Australian Government
Department of Health

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An Australian Government Initiative

Primary Health Network

Core and Mental Health Needs Assessment Reporting Template

15 November 2017

Name of Primary Health Network

Australian Capital Territory

When submitting this Needs Assessment Report to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Section 1 – Narrative

Needs Assessment process and issues

The process for the 2017-18 Needs Assessment has involved an update/enhancement of the quantitative information contained in the 2016-2017 Needs Assessment (NA) and further collection of qualitative data via consultation with stakeholders. In addition to this, we have included a number of supplementary focus areas not explored in the 2016-2017 NA. These focus areas include disability (transition to the NDIS) and the interface between the NDIS and primary health care; further exploration of early childhood (in particular vulnerable children), 'middle years' (8-12 years) and youth (12-25 years); carers (in particular carers' health and wellbeing); families with complex health and social care needs (in particular, coordination of services/agencies dealing with families with multiple diagnoses); digital health, people exiting prison; people living with blood borne viruses (HIV and Hepatitis B and C) and chronic pain management.

As with the 2016-17 NA, we have been tapping into existing networks (providers and consumers) and utilising key informants to provide information or seek validation around the articulation of issues.

The ACT PHN Community Advisory Council, established in October 2015, has provided guidance and input into the issues in relation to the supplementary focus areas. The Community Advisory Council has also been involved in the prioritisation of needs/issues process and associated strategies/options to address these needs. The prioritisation process, which involved trialing a fit for purpose prioritisation method, was undertaken in a workshop with the Community Advisory Council and out of session via email.

As with the 2016-17 NA, the consultation data was analysed thematically and then triangulated with the relevant statistical data. The consultation data has added invaluable anecdotal evidence to the overall picture provided by the quantitative data and information. Any relevant findings from community consultations undertaken by other organisations was incorporated into the needs assessment findings.

We have continued to keep in mind ACT Government priorities so that local priorities reflect these as well as issues/needs identified by local stakeholders. We will also continue to work closely with the ACT Government (Health, Community Services, Justice and Education Directorates) to ensure that we have maximum alignment of priorities where possible.

Community consultation is an ongoing process and will continue to occur beyond the needs assessment process, as it is essential to ensure that population health needs are accurately reflected and that plans and actions are appropriate. An ACT PHN community and consumer engagement framework has been developed and this framework provides guidance on the various engagement strategies that may be most effective at various stages of the commissioning cycle.

We continue to consider it important to collect information about health inequalities in the ACT population and to have a focus on those groups who are disadvantaged or vulnerable. There are vulnerable populations in the ACT that are at greater risk of poor physical, psychological and/or social health status and health care access. For these vulnerable populations, there is a need to understand the link between social determinants of health and

how these affect health outcomes. Stakeholder engagement in relation to issues for vulnerable populations will be ongoing as part of the commissioning process.

Updates to the mental health and alcohol and other drug sections of the needs assessment have been made based on needs identified by stakeholders during ongoing consultation. Updates to the After Hours component have been undertaken based on a more comprehensive after hours needs assessment being undertaken as part of the joint commissioning process with ACT Health.

Additional Data Needs and Gaps

The ability to obtain comprehensive data on target populations at the sub-regional level in the ACT continues to be a challenge as is the ability to access relatively recent data. We welcome the improvement in the release of Commonwealth data to assist PHNs.

Where possible, ACT PHN attends the PHN Data Collaboration Network meetings organised by AHHA which is a good forum for networking in relation to the use of health data and to hear about what others are doing regarding sourcing, analysing and presenting their data.

The Population Health team are members of the NSW/ACT PHN Population Health, Data and Information Network (PHDIN).

ACT PHN plans to build capability in regard to GIS mapping technology. Maps produced from GIS data can be used to visualise and interpret the data to depict relationships and significant hotspots within a community. GIS technology is a powerful tool because it can be used to communicate important facts about a community and can often be more easily interpreted by stakeholders. We will await further developments in the work being undertaken by the Commonwealth Department of Health regarding the development of GIS mapping systems for PHNs.

Additional comments or feedback

Population Health Needs Assessment will be an ongoing process for ACT PHN as it is a crucial step in the commissioning process. As part of this process we will continue to undertake stakeholder engagement and collection of quantitative data in an effort to build our evidence base and obtain a good understanding of the current and likely future needs of the local population. To that extent this document sets out some of the key issues at this point in time, and consideration of these will continue to evolve as more evidence is collected or updated.

A comprehensive report on the 2017-18 Needs Assessment will be uploaded to the CHN website in late 2017 and contains detailed documentation of the outcomes of the needs analysis and a more extensive range of issues than contained in the summary. It is intended to be used as a resource for the community to further engage in articulating health needs and issues in the ACT.

Sections 2 & 3 – Outcomes of the health & service needs analysis

Outcomes of the health & service needs analysis		
Priority Area	Key Issue	Description of Evidence
Transitions of care	Poor communication between different parts of the health system often results in delays in appropriate treatment or community supports, duplication of diagnostic tests and in some cases re-hospitalisation	Poor communication between different parts of the health system often results in delays in appropriate treatment or community supports, duplication of diagnostic tests and in some cases re-hospitalisation. The quality of communication between different parts of the health system has considerable implications for patients, the health care system and health care costs. The transfer of information between care providers is an essential component of any transfer to ensure patient safety. Apart from the risk of achieving sub-optimal outcomes, poor communication wastes both patients' and clinicians' time and ultimately health system resources. 33% of GP survey respondents to a 2015 TCH GP Survey said that it was rarely or never clear who was responsible for following up results and 47% said that this usually resulted in clinical consequences to the patients. Outpatient clinic communication issues were particularly prominent with GP comments about delays in receiving responses, difficulties in accessing clinicians required and the general sense that the system was overburdened and unable to respond effectively.

Outcomes of the health & service needs analysis		
	Lack of consistency in discharge planning and transitions of care processes	Lack of clearly articulated arrangements with regard to follow-up post discharge highlights poor systems that appear to be in place in at least some clinical units. Audits show significant quality issues with discharge summaries around timeliness, recording of principal diagnoses, complications and medications. 33% of Canberra Hospital and 43% of Calvary Hospital discharge summaries are rated average or below average. This level of performance with regards to discharge information poses safety and quality risks for patients and makes continuity of care a major challenge.
	Variable access to Outpatient Services leading to suboptimal management of a particular condition or delayed diagnosis	Current growth in demand for outpatient services is unsustainable and is already well beyond capacity. ENT, urology, neurology and dermatology currently are significant outpatient pressure points that require better defined shared care arrangements. Variability evident in how referrals are organised, lack of an effective e-referral system, quality of GP referrals, multiple referral pathways, systems and booking protocols, lack of engagement with clinical decision-makers, timely referral of patients back to GPs have been highlighted as significant issues.
	Lack of knowledge and awareness of support services	This issue has been raised by GPs, specialists, allied health providers, alcohol and drug service stakeholders, mental health providers, Aboriginal and Torres Strait Islander community representatives and refugee advocates.

Outcomes of the health & service needs analysis		
		Accurate information is a fundamental building block for coordination of comprehensive consumer focused care and the development and up-to-date maintenance of referral pathways. There is significant evidence that active integration of community and social support networks addressing needs of patients discharged from hospital is one of the top three interventions associated with success in reducing re-admissions.
	Poor information infrastructure to support shared care planning and transition of care	Key underlying theme in the 2013 ACTML ACT Health Interaction Survey was the need for improved communication across health sectors and between clinicians. There is significant evidence of the importance of multi-disciplinary care for chronic disease management. Very low uptake in ACT of shared care and allied health MBS items or utilisation of My Health Record. Development of ACT Health e-health systems to date have failed to adequately respond to the needs of GPs in terms of shared medical record requirements or seamless e-referrals.
Older people	Better admission and discharge planning and communication processes	It is well established that older people are more likely to: - Be admitted with existing health or community services needs or require step-down to these services on discharge - Experience delayed transfers of care - Report uncertainty, lack of confidence and lack of support on discharge from hospital - Be at high risk of re-admission because of their complex needs and frailty RACFs report significant issues around discharge processes from EDs and acute wards.
	Providing rapid access to GPs for homebound patients	Ready access to a GP once a person enters residential aged care was identified as a priority area for action by the GP Taskforce in 2009 and still remains a significant issue. Only a small number of the ACT's residential aged care facilities have adequate GP coverage, and this is usually the result of an in-house GP arrangement or an arrangement with a local multiple GP practice.

Outcomes of the health & service needs analysis		
		Lack of timely access has knock-on consequences for not only the older person, their family and RACF staff but also for the ED and hospital system. When the health or independence of an older person deteriorates rapidly they should have access to rapid urgent care, including effective alternatives to hospital. The lack of an accessible GP is often the cause of referral to ED as an alternative, and many cases an inappropriate one.
	Avoidable ED presentations and potentially preventable hospitalisations (PPHs)	Older people constitute around 36% of hospital separations and 18% of ED presentations and per capita hospitalisation rates have increased by 23% and ED presentation rates by 14% over a decade. ED is a challenging environment for older people, particularly those with dementia. RACF residents are a particularly vulnerable group. Between 2004-2013, the proportion and rate of ED presentations for older persons in the ACT increased by 14.4%, with the increase driven by those 85 years and over. Some older patients have spent over a year in ACT hospitals. Some of this has been attributed to the lack of adequately resourced RACFs capable of administering continuous morphine infusions.
	Improved medication management (discharge medication; new medication; over medication; medication in RACF setting; closer involvement of GPs and pharmacists in medication reviews)	Older people are more at risk of experiencing side effects from their medicines. They may also experience difficulties with vision, hearing, memory or cognitive functions that can make managing medicines safely a lot harder. Approximately 50% of patients don't take their medication as prescribed by their healthcare professional. This medication non-adherence compromises the effectiveness of treatments, increases the risk of medication incidents, reduces health gain and quality of life.

Outcomes of the health & service needs analysis		
		There is a greater need for titration of medicines for those people with comorbidity who have complex pharmaceutical regimens. There is also limited knowledge and understanding about the ongoing interface and interaction between medications and nutrition.
	Improving the integrity and uptake of end of life care planning	It is widely accepted that hospitals remain the last preferred place of death but still remain the most common places to die, with many being actively treated right up to the moment of their death, in some cases involving expensive and futile treatment. Many of the problems associated with the effective provision of end of life care relate to barriers that occur at the interfaces between settings, services and health care professionals. Advance Care Planning should be a part of routine health care and GPs can play a guiding role in this process. Consultation highlighted the need for more effective doctor-patient communication, which is likely to have specific benefit (such as patients being more likely to adhere to treatment, have better outcomes and express greater satisfaction with treatment). Education for families, carers and RACF staff in end of life care and support during difficult times, has also been raised by stakeholders.
Vulnerable populations ***People who are homeless or at***	Access to primary health services - ongoing need for outreach services	Homeless people encounter substantial barriers to accessing mainstream primary health care services, including long waiting times, inflexible scheduling and inadequate service options. Poor access can lead to delayed clinical presentation, increased reliance on emergency departments and higher rates of hospitalisation, often for preventable conditions.

