder target population, including:

- Coordination of support when seeking to access aged care.
- Understanding of aged care services and how to access them.
- Improved openness to engage with the aged care system.
- Increase care finder workforce capability to meet client needs.
- Increase rates of access to aged care services and connections with other relevant supports.
- Increase rates of staying connected to the services they need post service commencement.

b) Improve integration between the health, aged care and other systems at the local level within the context of the care finder Program.

DESCRIPTION OF ACTIVITY

In line with the Royal Commission's (Final Report 2021) recommendations for improvement of aged care services in the community, the Care Finder program is funded by PHNs to provide a support workforce to help older people navigate and access aged care services at-home and in their communities.

To continue to improve outcomes for older people in the care finder target population, our PHN continues to commission three service providers in the Darling Downs and West Moreton PHN region. These service providers are:

Aged and Disability Advocacy Australia (ADA)

- ADA covers the entire Darling Downs and West Moreton Region, and their associated target populations.

Footprints Community Limited

- Footprints Community Limited covers the Ipswich and Boonah areas. They cover all target populations.

STAR Community Services

- STAR Community Services covers the Warwick and Stanthorpe areas. They cover all target populations.

The PHN supports these commissioned services by:

- Monitoring processes and supporting quality improvement activities to meet data collection and reporting requirements.
- Supporting the integration of the care finder network into the local aged care system.
- Supporting continuous improvement of the care finder program.
- Identifying and addressing opportunities to enhance integration between the health, aged care and other systems at the local level.
- Increasing the awareness of care finder services among General Practitioners and primary health care providers, by developing and embedding local referral pathways within the Health Pathways sites and ensure contracted providers directly undertake adequate promotion of their services to community referrers and intermediaries.

In addition, the PHN:

- Continues to collaborate with other PHN's through the care finders Aged Care Working Group. This group shares experiences, learnings and is solution focused.
- Continues to promote and raise awareness of the care finder network with potential referrers, intermediaries and the target population.
- Continue to share aged care updates and changes with General Practitioners and primary health care providers.
- Continues to add to our existing knowledge of the need in relation to care finder support through ongoing analysis of available data sources to understand the demographics, profile, and geographical distribution of those that may form the local care finder target population.
- Continuing to respond to information gathered by attending networking meetings and connecting with other networks such as multicultural organisations, LGBTIQ+ organisations.

NEEDS ASSESSMENT PRIORITES

Joint Regional Needs Assessment 2025/28

PRIORITY
Priority populations
Enablers
Care across the lifespan

ACTIVITY CONSULTATION AND COLLABORATION

Collaboration

A DDWM PHN Community of Practice has been established to provide a forum where our funded care finders and other representatives (including community and First Nations) share their experiences and learnings of the care finder program across the region. The Community of Practice supports continuous improvement through collaboration, responding to the evaluation of the program and adapting to the needs and trends within the target population.

Expansion of the CoP was necessitated at the commencement of the Support at Home program (November 2025), to include our regional Aged Care Assessment organisations. Inclusion of Assessors enhances the ways of working together and deeper understanding of business requirements. It is anticipated the partnerships formed between care finders, Assessors and representatives will benefit older people in receipt of care finder and broader aged care services.

This Community of Practice meets also includes our other partners, the Elder Care Support Program and the Healthy Ageing Program.

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