Outcomes of the health & service needs analysis		
risk of being homeless		
People experiencing domestic and family violence	A more pro-active role of GPs in screening, risk assessment and referral and a need for information and training	According to the ABS Personal Safety Survey 2012, in the 12 months prior to the survey, around 8,900 ACT women had experienced some form of violence; 6,900 had experienced physical violence and 3,200 had experienced sexual violence Key themes in the Domestic Violence Prevention Council Report (2015): - clinicians can miss domestic violence as they tend to be very focused on symptoms and interventions and some clinicians are hesitant about asking questions as they are unsure about what they can do and to whom they can refer - there is a need for information on domestic violence and skills development on how to talk to clients, how far to go to elicit more information, what to do with disclosures, when to refer, who to refer to and how far to go with the client.
CALD populations / Refugees	Lack of interpreters and bilingual staff and need for their appropriate use	Use of interpreters is essential in facilitating access to care and delivering quality of care. Low levels of English proficiency and access to qualified interpreters is a systemic problem compounded by providers reluctant to use interpreter services and/or insufficient interpreters for certain language groups.
	Health literacy/language barriers	Language barriers impede access to healthcare, can compromise quality of care and may increase the risk of adverse health outcomes among patients with limited English proficiency. People with inadequate health literacy have limited ability to search for and use health information, make informed decisions or maintain their basic health. Research demonstrates that there are strong correlations between low health literacy and less healthy behaviours, poorer self-management of chronic conditions, higher rates of hospitalisation, difficulty communicating with providers and poorer health status in general.

Outcomes of the health & service needs analysis		
		A culturally competent health care system is essential to improved health literacy in CALD communities.
Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) population	Lack of LGBTIQ inclusive referral options and access to a health service sector which can often be very heteronormative	Consultation undertaken by Health Care Consumers' Association in 2013 highlighted that the search for an appropriate GP becomes crucial for LGBTIQ consumers as the GP needs to possess both adequate knowledge and sensitivity to assist them in treating/managing their condition and navigating through the system. Consumers stated that for transgender people, the GP is the gatekeeper to the very first elements of their transition, usually access to hormone therapy.
People exiting prison	Access to high quality, well-coordinated health care	People in prison experience increased rates of mental illness, substance abuse, and chronic and infectious disease. These populations are also frequently adversely affected by socioeconomic risk factors for poor health, including lower educational attainment and higher rates of poverty. Given this, such populations are in clear need of significant health services. Particularly upon release from prison, former inmates may require substantial assistance in securing health care access. In the ACT, a lack of bulk-billing GPs creates a barrier for this population, as well as transportation and location of services, which can limit access to health facilities. Accessing health care post-imprisonment requires reapplying for a Medicare number as Medicare cards are frozen when a person enters prison. This creates an additional barrier to addressing health issues while managing competing priorities of re-establishing housing, employment and relationships with family and community.
People living with blood-borne viruses	Prevention, detection and treatment services of hepatitis B and C	Hepatitis C virus (HCV) and hepatitis B virus (HBV) are strongly linked with liver cancer, which is the only common cancer where mortality rates have increased between 1982-2017. The number of people living with chronic hepatitis C in the ACT in 2016 has been estimated at approximately 3,600. There is no vaccine for hepatitis C and previous infection does not provide

Outcomes of the health & service needs analysis		
		immunity to reinfection. However, new direct-acting antiviral (DAA) treatments for hepatitis C, with a cure rate around 95%, are now available on the Pharmaceutical Benefits Scheme (PBS) and have become more accessible to people living with hepatitis C in Australia. Data suggest the ACT has a much higher rate of specialist DAA treatment compared to GP treatment, than the rest of Australia. Hepatitis B disproportionately affects often already marginalised populations such as migrant communities, Aboriginal and Torres Strait Islander people, people with a history of injecting drug use and men who have sex with men. Hepatitis B is under-diagnosed and under-treated, with estimates that approximately 38% of people chronically infected with hepatitis B are undiagnosed, and only 6% in the ACT are receiving treatment for their condition. Timely diagnosis and clinical management, including antiviral therapy, can prevent chronic hepatitis B related deaths from cirrhosis and liver cancer. Regular training, education and continuing professional development are needed to support GPs and other health care providers to deliver quality prevention, detection and treatment services. Ongoing education, training and professional development is essential, given growing service demand and constantly evolving treatment modalities.
	Testing and treatment of HIV by GPs	About half of all people living with HIV in Australia are managed predominantly by GPs. GPs play a vital role in HIV care, particularly in early diagnosis and support of patients to remain in long-term care. Early diagnosis of HIV infection is important so that patients can be offered timely monitoring and treatment to prevent immune suppression and resulting complications. As well as the individual benefits of early treatment, the reduced risk of transmission of HIV to sexual partners is an additional consideration. People living with HIV will require regular and consistent monitoring throughout their lives. Patient education, support and adherence to treatments should be encouraged and provided at every monitoring visit.

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		Many GPs have little or no contact with people living with HIV so the traditional model of referral to a specialist for HIV care is appropriate. There is evidence that many GPs have a poor knowledge of HIV testing and treatment. For people with HIV who wish to maintain contact with their regular GP who is not a prescriber, there is often a shared care arrangement with doctors at the Canberra Sexual Health Centre.
Families with complex health and social care needs	Need for better coordination of services for families with complex health and social care needs	A family may be experiencing a number of issues relating to poor mental or physical health, financial hardship and finding support for a child with disability. This will involve contact with multiple services and a wide range of providers, usually on a long-term basis, and their care often becomes fragmented. There is often a lack of coordination between all the agencies/services involved. This can result in more hospitalisations and lower patient satisfaction. Not only does this place considerable strain on public resources but there is little or no signs of improvement in the lives of these families. For this reason these patients need a dedicated person/case manager who is responsible for coordinating all their health and social care. This coordinated approach may also include a form of case conferencing for all identified agencies. No case conferencing is available as there is no longer funding for this from NDIS.
	Identification of families with complex needs	It is crucial to identify families with complex needs and to assess the characteristics, needs and wants of the family prior to intervening. It is also important to gather information about a family from both the family themselves and other sources where possible (e.g. other service providers or case notes) and to identify and meet immediate needs for practical support and access to other services.
	GP advocacy for families with complex needs	The GP plays a key advocacy role for all patients and helps them access the care they need in an increasingly complex system. This advocacy role is particularly important for families with complex health and social care needs. The advocacy role of the GP includes: • helping the patient and/or family to take an active part in the clinical decision-making process

Outcomes of the health & service needs analysis		
		• working with government, non-government and private organisations to maximise equitable services to all members of the community • for disadvantaged/vulnerable patients, the GP is ideally placed to facilitate their access to other services and assist them in navigating the health and social system
Aboriginal and Torres Strait Islander health	Social, emotional and cultural wellbeing	In ACT, almost one third of Aboriginal and Torres Strait Islanders reported having a high level of psychological distress and the percentage is 3.4 times higher than the non-Indigenous population. The ACT rate of hospitalisation for principal diagnosis of mental health related conditions is 2.3 times higher than the non-Indigenous population. The Aboriginal and Torres Strait Islanders in ACT accessed the community mental health services at a rate 2.6 times higher than the non-Indigenous population.
	Difficulty accessing non-Aboriginal and Torres Strait Islander-specific services	Indigenous patients and families experience barriers when trying to access mainstream primary health care services (i.e. non-Aboriginal and Torres Strait Islander-specific services), including: - Long wait times - Lack of bulk-billing in the majority of practices - Lack of information about which practices are "incentivised" to provide primary care to this population group - Lack of transport Some GPs may not provide the types of services required by many Aboriginal clients with complex needs, resulting in clients needing to travel some distance for appropriate services.
After Hours	More cost-effective deployment of after hours primary care resources for urgent care – enhancing primary care and ED integration	Significant resources are provided by governments for after hours care but could be more effectively targeted and integrated, particularly for urgent care.

Outcomes of the health & service needs analysis		
		It is clear that whatever services are put into place in the community sector, EDs are still going to be places that patients will visit for a variety of reasons, particularly as a "one stop shop". There is emerging evidence that integration of GP models with EDs produces good outcomes at both system (better utilisation of expensive ED clinicians, less diagnostics, more direct connectivity to primary care homes) and patient (less waiting, more appropriate match of clinician to problem, maintains primary care connectivity) levels. In the ACT the Canberra After Hours Locum Medical Service (CALMS) infrastructure is already in place which may be able to sustain a more integrated model, but to date insufficient integration between EDs and CALMs has occurred It may be desirable also to assess the feasibility of diverting 0-4 year old primary care type presentations away from ED, therefore creating a primary care focused paediatric streaming service that would provide for quicker and more appropriate throughput of 0-4 year olds.
	More cost-effective deployment of after hours primary care resources for urgent care – enhancing primary care and ambulance service integration	There are significant examples in both Australia and overseas around initiatives that successfully integrate ambulance services with primary health care services which have significantly decreased unnecessary transport to ED and have provided a more appropriate system response to match the patient's condition. Patients with minor illness and injuries, who are able to be treated by a paramedic at their own homes (or in RACFs), are less likely to be transported to ED or need hospital admission within 28 days. There are potential savings to be recognised given the high cost of ambulance services and subsequent treatment in ED.

Outcomes of the health & service needs analysis		
		There is sufficient evidence about the efficacy of integration of ambulance services into primary health care networks to more effectively support more appropriate after hours service provision to warrant further investigation of the options.
	Residential Aged Care Facilities & elderly housebound patients – lack of rapid access to GPs in After Hours period	RACFs have reported difficulty in accessing GPs during the after hours period, particularly for rapid responses for deteriorating patients. No acute care rapid GP response service exists in the ACT. MBS data indicates a low per capita number of RACF GP visits in the after hours period compared to the Australian average. Evidence shows that the elderly have higher rates of ED re-presentation, admission to hospital and inferior clinical outcomes after discharge from ED. Strategies which allow the population to be treated where they are, rather than being transported to hospital, are important when considering this elderly cohort. There are international and local examples of extended paramedics, or 'see and treat' models, or GRACE models, which have been effective in improving patient outcomes and reducing hospital admissions.
	Limited access to diagnostic services	Limited access to diagnostic services such as radiology and pathology during the after hours period (particularly co-located with general practice). The awareness of this within the community results in people choosing to attend ED as a "one stop shop" rather than having to visit numerous providers.
	Limited awareness of After Hours services	Data from a 72 hour ED snapshot survey undertaken by ACTML in 2013 shows that when respondents were asked about their knowledge of after hours services available, there were significant gaps (i.e. fewer than 50% of participants were aware of extended hours general practice).

Outcomes of the health & service needs analysis		
		The Health Care Consumers Association have identified 'navigating the system and identification of the right service for the consumer's needs' as a significant barrier to access in the ACT. International literature suggest that a patient's perception of urgency is a key part of the decision making process when choosing where/how to access care. Drivers of health care seeking behavior vary between population groups. Initiatives need to be targeted at providing the right care, at the right time to the right patient, even if they are in the 'wrong place'. The perception of urgency can often negate awareness raising campaigns due to heightened anxiety and stress levels during periods of illness. While the evidence about the utility of community awareness campaigns is marginal at best, there is very little evidence about segmented targeting of various population cohorts within the market, nor the impact of new forms of social media on this. Targeting parents of 0-4 year olds and the 18-24 year old cohort via social media may be worthwhile.
Workforce	Need to support sustainable primary health care workforce supply including providing increased support for new graduates	Changing nature of primary care influenced by ageing population, marked increase in chronic diseases, increased use of telemedicine, more informed consumers. Increased need for team based care and care coordination. Fall in average hours worked by GPs and increased female workforce participation. Increased pressure on practices for training places for medicine, nursing and allied health disciplines.

Outcomes of the health & service needs analysis		
		Lack of a structured program to support graduate nurses entering general practice. Lack of support to coordinate allied health student placements in ACT practices. Limitations to GP infrastructure to accommodate growing team numbers. Uneven distribution of the GP workforce. Move towards health care homes / patient centred medical homes will require new roles (e.g. Medical Assistants) and redefinition and rethinking of existing roles (e.g. expanded role for Practice Nurses).
	Increased demand for more complex multidisciplinary primary care services	There is a growing burden of chronic disease in the ACT which has resulted in an increasing role for general practitioners in conjunction with other health care practitioners to deliver multidisciplinary team based care. Multidisciplinary care provides a more diverse range of skills and experience than care delivered by a single provider and its importance in chronic care has been well established. The multidisciplinary team requires specific skills in coordination and continuity of care and clinical team leadership, in order to meet the comprehensive needs of patients with chronic and complex conditions.
	Need for more integration with allied health providers, including peak organisations	Anecdotal reports that there is a need for better coordination and communication between general practice and allied health providers, in particular relating to chronic disease care plans. The very low rate of chronic disease management item numbers, including Team Care Arrangements, claimed in the ACT, indicates that there is a need to improve integration and communication between general practices and allied health.

Outcomes of the health & service needs analysis		
Digital Health	Need for increased support and information for health providers around digital health	The use and availability of technology in health care is increasing exponentially, and has the potential to significantly improve patient and provider experiences, as well as patient outcomes. However the rapid pace of change means that health care providers will need support and education to be able to keep up with new technology requirements and opportunities. New and emerging technology has the potential to, among other things: • Improve service efficiency • Improve patient access • Improve patient health literacy and activation (e.g. through consumer apps) • Improve communication between service providers • Improve patient/provider communication; and • Improve quality and safety of care
Chronic conditions	The identification of individual levels of activation and the education of consumers and carers using principles of health literacy, teach-back, self-advocacy and self-management and decision support	Tailoring patient care in line with their measure of activation to improve their health and lifestyle can be used to reduce health inequalities and deliver improved outcomes, better quality care and lower costs. Measurement of patient activation, levels of health literacy and the ability of individual to self-manage is not routinely conducted. Target populations include: people of low SES status, marginalised and disadvantaged communities (i.e.: those at risk of developing a chronic condition). Patient activation through enhanced health literacy is considered a primary preventative and quality and safety measure (NSQSH). 60% of Australians aged 15–74 years do not have adequate health literacy (circa 45% of ACT pop). Low health literacy is associated with less healthy behaviours and poorer health status, higher rates of PHC utilisation, avoidable ED presentation and hospitalisation, and increased health care cost.

Outcomes of the health & service needs analysis		
		Patient activation measurement and tailored health literacy and self-management initiatives in the ACT are limited. The now defunded HCCA Health Literacy for All program demonstrated greater understanding of health system and 71% increase in confidence to self-manage personal and family health. The ACT has a range of self-management and health coaching (i.e. behaviour change) and supported decision making programs for people with chronic conditions and disability spanning public and private health systems. However, there is limited awareness of these amongst consumers and clinicians; eligibility criteria and access routes are unclear; programs are not integrated into care planning nor health pathways. Educated and empowered consumers achieve better health outcomes, reduce demand on both primary health care and hospital services when, the culture is supportive, consumer centred education programs and supports are fully integrated into the CD management system and ongoing therapeutic relationships established with a single health care provider responsive to multiple patient needs (e.g. GP).
	Increasing the capacity of general practice – early identification, assessment and intervention	Advanced or high performing general practice is the foundation of an effective and efficient health care system. Evidence confirms that patient centred medical home initiatives (encompassing voluntary enrolment) have the potential to: increase consumer satisfaction and health outcomes; reduce health care costs associated with unnecessary use of ED, hospital and specialist services. (Note: most frequent avoidable ED presentations and hospital admissions relate to diabetes, heart disease, COPD and mental illness).

Outcomes of the health & service needs analysis		
		The QiData initiative strengthens general practice ability to identify those at risk of poor health outcomes and enhance quality and safety through appropriate call/recall (i.e. CD screening, assessment and management) capability. Timely diagnosis and treatment – see *Whole of System.* (Issue: TCPH wait lists and times).
	Need for shared, coordinated comprehensive person-centred care	Ineffective management of chronic conditions leads to poorer health outcomes and higher costs. 12.9% of GP-attenders are responsible for 41% of Medicare expenditure. High users tend to have more chronic conditions, lower levels of health literacy and greater levels of disadvantage than low-attenders and they need multi-disciplinary and coordinated care to address health needs. In 2014-15, ACT had less than half the national services per 100,000 population for Medicare GP Management Plans (GPMPs) (47%) and Team Care Arrangements (TCAs) (47%) and review of GPMP/TCA (44%), the lowest rate in Australia. CDM podiatry and physio referrals are at 24% and 26% of the national per capita rate. Chronic disease management is complex and multifaceted: many consumers requiring multiple, contingent and/or complementary services, spanning a complex and disconnected health system. Health systems are stronger if they are more comprehensive, coordinated, community focused, universal, affordable and person/family oriented:

Outcomes of the health & service needs analysis		
		- Both shared care and care co-ordination are critical components of all best practice chronic care arrangements and advanced primary health care. - A consistent approach to clinical care protocols and pathways for specific chronic diseases can make a real difference to health outcomes (e.g. Heart Failure and Respiratory Disease) - Responsive step up/step down capability spanning PHC/Community/Sub-acute (re-ablement and rehabilitation)/Acute and specialist services achieve better health outcomes - Digital technology, electronic health records and information sharing tools are key system enablers - enhancing service quality and safety, reducing duplication and waste - Person focused and integrated care spans holistic health and social care needs of individuals
Chronic pain and pain management	Model of Care	Chronic pain is pain that lasts beyond the time expected for healing following surgery or trauma or other condition. It can also exist without a clear reason at all and is a symptom of an underlying health issue. Approximately one in five Australians suffer chronic pain, with the prevalence rising to one in three in people aged 65 years and over. It is more common with increasing age, with prevalence peaking in the 65-69 year age group for males and in the 80-84 year age group for females. Women are more likely to experience pain than men. Chronic pain is strongly associated with: • increased hospitalisation and a high level of GP visits and ED presentations • markers of disadvantage - treatment and management options need to be affordable.

Outcomes of the health & service needs analysis		
		Some forms of chronic pain (e.g. pain associated with severe osteoarthritis) may be treated with therapy which may include medication or surgery; however, other types of chronic pain, such as neuropathic pain or migraine, may be far more difficult to diagnose and treat. The vast majority of people living with chronic pain can be managed in the community if appropriate and timely diagnostics, services and supports are provided in PHC and community settings. The current Model of Care is predominantly specialist focused with pain management services centralised on the Canberra Hospital setting. There is currently a significant wait for specialist services (often above the recommended wait times) and an increasing demand for services. Feedback from consultation suggests the current model of care is unsustainable and consideration should be given to alternative PHC and community based approaches, integrated and team based models of care.
	GP Education and PHC capacity	GPs play a fundamental role in the diagnosis and management of chronic pain and practice nurses have a key role in ongoing management and care coordination. Consultation suggests that GPs and PHC practitioners would benefit from enhanced education and capacity building opportunities.
	Health Pathways	If pain cannot be managed in a PHC setting, specialist services may be warranted. Whilst multiple Health Pathways have been developed consultation suggests: there appears to be limited knowledge and application of these; determining which specialist or service to refer to can often be challenging; however if applied, Health Pathways could be utilised to inform clinical decision making, enhance the quality of referrals and accelerate referral processes.
	Opioid prescribing changes	From 1 February 2018 medicines that contain codeine will no longer be available without a prescription. Chronic pain sufferers who are self-medicating will need to consult with their GP to

Outcomes of the health & service needs analysis		
		be prescribed codeine. Whilst a warranted patient safety initiative this may lead to an increased demand on both general practice and specialist services and in specialist demand, with GPs referring to specialists for expertise on pain medication management.
	Limited access to self-management programs in the community	Early access to tailored self-management programs are crucial to the success of pain management. While specialist services (both public and private) run self-management programs (with potentially considerable waiting times) there are limited primary intervention self-management programs available in the community.
Disability	Need for education and support in relation to GP knowledge around the NDIS	GPs may not always be comfortable undertaking the NDIS assessment for a patient and may refer to a specialist, which increases cost. If GPs don't describe the 'impact on daily function' sufficiently on a patients NDIS access request form, it may not be approved. There is a perception in the community that a doctor is required to complete the assessment form, however, other clinicians can complete the evidence required on the NDIS forms (and may be more equipped to do this in regards to knowing the patient and the impacts on their daily function). As at 31 December 2016, 752 (10.6%) of NDIS access requests made in the ACT were deemed ineligible. Some of these are due to insufficient GP descriptions. Only 20% of ACT plans were approved within 90 days of an access request being submitted during the third quarter of 2015-16. Early identification and intervention in child development is vital - any delay applying for an NDIS plan, along with the long time it takes once an access request form is submitted to when services begin, can be critical in child's development. GPs need to be aware re whether or not their patient has an NDIS plan, and if it is self-managed (and a patient can see any provider) or if it is agency managed (and a patient can only see registered providers). GPs also need to be aware of who the NDIS registered providers are. The ACT has the highest rate of self-managed plans (15%) of all trial sites, and the second highest rate of combination managed plans (48%) and the lowest rate of agency managed plans (37%).

Outcomes of the health & service needs analysis		
		GPs could play a big role in helping and supporting patients and families to navigate the NDIS system.
	People ineligible or who choose not to transition to the NDIS	If a person is deemed ineligible for the NDIS there is a degree of suffering and stress involved. If it was due to an insufficient description of impact on daily function, it might take quite a while for the individual to gain the confidence to apply again. Clinicians also feel frustrated after putting time and effort into completing the form. Health workers and consumers need the knowledge and support about what services are available to those people who aren't eligible for the NDIS. Vulnerable families have a high level of association with the health system and with Care and Protection Services so these services (including GPs) could help in this space. Implications for the health system - some people may not be able to access mental health care (due to cost) or there are issues of people presenting to ED because they can't afford other care. Those aged over 65 years cannot access NDIS and rely on My Aged Care, which provides less financial support. Refugees and those on visas are not eligible for the NDIS due to their visa status.
	Access to allied health services	Allied health services are experiencing high demand and long waiting lists. There are limited NDIS registered services for some domains (e.g. physiotherapy, psychologists, speech pathology, OT). Some allied health providers aren't registering as NDIS providers as they believe they would be financially worse off, or they are registering and then deregistering, allegedly because of the loss of potential income and the undesirable processes that come with the NDIS. Cost and physically getting to the provider can be major access issues for people.

Outcomes of the health & service needs analysis		
	Child development and early intervention	Speech (language and communication) is the most common issue seen at the ACT Child Development Service. Many of the challenging behaviours exhibited by students at school have a much longer history, often developing in early childhood, before starting school. To minimise the negative impact of these issues on children's behaviour and development, appropriate interventions must start as early as possible (e.g. at the time of their recognition or diagnosis). Supports offered should be tailored to meet the individual needs of children and should be available early, when help is most likely to be beneficial. It is very difficult to target vulnerable children and get them to transition to the NDIS. There are many reasons why families are not transitioning to the NDIS: not aware of additional services that may be available to them (e.g. respite), overwhelming or stressful, misinformation (e.g. lose Centrelink entitlement), fear that the data will be shared with Care and Protection, mistrust of Government etc. Even once some participants have been approved for a plan, it is overwhelming to begin and choose their own services, and therefore they may not be using their funding allocation.
	Child and adolescent mental health (also see Mental Health section)	Data suggests that the prevalence of mental health disorders in Australian young people and their use of services for these problems has significantly increased between 1998 and 2013-14. These mental health disorders can impact on functioning at school, with family and friends and personal distress symptoms. Adolescents are almost three times more likely to experience a severe mental health disorder compared with 4-11 year olds. There has been an increase in the number of children (0-12 years) referred to early intervention programs in the ACT.

Outcomes of the health & service needs analysis		
		ACT has the highest dispensing rate of antidepressants in Australia, for adolescents up to 17 years.
Early Childhood, Middle Years and Youth	Healthy growth and development	Childhood overweight and obesity impacts around 26% of ACT children in the 5–17 year age range and this figure has remained relatively stable between 2007 and 2014. While rates of overweight and obesity in children have remained reasonably stable, significant numbers of children will continue to be at risk of developing serious disease and chronic health conditions in adulthood if action is not taken early in life to prevent childhood overweight and obesity. According to the Australian Early Development Census (AEDC) results, 1,161 (23.2%) kindergarten children in the ACT are developmentally vulnerable in one or more domains. Belconnen saw the greatest rise in developmental vulnerability in each of the domains between 2012 and 2015, with 327 (25.1%) of children developmentally vulnerable in one or more domains.
	Identification of children in their middle years in primary health care and the issues associated with this	Primary health care professionals need to be aware of issues that are associated with children in their middle years, including the challenges that puberty and transitioning to high school can bring. Young people in marginalised groups are at higher risk of poor wellbeing. This includes young people with disability; LGBTIQ young people; young carers; materially disadvantaged young people; Indigenous young people; culturally and linguistically diverse young people and young people in out of home care. Early identification of mental health issues and healthy growth and development are the most important issues in this period of childhood.
	Identification and management of vulnerable children and youth (and their families) in primary health care	At 30 June 2016, there were 748 children (0-17yrs) in the ACT in out of home care. Children going into care have usually suffered abuse and neglect and have problematic health issues so need an engaged and effective GP. Children in out of home care are more likely, in the

Outcomes of the health & service needs analysis		
		long term, to have poorer health, lower education, increased mental illness, have children earlier and increased risk of their children being in out of home care. Aboriginal and Torres Strait Islander children are over represented in out of home care in the ACT, accounting for 27% of the children in out of home care, but less than 2% of the total population. Vulnerable children can be identified by schools, MACH Nurses, GPs, Community Health Centres and Child and Family Centres. GPs are a critical source of information, referral and support to parents who have limited financial means and who are raising young children on their own. However parents can have difficulties accessing appointments and finding a GP, particularly a GP who bulk bills. Due to the time constraints of a 15 minute appointment, referrals to other support services are often not forthcoming. Research indicates that isolated families access the universal service system (Centrelink, Health, Housing, Education and Child Care). It is after this contact that parents seem to fall through the cracks, often failing to get information or referrals to targeted and intensive support systems designed to help them. Embedding supported linking practices across the service system will greatly increase the ability of targeted services to make contact with families whom those services have found 'hard to reach'. GPs could play a more proactive role and connect parents to formal service support systems.
	Access to mental health services in a timely manner	Access to mental health services is one of the biggest issues faced by children and youth in the ACT, in particular, vulnerable children, such as those in out of home care and child protection. It is the biggest issue faced by vulnerable children in Tuggeranong. There are long waiting lists for counselling even though there are many programs running (particularly through Child and Family Centres).

Outcomes of the health & service needs analysis		
		There is a lack of service availability for children with mental health issues (and their parents). This includes psychologists as well as community-run mental health assistance. People are being discharged from the mental health unit into the community with no follow-up.
Carers	Identification of carer needs in primary health care	Approximately one in eight (44,800) ACT residents provide unpaid care for a family member or friend. Four in five carers report below average wellbeing, with carers in Australia reporting the lowest personal wellbeing of any large population group. Carers often ignore their own health and are 40% more likely to suffer from a chronic health condition. Many carers are chronically tired and desperately need to refresh with just one night of unbroken sleep, a day off or an extended period with no caring responsibilities. As a population group, carers generally have a lower income and a lower standard of living than other population groups in Australia. This means that carers are at-risk of poor health and wellbeing due to the social and socioeconomic determinants of health. Providing carers with the opportunity for their own health assessment (e.g. blood pressure, stress levels, physical injuries related to caring, and management of chronic health conditions) could positively assist carers health and wellbeing. Carers are likely to feel better supported if they can access health professionals who ask about and help them manage their own health needs.
	NDIS and carers	Some carers struggle to understand and therefore embrace the NDIS (e.g. unclear language, inadequate communication with carers about what to expect etc.) Many carers don't feel prepared when the person they care for first applies for the NDIS, and even after receiving a plan many have little or no understanding of the NDIS. While the NDIS relies heavily on carers, through the NDIS there is no formal assessment of carers' needs, no funding package for carers

Outcomes of the health & service needs analysis		
		and no guarantee of involvement in the assessment of the care recipient's needs. There is a potential loss of funded supports for carers, particularly when the person they are caring for isn't eligible for the NDIS. There are health consequences for carers due to the stress associated with the NDIS (services not being provided; people not eligible). A survey conducted by Carers ACT found the NDIS had not improved outcomes for many carers in the ACT, for example, 63% found their time spent managing the support needs of the person they cared for had increased.

Mental Health

Outcomes of the health & service needs analysis		
Priority Area	Key Issue	Description of Evidence
Mental Health	Early intervention in life; in illness; and in episode - Lack of appropriate, evidence based early intervention and prevention services - Barriers to accessing early intervention services - Lack of mental health promotion activities including stigma reduction, early intervention and referral pathways, particularly for vulnerable groups	Early intervention promotes more effective recovery, and can reduce the duration of an illness and decrease the negative impact of mental illness on people, families and the community over the course of their life. Prevention and early intervention can also reduce the need for hospitalisation and inpatient facilities. Stakeholder feedback has highlighted the importance of a focus on appropriate, evidence based early intervention and prevention based services for those suffering from a mental health disorder.

Outcomes of the health & service needs analysis		
	- Access barriers to services for early in illness due to imposed eligibility criteria - Access barriers to early intervention services for children 8 to 12 years with symptoms of high prevalence disorders, in particular anxiety - Access barriers to affordable or free psychological assessment services for children under the age of 12	Stakeholders highlighted the need for an increase in mental health promotion activities for the community, as well the role GPs can play in promoting online mental health resources to all patients who present with mental health symptoms. Stakeholders stated that mental health consumers often struggle to access appropriate services early in illness and episode due to eligibility criteria, for example ATAPS and ACT Health services. Stakeholders identified the lack of resources and capability to support families, carers and peers to access early intervention services, including description of services and referral pathways. Stakeholders highlighted the importance of addressing anxiety and depression symptoms before high school for the 8-12 year old cohort. It was identified by stakeholders that this cohort experience access barriers to early intervention services including lack of teacher/school awareness of mental health conditions and referral pathways, lack of school counsellor capacity, high demand and lack of capacity for child and family based services, including Cool Kids and Worry Busters. Through the ACT Primary Health Network Mental Health Centralised Intake and consultation with stakeholders, the need for affordable assessment services for children under 12 has emerged. GPs and School Counsellors are often seeing children under the age of 12 that require a psychological assessment from a suitably trained and experienced mental health professional, but have limited referral pathways for parents who cannot afford to pay for assessments to be completed privately. Parents cannot access these types of services for their children through Better Access, which only focuses on the provision of focused psychological strategies.
	Physical Health	There is strong evidence to indicate that people who experience severe mental ill health have poor physical health outcomes. This is the result of a lack of physical care at the right time and

Outcomes of the health & service needs analysis		
	- Lack of awareness of the physical health outcomes for people experiencing severe mental ill health - Lack of General Practitioners willing to manage people with mental ill health in the community - Lack of public transport to access physical health services - Issues for people with financial barriers to gaining treatment to see a GP and being able to pay for scripts and tests - Lack of specialists with skills to work with disabilities, such as mental health professionals for deaf clients - Lack of mental health screening for people with chronic physical conditions and disabilities	side effects of psychotropic medication, often leading to chronic diseases such as Type 2 Diabetes and Cardiovascular Disease. Stakeholder feedback has highlighted the importance of improved awareness of Metabolic Disorder, education for GPs and the importance of people who experience mental ill health having a regular GP in the community. Stakeholders stated that mental health consumers with financial barriers to gaining treatment experience barriers to accessing GPs and being able to pay for scripts and tests. Stakeholders highlighted the need for mental health screening for people with chronic conditions and disabilities, as 49% of people with disabilities have a mental health condition.
	Services for moderate to severe presentations - Lack of services focusing on psychological interventions for people with moderate to severe presentations	Lack of services focusing on psychological interventions for people with moderate to severe presentations, who require more than 10-12 sessions with a mental health clinician in a calendar year. Stakeholders highlight need for better primary mental health care services, following a stepped care model with low intensity through to high intensity services.

Outcomes of the health & service needs analysis		
	- Lack of integration between primary mental health care services and tertiary services - Lack of integration with non-clinical services, including psychosocial based support services and other services to address mental health consumer needs across the social determinants of health including vocational support, education and housing. - Lack of integration with My Health Record - Lack of psychosocial support for people with severe and complex mental health	Stakeholders highlighted need for better integration between primary mental health care services and tertiary services and stepping up and down between these, and for these services to have a holistic whole of person focus. Stakeholders identified the need for services to upload information to My Health Record so mental health consumers can easily share their information.
	National Disability Insurance Scheme (NDIS) – Psychosocial Disability - Uncertainty surrounding system capacity to support people who are not NDIS eligible - Lack of GP awareness in regards to NDIS and the access, pre-planning and planning process	With the commencement of the Psychosocial Disability component of the NDIS in the ACT, stakeholders have expressed uncertainty in regards to future system capacity to support those who are eligible for Psychosocial Disability Packages of care through the NDIS and for those who are not. Stakeholders have highlighted the importance of the need for a continuing care coordination service for those with severe mental ill health who do not transition to the NDIS. Stakeholders have expressed the need for GPs to be educated around the NDIS, including provision of documentation for package planning. More broadly, stakeholders have identified that the existing workforce lack specific skills in working with NDIS clients, in particular when clients experience comorbid developmental disability and mental health issues.

Outcomes of the health & service needs analysis		
	- Lack of care coordination services for people who do not transition to NDIS (ineligible or non-consenting) - Lack of skilled workforce, for example, experience in working with comorbid developmental disability and mental health issues - Lack of resources for complementary services (e.g. social activities, recreation options, school holiday activities and after school activities) - Lack of support services and psychosocial rehabilitation for people with packages - Lack of delineation between state and federal government funded programs, leading to an uncoordinated response - Lack of support for carers who are under increased pressure in navigating a system that is new - Reduction in scope of support services, NDIS does not meet the range of needs supported	Stakeholders have stated that as a result of a transition of NDIS that there is a lack of support services and psychosocial rehabilitation for people with packages. Poor delineation between federally funded and territory funded programs was identified by stakeholders, who feel that there is not a coordinated response in the ACT. Stakeholders have expressed growing concerns with regards to future system capacity to support both those who are eligible for Psychosocial Disability Packages of care through the NDIS and those who are not. Stakeholders highlight that the NDIS does not deliver the intensity or range of supports available through previous mental health programs, including in the area of psychosocial rehabilitation. Stakeholders have highlighted the importance of continued access to a range of supports, including care coordination services, for those with severe mental ill health who do not transition to the NDIS. This includes current service participants as well as those yet to develop the need for or access services. A number of community-managed mental health services and programs have now ceased to exist. Stakeholders identified the following gaps: ○ Psychosocial rehabilitation services ○ Peer support and mentoring ○ Medium term high intensity daily living supports and capacity-building ○ Low intensity daily living supports and capacity-building (for sustained and continuing recovery) ○ Recovery-oriented independent living supports ○ Recovery-oriented recreational & social supports, including group programs ○ Care coordination services

Outcomes of the health & service needs analysis		
	by previous programs and services leading to service gaps, including in psychosocial rehabilitation. NDIS participants require access to mental health supports in areas not covered by the NDIS.	○ Mental health specific employment support services ○ Vocational rehabilitation and training ○ Support for carers who are navigating a new system
	Vulnerable populations - Lack of specialist multidisciplinary services for Transgender population - Barriers to accessing services for people who are homeless or at risk of homelessness - Lack of trauma informed care - Access barriers for Aboriginal and Torres Strait Islander Peoples - Barriers to accessing services for Culturally and Linguistically Diverse (CALD) communities - Access barriers for people who experience trauma or domestic violence - Lack of early intervention programs for vulnerable groups, such as children who experience domestic violence	Evidence suggests that vulnerable groups experience higher rates of mental ill health. Stakeholders have highlighted the following areas of need: - An increase in the provision of specialist psychiatric support for Transgender population - Increased social awareness for the general community to reduce the stigma for LGBTI communities - Need for more training and support for mental health professionals to work effectively with vulnerable populations; - Connection and referral between other services (particularly improved systems integration and referral pathways between services for vulnerable groups. Stakeholders particularly identified this as a need for transgender people - Improved accessibility and provision of mental health services for people who are at risk of homelessness or who are homeless - An increase in the provision and knowledge of specialised mental health services for refugees, particularly in regards to trauma informed care - Specialist service provision for Aboriginal and Torres Strait Islander People focusing on their social and emotional wellbeing (including mental health) - Lack of mainstream partnerships and integrated referral pathways with Aboriginal community controlled services - Lack of information on and access to bilingual GPs and health professionals - Lack of mental health expertise interpreters, as well as poor continuity in the provision of interpreter services

Outcomes of the health & service needs analysis		
		- Need for more culturally appropriate mental health and health services
	Suicide prevention - Lack of community based support services for people discharged from hospital following a suicide attempt or suicidal crisis - Lack of screening for suicidal ideation within primary care - Lack of primary mental health care services for people with suicidal ideation - Access barriers to existing primary mental health care services, e.g. requiring a GP or Tertiary Service referral - Lack of services to address adverse circumstances that increase risk of suicide e.g. poverty, homelessness, relationship conflicts, exposure to violence and/or abuse, joblessness, lack of education and future prospects - Lack of support/respite for families who are looking after a loved one at risk of suicide	There is currently a perceived lack of support and primary mental health care services for suicide prevention in the ACT. Stakeholders highlighted the following areas of need: - Improved support services for people discharged from hospital following a suicide attempt or suicidal crisis - Improved screening of individuals accessing primary care services, including seeing their GP - Increased access to primary mental health care services for people with suicidal ideation - Increased understanding of referral pathways for people with suicidal ideation who are not at immediate risk of self-harm - Improved ease of access to primary mental health care services and community based services for people with suicidal ideation, for example, self-referral. - Development of additional postvention services and intervention services

Outcomes of the health & service needs analysis		
	- Lack of postvention and intervention services	
	Peer Participation - Lack of meaningful peer participation in service development, implementation, delivery and evaluation - Lack of funding for peer led service models, interventions and peer specific positions	People with lived experience of mental illness offer perspectives that enrich how services are delivered. Stakeholders stated that there is a lack of peer participation in primary mental health in all phases of commissioning. In addition to this stakeholders acknowledged that there were a lack of peer led service models and funding to develop these.

Section 4 – Opportunities, priorities and options

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
Transitions of care				
Lack of consistency in discharge planning processes	• Continued engagement with ACT Health on the review of the discharge planning system, which would include an approach to discharge summaries across all clinical units; a system-wide standard around key performance metrics based on benchmarks with "real time" measurement of these; and	• Patients and primary care teams experience smooth transition between hospital and ongoing care in primary health care settings • Higher degree of efficiency across the whole health sector with a reduction in duplication and time	• Change against baseline measures (2015) for timeliness, accuracy and quality of content in yearly GPLU medical record audits • Change against baseline measures (2015 GP survey) of GP satisfaction with discharge planning	ACT Health

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	an integrated uniform system for outpatient clinic appointments. • *See also chronic care section below*	wasting on following up information and follow-up appointments		
Variable access to outpatient services	• Continued engagement with ACT Health together with the Canberra Hospital GPLU in the development of the Waiting List Reduction Strategy that includes timelines and communication points to primary care referrers; referral clarity and redesign; access for timely specialist advice for GPs; "real time" clinic waiting time information.	• Improved quality and appropriateness of referrals to outpatient services	• Change in quality of referrals against baseline audit measures of completeness of required information in selected clinics	ACT Health
	• Support as a priority the completion of an e-referral module that internal ambulatory care management processes and integrates seamlessly with GP patient management systems.	• Improved communication processes with GPs and patients on access to specialist services	• Seamless integration between all GP desktop systems and e-referral and messaging systems	ACT Health
	• Continued development and promotion of integrated patient care pathways through *HealthPathways*, including facilitating agreement on and supporting system changes to ensure seamless referral in and out of ambulatory services.	• Improved clinician knowledge of the options available to support timely and appropriate patient care management	• Visitation rates on HealthPathways referral pages • Service provider feedback on self-reported usage and satisfaction with HealthPathways (integrated into 2016-17 commissioned evaluation)	ACTPHN
Poor information infrastructure to	• Continued engagement with ACT Health on its current "2020 e-health strategy" to jointly design a joined-up	• Improved communication between clinicians.	• Per capita uptake of TCA MBS Items against ACT and national baseline year data	ACT Health

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
support shared care planning and transition of care	whole of system electronic health record platform that enables seamless patient information transfer and the sharing of comprehensive health records across care teams – including shared care enabling platforms.	• Improved patient transitions between services • Improved health outcomes in the management of chronic complex conditions	• Per capita uptake of allied health CDM MBS Items against ACT and national average baseline year data	
	• Continued support through QiData and practice development team initiatives for improvement in the quality of data entry to support the effective roll-out of My Health Record	• Improved quality of data that is contained in My Health Record	• PDSA data quality outcome measures against baseline in CDM QiData practices	ACTPHN
Lack of knowledge and awareness of community based support services	• Continued development and promotion of integrated patient care pathways through *HealthPathways* incorporating comprehensive information on community based support services.	• High quality local information available to health care providers and clinicians at point of care in a single place	• Service provider feedback on self-reported usage and satisfaction with HealthPathways (integrated into 2016-17 commissioned evaluation)	ACTPHN
	• *Also see HealthPathways community portal below.*			
Older people				
Improving hospital/community care integration	• *See cross-sector CDM model below* • *See GRACE model below*			
Prevention of avoidable ED	• Extension of the ACT Palliative Care Service/Goodwin integrated model of specialist palliative care to additional	• Reduced hospitalisations / inappropriate service use	• Number of RACF residents who are transferred to ED	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
attendances and – End of Life Care	RACFs – model incorporates PC Tool Kit plus Palliative Care Needs Rounds and goal of care discussions. • Completion of Phase 2 of the Enabling a Quality End of Life Journey pilot project focusing on supporting clinicians at health system "touch points" to engage in patient and carer conversations to facilitate ACP take-up and the development of associated pathways • Investigating the introduction of a systematic approach for RACFs in the ACT with a view to establishing a comprehensive ACP program (e.g. NHS Gold Standards Framework). • Development of a Compassionate Communities approach which reorientates the service delivery model towards the integration of community based networks and support structures.	• Increase in the capacity of RACFs to support the demand for end of life care – in preferred place of death	• Number of RACF residents who are transferred to ED and returned to participating RACF without hospital admission • Number of Advance Care Plans completed in participating RACF • Number of RACF residents dying in preferred place of death	
Prevention of avoidable ED attendances	• Commission and evaluate a Geriatric Rapid Acute Care Evaluation (GRACE) type model integrating RACFs, GPs and ED – jointly with Calvary Health.	• Reduction in presentation of RACF residents to ED • Increased supports for GPs with specialist geriatric resources	• Number of RACF and GPs using this service within 6 months of *chosen* MOC implemented • Number of GP/RACF coordinated management plans in place for RACF residents	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
		• Improved patient experience for older patients	• Education and support needs of RACF staff and GPs have been identified and a program is in place to deliver education/support program • RACF resident hospital LOS • Patient and carer experience surveys (developed and implemented)	
	• Assess feasibility of developing a rapid acute response service to support GPs with the management of older patients with mobility or access issues and who may be in danger of rapid deterioration or other adverse outcomes.	• Improved continuity of care for older patients • Reduced avoidable ED presentations	• Market assessment completed	ACTPHN
	• Continue the development and planning for a whole-of-system approach to hospital avoidance for older people – particularly advocacy for specialist aged care resources to be front loaded into ED to ensure that aged related whole-person assessment and care initiated quickly (i.e. Geriatric streaming)	•		ACTPHN
	• The introduction of Geriatric Streaming in EDs. Considered as international best practice this approach ensures services are designed for the most frail and vulnerable and has demonstrated	• Better health outcomes and increased patient satisfaction, higher rates of post discharge independence, fewer		

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	better health outcomes and increased patient satisfaction, higher rates of post discharge independence, fewer representations, lower admission and readmission rates.	representations, lower admission and readmission rates.		
Improved medication management	• Continue undertaking a pilot program to examine the feasibility and viability of establishing a model to pharmacists within general practice with a focus on older people	• An increase in the number of Home Medicines Review and Residential Medication Management Review by pharmacists • The majority of older people taking their medication as prescribed by their health care professional • Reduction in the risk of medication incidents for older people	• The number of Medication Management MBS items (900 and 903)	ACTPHN
Aboriginal and Torres Strait Islander people				
Access barriers for support of social, emotional and cultural wellbeing	• Facilitation of training in working with Aboriginal and Torres Strait Islander People for primary mental health stepped care service workforce	• Improved service provision for Aboriginal and Torres Strait Islander People	• Referral rate of identified cohort - PMHCMDS • Clinical outcomes for cohort - PMHCMDS	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
(ACT Aboriginal and Torres Strait Islander Health (Joint) Forum priority area)	• Development and integration of culturally appropriate psychological interventions, for Aboriginal and Torres Strait Islander people, into the primary mental health stepped care model		• Consumer satisfaction with service - Consumer satisfaction survey • Workforce competency - workforce skills survey	
Difficulty accessing non-Aboriginal and Torres Strait Islander-specific primary care services	• Commission a model of service provision and cultural support to improve access to general practice for vulnerable populations– this model will address cultural sensitivity for Aboriginal and Torres Strait Islander people as well as the difficulties/barriers typically experienced by all vulnerable populations	• Higher level of access to non-Aboriginal and Torres Strait Islander specific primary care and specialist services	• Number of MBS 715 health assessments and follow up rate	ACTPHN
People who are homeless or at risk of being homeless				
Access to primary health services and ongoing need for outreach services for people who are homeless or at risk of being homeless	• Continuation of the primary health care service at the Early Morning Centre (EMC) and assessment of the potential for this type of 'in-reach' model to be expanded to other locations that have concentrations of homeless people	• Provision of tailored high quality access to primary health care services.	• Structured feedback from stakeholders and community in the housing/homelessness sector • Access to MBS services	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	(subject to current feasibility assessment)			
People experiencing domestic violence				
A more proactive role of GPs in screening, risk assessment and referral and a need for information and training	• Facilitate for GPs and other primary health care providers training sessions and skills development • Support GPs in the use of the RACGP White Book, *Abuse and violence: working with our patients in general practice (4th edition)*, a resource developed by GPs and experts • Have developed a suite of domestic and family violence HealthPathways	• GPs, practice nurses and allied health providers well informed about how to talk to clients experiencing domestic violence and play a more pro-active role in screening, risk assessment and referral.	• Structured feedback from Domestic Violence Crisis Service and other ACT services dealing with people experiencing domestic violence	ACTPHN
CALD populations / Refugees				
Lack of access to timely interpreter services and need for appropriate use of interpreter and translator services by primary care providers	• Develop a communication strategy to inform GPs of TIS services, procedures and risks/benefits • Promote Health Pathways Interpreter Services information to GP practices • Explore the potential to develop a toolkit/flowchart for GPs in the ACT based on existing models (e.g. The New Zealand model by Grey et al.)	• A communication strategy and information developed re GP use of interpreter services. Improved use of interpreter services.	• Use of interpreter services by GPs and other primary health care providers (TIS data base) • Feedback from CALD/refugee population in relation to use of interpreter/translator services	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	Develop further information on HealthPathways for GPs regarding interpreter use and processes, including a flow chart			
Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) population				
Lack of LGBTIQ inclusive referral options and access to a health service sector which can often be very heteronormative	• Building visibility of and reducing use of heteronormative approaches to health access, assessment and interventions • The development of HealthPathways in consultation with relevant community organisations	• LGBTIQ individuals have access to appropriate services and health-related information that are non-judgmental and without discrimination • GPs that are well informed about or sensitive to LGBTIQ specific issues or concerns and well educated and equipped to connect LGBTIQ people to supportive services as required	•	ACTPHN
People exiting prison				
Access to high quality, well-	• Establish an out-reach primary health care service, preferably on the north	• Provision of tailored high quality access to primary	• Structured feedback from stakeholders and community in the justice sector	ACTPHN and ACT Health

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
coordinated health care	and south side of Canberra (similar to the model operating for homeless people at the Early Morning Centre). In terms of a south side clinic, negotiations are underway in relation to an outreach clinic at The Canberra Hospital Alcohol and Drug Services – CHN will commission Directions Health Services to provide the primary health care service. Directions also have the contract for a once a week drop-in service (nurse only clinic) at the Needle and Syringe Program (Civic) with once a fortnight in reach to Ainslie Village for opportunistic drop-ins. • Organise an event for GPs and Allied Health Providers to raise awareness about the issues faced by people exiting prison and to develop strategies to address some of these issues in primary care. • CHN has facilitated the development of an MOU between National Health Coop (NHC) and Justice Health which will result in people referred by Justice Health to NHC not being	health care services for people exiting prison	• Access to MBS services	

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	required to pay membership fees. The membership fee was seen as a barrier to access to primary care services for people exiting prison and other vulnerable populations.			
People living with blood-borne viruses				
Prevention, detection and treatment services for hepatitis B and C	• CHN to provide ongoing training and education to support GPs and Practice Nurses to deliver prevention, detection and treatment services for people with hepatitis B and C. • To support GPs to maintain up-to-date information and knowledge of treatments and medications in relation to prevention, detection and treatment services for hepatitis B and C • HealthPathways have been developed for HCV including Hepatitis C Screening, Chronic Hepatitis C, and Hepatitis Counselling and Support. • HealthPathways for HBV are on a prioritisation list to be completed within the next 12 months.	• Provision of ongoing training and education for GPs and Practice Nurses in relation to the prevention and management of hepatitis B and C. • GPs and Practice Nurses well informed about the prevention and management of hepatitis B and C	• Feedback from stakeholders and consumers re GP and Practice Nurse prevention and management of hepatitis B and C	

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
Testing and treatment of HIV by GPs	• CHN to provide education and training to support GPs in HIV prevention, treatment and testing. • Increase the options for testing across a wide variety of environments, including primary, tertiary, allied, community and peer led health care. • The ACT is currently trialling the impact of a pre-exposure prophylaxis (PreEP) preventive drug for those at the highest risk of becoming infected with HIV. The ACT trial will be conducted through the Canberra Sexual Health Centre and the Interchange General Practice. Clinical studies have shown that PrEP, taken daily, can prevent at-risk HIV-negative people from becoming infected. • HealthPathways for HIV are on a priortisation list to be completed within the next 12 months.	• Increased options for HIV testing in the community • A reduction in HIV transmissions in the ACT due to the PrEP trial	• Feedback from stakeholders and consumers re prevention, treatment and testing of HIV by GPs	
Families with complex health and social care needs				
Need for better coordination of services for families	• Support GPs and other primary health care providers to identify families	• GPs and other providers more aware of families and their needs and assisting	• Feedback from consumers/community and providers of services to families with complex needs	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
with complex health and social care needs	with complex needs and refer them to appropriate services • The development of a whole of jurisdiction approach to the sharing of information between relevant providers/services supporting families with complex needs. • Explore the feasibility and acceptability of using a 'care navigator' model based in general practices which can offer people/families help to access the care they need. These could be either support and administrative staff, who are trained to direct patients to the most appropriate care; student volunteers (health leads) connecting families to local resources to meet their needs or a social work service which supports patients in addition to the care provided by the GP.	them to obtain the support/services that they require • Joined-up approaches to supporting families • Well integrated services and supports for these families in addition to GP and Allied Health Provider care, including information sharing and identification of psychosocial, health, social and welfare issues • Appropriate services in place that will prevent patients being admitted or re-admitted to hospital • Patients supported to stay well and in their own homes • Reduced workload for primary care health professionals in supporting non-health needs of patients • Increase in patient's ability to manage their own health	• Feedback from consumers/community and providers • Feedback from stakeholders/providers/consumers	

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
Identification of families with complex needs	• Support GPs and other primary health care providers to identify families with complex health and social needs and refer them to appropriate services.	• Families with complex health and social care needs are referred to appropriate services to meet their needs	• Feedback from consumers/community and providers of services to families with complex needs	
GP advocacy for families with complex needs	• Support GPs to play an advocacy role for families with complex health and social needs to facilitate these families' access to other appropriate services and assist them to navigate the health and social system as required.	• GPs are strong advocates for families with complex needs	• Feedback from consumers/community and providers of services to families with complex needs	
After Hours				
More cost-effective deployment of after hours primary care resources for urgent care – Primary Care Service/ED Integration	• Commissioning a scoping study to develop a proof of concept trial on the integration of primary care and ED to more appropriately and efficiently provide services for lower acuity presentations after hours	• Improved ability to provide the right care at the right time to patients who present to ED unnecessarily.	• Delivery of scoping study.	ACTPHN
Increasing awareness of after hours services (both in the community and profession)	• Design and implementation of targeted marketing through new technologies to two demographics - the parents of 0-4 year olds and 18-24 year olds – using social media and Healthdirect Australia resources	• Higher level of awareness among the parents of 0-4 year olds and young adult (18-24 year olds) demographic of service availability options	• Marketing analytics • Community survey and/or ED snapshot survey to assess awareness levels • Healthdirect usage trends	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	including Healthdirect "find a service" apps and video consultations (e.g. Pregnancy, Birth and Baby Helpline).	• Increased utilisation of Healthdirect help lines		
Aboriginal and Torres Strait Islander appropriate After Hours Services	• Commission the ACT Aboriginal Medical Service to deliver after hours clinics to its patient population.	• Increased access to culturally appropriate primary health care services during the after hours period.	• Activity data from the Aboriginal Medical Service	ACTPHN
After Hours Radiology	• Develop an approach to the market for the provision of innovative solutions to the provision of after hours radiology services in the ACT for primary care providers.	• Better access to radiology services during the after hours period for primary care patients.	• Activity data • GP awareness and uptake surveys	ACTPHN
Ambulance – extended scope/see and treat/referral	• Commission a scoping study to determine the most effective model and business case (including whole of system costing and implementation plan) that would fit the ACT to support the integration of ambulance services into primary health care networks to more effectively and appropriately support after hours service provision.	• Reduction in the number of unnecessary transports to ED • Increase in the treatment of non-urgent presentations at patient location (home, RACF) or with a more appropriate service linked to a person's health care home.	• Delivery of study report	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
Workforce Development				
Need to support sustainable workforce supply	• Engage with local universities to facilitate additional clinical placement opportunities for health care students in primary care. • Develop and manage a structured program for graduate nurses to gain experience in general practice • Engage with local service providers to develop structured programs and systems to support newly graduated allied health care professionals opportunity for employment in primary care.	• Increased opportunities for health care undergraduates to undertake a clinical. placement in primary care • New pathway for graduate nurses to enter general practice with appropriate support and education. Supported post-graduate transition to practice in primary care.	• Change against baseline in the number of students undertaking clinical placements in general practice. • Number of graduate nurses that participate in the program, participant satisfaction and employer feedback. • Change against baseline measures in the number of newly graduated clinicians employed in primary care.	ACTPHN
Increased demand for more complex multidisciplinary primary care services.	• Support workforce capability to deliver high quality care through increased scope of practice and extended roles for primary care professionals to meet the increasing complex needs of consumers. • Support the general practice workforce to provide increased team based and coordinated care.	• Improved access to quality care for people with chronic and complex conditions. • Increased opportunities for interdisciplinary learning for the diverse range of primary care professionals.	• Change against baseline in the number of MBS Items claimed in the ACT for GP management plans, team based care arrangements, and multidisciplinary care plans. • Change against baseline in the number of professional development programs offered across disciplines focusing on building team based skills, knowledge and attitudes.	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
Digital Health				
Need for increased support and information for health providers around digital health	• Provide increased support and information for health providers around digital health developments, including 'patient portal' type systems and health apps.	• Increased uptake of digital health opportunities amongst primary health care services and corresponding improvements in patient access, provider – provider communication, and provider – patient communication and patient health outcomes	• Increase in general practices and allied health practices utilising secure messaging • Number of practices trialling new digital health systems and apps.	ACTPHN
Chronic conditions				
Development of higher levels of health literacy and competence in patients for managing their own health – "activated consumers"	• Scope the application and feasibility of introducing the Patient Activation Measure into PHC, community and hospital based services.	• Understanding of the application and feasibility of introducing the Patient Activation Measure into PHC, community and hospital based services.	• Results and findings contribute to future actions/strategies	ACTPHN / ACT Health
	• Research targeted patient activation measures for a specific chronic disease cohort of patients (i.e. Heart Failure)	• Increased understanding of evidence informed activation measures that could benefit Heart Failure patients	• Results and findings contribute to future actions/strategies	ACTPHN
	• Provide patient education and self-management support as an integral part of the cross-sector chronic	• Increased patients' ability to self-manage their conditions	• Patient education and self-management services and supports integrated into patient pathways.	ACTPHN / ACT Health

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	disease management initiative outlined below.		• Proportion of "enrolled" patients with a chronic condition who have completed (fully or partially) a self-management program • Proportion of "enrolled" patients who report they feel more confident in their ability to self-manage their health.	
	• Integrate supported decision making (for people whose decision making capacity is impaired) information, tools and resources into *HealthPathways* (clinical and consumer portals, as appropriate). (See ADACAS site at http://www.adacas.org.au/decision-support)	• Increased engagement in decisions that are important for people's ongoing health and well-being	• *HealthPathway*s integration (clinical and consumer) of tools and resources • Extent of primary health care workforce education and training	ACTPHN / ACT Health
Increasing the capacity and capability of general practice to undertake early identification, assessment and intervention for patients at risk	• Continue to expand the QiData initiative – support practices to stratify patient cohorts/identify people at risk, develop practice based CDM registers, enhance call and recall (screening, assessment and management)	• Practices are in a better position to provide comprehensive and coordinated chronic disease care to their patients with complex health conditions	• Number and proportion of participating practices /practitioners • Number of practices with 'at risk' registers and/or CDM registers • Number and proportion of CDM cycles of care by practice/target groups in practices - GPMPs, TCA, review - GPMHTPs/reviews - HMR and RMMR	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
Increasing high performing general practice capability across the ACT	• Practice Development Team to support a cohort of general practices to build the systems and expertise to be high performing practices (initially, leadership, data usage, voluntary patient "enrolment", team care)	• General practices are in better position to be truly patient-centred delivering quality care for their patients	• Number of practitioners who participate in the clinical leadership program • Number of practices that participate in the QiData initiative • Patient reported experience	ACTPHN
Increase the capacity and capability of the health care system to deliver coordinated care (including shared care) to patients with complex chronic conditions that would most benefit	• Provide education and practice support on the use of GPMPs and treatment plans (inc. follow-up and reviews) through the Practice Development Team	• Increased use of disease management strategies to improve the quality of care • Increased care planning and multidisciplinary team care arrangements	• Number and proportion of cycles of care by practice/target groups - GPMPs, TCA, reviews - GPMHTPs/reviews - HMR and RMMR	ACTPHN
	• Consider the results of research the cause of the under-utilisation of GPMPs/TCAs and reviews in the ACT and develop a strategy to address any barriers.	• Increased understanding of the current barriers to uptake of allied health services	• Results and findings contribute to future actions/strategies	ACTPHN
	• Continued co-design, development, commissioning implementation and evaluation a proof of concept service model for the effective transition of care of service targeted at (risk stratified) chronic and complex hospital inpatients.	• Improved transition of care supports between hospital and home settings • Decrease in ED and hospital re-presentations	• Co-designed consumer focused service delivery model (identification, eligibility criteria, pathways, protocols etc.) • Commissioned and integrated service provider • Acute inpatient re-admission rates for "enrolled" patients • Patient reported experience	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	• Fully implement the locally developed Heart Failure Model of Care within and across the ACT health system that has been co-designed by clinicians, consumers and peak bodies and adopts a person-centred and consensus-based whole-of-health system (i.e. multi-level) approach to the management and palliation of Heart Failure	• Better care experienced by patients including higher functional status • Improved clinician satisfaction • Shorter lengths of stay in hospital • Reduced ED re-presentations • Reduced medication errors	• Adoption the HF of consensus based whole of system framework: care model; data sharing; workforce planning; research • Service system review - (compliance) • Service system improvement agenda and investment strategy • Implementation strategy (includes change and adoption) • Evaluation framework	ACTPHN
	• Expansion of "pharmacy in general practice" and aged care pilot *(subject to outcome of evaluation)*	• Reduced medication errors • Improve consumer medication health literacy • Reduced medication related admissions	• pharmacist time spent on activities previously undertaken by a GP against baseline measure • practice patients with chronic conditions receive a medication reconciliation by the practice pharmacist post discharge from hospital. • practice patients with chronic conditions have a medication review conducted by the pharmacist. • 70% of patients' surveyed report improved knowledge and compliance with their medications. • GPs surveyed report a high level of satisfaction with the medication	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
			management support provided by the pharmacist. • Pharmacists' satisfaction with the role. • GP time freed up for other care in each practice against benchmark set by the practice in February 2017. • increase from baseline in health indicators for sample group of patients at high risk of hospitalisation due to medication misadventure.	
	• Continuing the implementation of a joint collaborative working agreement (including the establishment of a Coordinating Committee with ACT Health, Calvary Health Care and the Health Care Consumers' Association) to drive cross sector activities.	• Key acute / primary / community initiative to facilitate cross sector health care solutions	• Establishment of a collaborative working agreement between ACT Health, Calvary, HCCA and ACTPHN	ACT Health
Chronic pain and pain management				
Management of chronic pain in the community	• Research alternative PHC and community approaches and integrated/team based models of care.	• Knowledge of alternative models of care	• Results and findings contribute to future actions/strategies	ACTPHN
	• Undertake a needs assessment of the PHC workforce in the diagnosis and management of chronic pain and map	• Increased understanding and promotion of educational programs and resources available	• Increased awareness of and access to chronic pain related educational programs and resources	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	the range of educational programs and resources available • Deliver a PHC focused master class in the diagnosis and management of chronic pain	• Enhanced PHC capability	• Enhanced clinical capability and increased confidence on the ability to manage chronic pain in the PHC setting	
Health pathways	• Socialise the adoption of the multiple pain related health pathways	• Increased awareness and utilisation of pain related health pathways	• Quality of referrals	
Community based pain related self-management programs	• Scope the availability of and alternative approaches to early intervention pain related self-management programs in the PHC/community setting	• Increased understanding of the benefits of and approaches to early intervention pain related self-management programs in the PHC/community setting	• Results and findings contribute to future actions/strategies	ACTPHN
Opioid prescribing changes	• Monitor the impact of changes on demand for GP and specialist pain management services	• Increased understanding on the impact of changes on demand for GP and specialist pain management services	• Results and findings contribute to future actions/strategies	ACT Health
Disability				
Lack of GP knowledge in relation to the NDIS	• Provide education and support to GPs • HealthPathways have developed an NDIS resource page for GPs.	• GPs aware of what NDIS services are available for their patients and able to assist them to navigate the system according to their needs	• Feedback from consumers • Feedback from GPs	ACTPHN
People ineligible or who choose not to	• Support and educate GPs and other primary health care providers about	• GPs aware of services available for people who are not eligible for the NDIS and	• Feedback from consumers	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
transition to the NDIS	services available for those not eligible for the NDIS.	referring them to these services		
Access to allied health services	• Collaborate with NDIS and professional associations on examining the options for increasing allied health service supply.	• Increased access to allied health services	• Feedback from consumers	ACTPHN
Child development and early intervention	• Support and educate GPs about available resources/services in relation to the NDIS • Provide educational opportunities for focusing on vulnerable children and the ways in which GPs can support families and identify and refer children to appropriate services. • Continuous development and promotion of paediatric HealthPathways to assist GPs with assessment, management and referrals.	• GPs more knowledgeable about the NDIS and how to assess, manage and refer a child in need	• Feedback from consumers • Feedback from GPs	ACTPHN
Child and adolescent mental health (see Mental Health section)	• *See Mental health*			
Early Childhood, Middle Years and Youth				

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
Healthy growth and development	• CHN coordinated the 'Connect Up 4 Kids' Initiative which has provided support to primary care and community sector professionals focused on optimising healthy growth and development to families with children aged 3-7 years to both general practice and the community sector.	•	•	
Identification of children in their middle years in primary health care and the issues associated with them	• Support GPs to identify children in the middle years and to be aware of the issues and challenges these young people may be experiencing that could have an impact on their health and wellbeing. These issues include lack of school engagement; bullying; mental health problems; puberty; transition to secondary school and significant disadvantage and marginalisation.	• GPs more aware of the issues faced by children in the 'middle years' and better able to manage them and/or refer them to appropriate services	• Feedback from consumers	
Identification and management of vulnerable children and youth (and their families) in primary care	• Provide educational opportunities for focusing on vulnerable children and the ways in which GPs can support families and identify and refer children to appropriate services.	• GPs and allied health providers more knowledgeable about the issues in relation to vulnerable children and their families and better able to identify them and	• Feedback from consumers	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	• Provide support for strengthening whole of jurisdiction early intervention initiatives	refer them to appropriate services		
Access to early intervention services around mental health (*Also see Mental health)*	• Undertake a scoping project to determine the feasibility and acceptability of commissioning an 'out-reach' model of primary health care services for those families who have been identified as vulnerable and are participating in a parenting support program (such as NEWPin, HIPPY etc.) and are not connected with mainstream primary health care services. • *(Subject to outcome of current feasibility assessment)*	• Increased access to primary health care services for vulnerable families via parenting support services entry point	• Opportunities and pathways for increased access to mainstream primary health care services are identified and made available to families who have been identified as vulnerable	ACTPHN
Carers				
Identification of carer needs in primary health care	• Provide educational opportunities for primary care professionals on domestic and family violence including issues in relation to elder abuse and also issues specific to carers. • Support and educate GPs and other primary health care providers to identify carers and provide them with the opportunity for their own health	• GPs and other primary health care providers more knowledgeable in relation to carer needs and addressing carers' health and wellbeing	• Feedback from consumers (carers)	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	assessment e.g. blood pressure, stress levels, physical injuries related to caring, and management of chronic health conditions.			
NDIS challenges and carers	• GP support and education in relation to the NDIS and awareness of supports available for those not eligible for the NDIS	• GPs more knowledgeable about NDIS related services and more able to assist their patients to obtain the support/service they require	• Feedback from carers/community	ACTPHN

Mental Health

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
Mental Health				
Early intervention in life (childhood, youth), in illness, and in episode	• Integration of low intensity psychological interventions model into stepped primary mental health care stepped model	• Implementation of low intensity model within primary mental health stepped care model • Improved client outcomes early in episode • Increased access to early intervention services • Improved clinical outcomes for clients • Increased awareness of referral pathways into early intervention services	• Low intensity service model implemented in 2016-17 • Referral rate - measured through Primary Mental Health Care Minimum Data Set (PMHCMDS) • Proportion of clients achieving 'recovery' in current episode of care (clinically significant change in symptom related outcome scores) – PMHCMDS	ACTPHN
	• Integration of new modalities for low intensity psychological interventions, for example, web based programs	• Increased referrals, ability to reach new cohort who may not have time to access face to face or phone sessions • Increased client participation due to flexibility of service model	• Referral rate from cohort that may not otherwise engage with low intensity services – PMHCMDS • Client retention rates – PMHCMDS	ACTPHN
	• Promotion of early intervention services through non-traditional	• Increased referrals by non-traditional referrers	• Referral rate by referrer – PMHCMDS	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	referral pathways, such as large employers			
	• Ensuring eligibility criteria do not exclude people based on previous diagnosis of severe mental illness, referrals need to be assessed on need as opposed to diagnosis	• Appropriate referrals based on need • Improved individual client outcomes	Referral type (main presenting issue) • PMHCMDS Recovery rate • Proportion of clients achieving 'recovery' in current episode of care (clinically significant change in symptom related outcome scores) – PMHCMDS	ACTPHN
	• Integration of psychological interventions services for children under the age of 12 with symptoms of a high prevalence disorder within stepped care model	• Increased access for children under 12	Referral rate for children under 12 • PMHCMDS	ACTPHN
Physical Health	• Support for General Practitioners in managing physical comorbidities for example, metabolic disorder	• Improved management of mental health consumers' physical conditions in primary health care • Improved physical health outcomes for mental health consumers • Improved access to GPs – primary mental health service clients without GP linked in with GP	• Client physical health outcomes - PMHCMDS • Client GP status -PMHCMDS	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	• Integration of primary mental health care services with multidisciplinary primary health centres	• Improved access to GPs for mental health consumers	• Number of clients with severe mental illness with no GP – PMHCMDS and secondary and tertiary services MDS	ACTPHN
Services for moderate to severe presentations	• Development and integration of high intensity psychological interventions into stepped primary mental health stepped care model	• Improved access to appropriate mental health services for people with moderate to severe presentations • Reduction in presentations to the Crisis Assessment and Treatment Team and ACT Community Mental Health Teams • Improved identification of needs and linkages with appropriate services for people with severe mental illness	• Implementation of clinical intake function in primary mental health care stepped model in 2016-17 • Development of high intensity psychological interventions model in 2016-17 • Phased implementation of high intensity model, within the primary mental health care stepped model – 1st phase youth based services - commenced in 2016-17 • Number of referrals – PMHCMDS • Presentations to CATT and ED – ACT Health patient data bases and tertiary and secondary MDS • Referrals to tertiary and secondary teams for clients with moderate to severe presentations - ACT Health patient data , tertiary and	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
			secondary MDS, and PMHCMDS – intake and assessment data • Consumer satisfaction with primary mental health care services and referral pathways - consumer satisfaction survey	
	• Integration of primary mental health stepped care model with tertiary and community services	• Improved transition between tertiary/secondary services and primary mental health stepped care model • Ability for tertiary/secondary clinicians to refer into primary mental health stepped care model	• Clients' access to care - PMHCMDS • Time between referral and first occasion of service - tertiary/secondary service MDS • Referral rate into primary mental health stepped care services by referrer type - PMHCMDS • Clinical relapses - PMHCMDS and tertiary/secondary service MDS	ACTPHN
	• Integration of service navigation into stepped primary mental health care model	• Access to service navigation as part of multidisciplinary care package provided through primary mental health stepped care model	• Service navigation function phased implementation within primary mental health stepped care model commences in 2017-18	ACTPHN
	• Integration of stepped care model client information management system with My Health Record	• Improved access to psychological interventions treatment information for other treating clinicians e.g. GPs	Clients consenting to information to be uploaded • Client information management system	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
National Disability Insurance Scheme (NDIS) – Psychosocial Disability	• Providing advice to GPs on transitioning patients to NDIS • Provision of resources to GPs to assist in transitioning patients to NDIS	• Improved understanding of NDIS transition process, including, requests for documentation in regards to diagnosis and functional impairments	• Increased and timely applications received for NDIS packages – NDIA processing times	ACTPHN
	• Development and integration of service navigation into primary mental health stepped care model for consumers who are ineligible for NDIS	• Access to care coordination services for people with severe mental illness who are not eligible for NDIS packages	• Care coordination function implemented within primary mental health stepped care model in 2017-18	ACTPHN
Vulnerable populations	• Facilitation of training for mental health clinicians in trauma informed care for primary stepped care service workforce	• Improved service provision for consumers who have experienced trauma	• Referrals of identified cohort – PMHCMDS • Clinical outcomes for cohort – PMHCMDS • Consumer satisfaction with service - Consumer satisfaction survey • Workforce competency - workforce skills survey	ACTPHN
	• Continued and extended provision of primary mental health services for people with financial barriers to gaining treatment	• Increased access to affordable services for people with financial barriers to gaining treatment	• Establishment of partnerships with private Better Access providers who are able to bulk bill or charge reduced gap fees in 2017-18 • Phased implementation of affordable primary mental health	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
			stepped care services (fee structures and means testing processes being developed and introduced) commences in 2016-17	
	• Facilitation of training in working with Culturally and Linguistically Diverse Groups for primary mental health stepped care service workforce	• Improved service provision for people from Culturally and Linguistically Diverse backgrounds	• Referral rate of identified cohort - PMHCMDS • Clinical outcomes for cohort - PMHCMDS • Increased consumer satisfaction with service - Consumer satisfaction survey • Increased workforce competency - workforce skills survey	ACTPHN
	• Inclusion of a domestic violence screening question in psychological interventions model assessment • Identified referral pathways for clients who endorse domestic violence screening question	• Improved identification of people experiencing domestic violence • Improved access to domestic violence support services for clients	Endorsement of domestic violence screening measure: • Client information management system Signposting of clients to domestic violence support services: • Client information management system	ACTPHN
	• Facilitation of training in working with Aboriginal and Torres Strait Islander People for primary mental health stepped care service workforce	• Improved service provision for people for Aboriginal and Torres Strait Islander People	• Referral rate of identified cohort - PMHCMDS • Clinical outcomes for cohort - PMHCMDS	ACTPHN

Opportunities, priorities and options				
Priority	**Possible Options**	**Expected Outcome**	**Possible Performance Measurement**	**Potential Lead**
	• Development and integration of culturally appropriate psychological interventions, for Aboriginal and Torres Strait Islander people, into the primary mental health stepped care model		• Consumer satisfaction with service - Consumer satisfaction survey • Workforce competency - workforce skills survey	
Suicide prevention	• Development and implementation of suicide prevention service, for youth and adults, with open referral pathways (including culturally appropriate services for Aboriginal and Torres Strait Islander people) • Development and implementation of screener in general practice to identify patients experiencing suicidal ideation	• Suicide prevention service model implemented within the primary mental health care stepped model • Improved access to suicide prevention services • Improved identification of individuals experiencing suicidal ideation •	• Suicide prevention service model and referral pathways embedded in 2017-18 • Access/referral rate to suicide prevention services - PMHCMDS • Clinical outcomes for cohort - PMHCMDS • Crisis presentation rate to CATT and ED – tertiary services MDS • General practice screener implemented in 2017-18	ACTPHN
Peer participation	• Development of Consumer Engagement Framework, including involvement of consumers in each stage of the commissioning process	• Increased involvement of mental health consumers in the primary mental health commissioning process	• Ongoing representation of consumers and carers in the commissioning process – measured through participation in commissioning process e.g. attendance at Primary Mental Health Strategic Reform Group meetings	ACTPHN

Section 5 - Checklist

Requirement	✓
Governance structures have been put in place to oversee and lead the needs assessment process.	✓
Opportunities for collaboration and partnership in the development of the needs assessment have been identified.	✓
The availability of key information has been verified.	✓
Stakeholders have been defined and identified (including other PHNs, service providers and stakeholders that may fall outside the PHN region); Community Advisory Committees and Clinical Councils have been involved; and Consultation processes are effective.	✓
The PHN has the human and physical resources and skills required to undertake the needs assessment. Where there are deficits, steps have been taken to address these.	✓
Formal processes and timeframes (such as a Project Plan) are in place for undertaking the needs assessment.	✓
All parties are clear about the purpose of the needs assessment, its use in informing the development of the PHN Annual Plan and for the department to use for programme planning and policy development.	✓
The PHN is able to provide further evidence to the department if requested to demonstrate how it has addressed each of the steps in the needs assessment.	✓
Geographical regions within the PHN used in the needs assessment are clearly defined and consistent with established and commonly accepted boundaries.	✓
Quality assurance of data to be used and statistical methods has been undertaken.	✓
Identification of service types is consistent with broader use – for example, definition of allied health professions.	✓
Techniques for service mapping, triangulation and prioritisation are fit for purpose.	✓
The results of the needs assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views.	✓
There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation).	✓