Brisbane North - Aged Care
2022/23 - 2026/27
Activity Summary View

AC-EI - 1000 - Early intervention initiatives to support healthy ageing

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-EI

Activity Number *

1000

Activity Title *

Early intervention initiatives to support healthy ageing

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The Brisbane North region has a high prevalence of chronic disease within the older population as confirmed by a 2016 study which showed 74.1% of the Brisbane North residents aged 45 years and over had at least one long-term health condition.

Hypertension, arthritis and chronic pain are among the highest reported chronic conditions in the region, having negative social and economic consequences which impact on individuals' quality of life.

Dementia is the second leading cause of death in the region at rates higher than the Queensland and National average. Frailty, which closely correlates with chronic disease, is also a major health concern for older people in the Brisbane North region.

Social isolation is a major issue for Brisbane North based older people, having negative impacts on health and wellbeing.

A 2020 Healthy@Home consortium report on shared outcomes revealed 18.2% of older people accessing services under the Commonwealth Home Support program (CHSP) had inadequate social contact to the level they wanted. Brisbane North general practitioners also cite the lack of a support person/network as a major contributing factor in chronic disease severity in older people.

There is strong evidence that social isolation and loneliness decreases immune function (Valtorta, 2016) and increases the risks of older adults for physical health conditions such as cardiovascular disease and stroke (Valtorta 2016; WHO, 2021b; Hawkley et al, 2010).
There is also strong evidence that social isolation and loneliness impacts mental health conditions such as cognitive decline, dementia, depression, anxiety, suicidal ideation and suicide (Cacioppo & Cacioppo 2014; WHO 2021b).

Loneliness also increases the risk of moving into a care facility even after adjusting for age and ability (Hanratty et al, 2018).

This activity aims to keep older people experiencing chronic disease living in their homes for longer by promoting healthy ageing practice. Through empowerment and capacity building, older people will be supported to manage their chronic disease, slowing disease progression and reducing risk for further multi-morbidity.

Brisbane North has a growing older community, many of whom are living with chronic disease and wish to remain living in their own home.
This activity aims to:
• Improve the quality of life for older people living with chronic disease
• Reduce the demand on local health services
• Increase awareness of older peoples' needs in the primary care workforce.
• Support older people to live at home for longer
• Promote healthy ageing and ongoing management of chronic conditions.

Description of Activity *

This project will commission the provision of community-based services aimed at enhancing social connectedness. The aim is to reduce social isolation and loneliness through a range of funded activities that support older people to maintain their health and wellbeing, stay at home, and reduce the need for medical services.

The project will target people who experience social isolation, with specific target groups including Aboriginal and Torres Strait Islander and culturally and linguistically diverse people.

To support the integration of these services, a community of practice will be established to promote the importance of early intervention as a population health measure, build greater awareness of early intervention services, encourage referrals amongst the services, and operate synergisticly to ensure the most appropriate services are provided for older people.

The project seeks to address the needs of priority groups and priority geographical locations by having 4 components to the Early Interventions program to keep people living in the community longer.

These include:
-An intergenerational program across 4 locations - provided by 3 different service providers. This will involve intentional and meaningful interactions between older people and younger people (aged under 16)
-Social prescribing
-A driving cessation program for CALD communities to promote road safety and independence and connection with community for older people who can no longer safely drive.
-A First Nations program to connect older people with chronic conditions to health resources and social networks.

Needs Assessment Priorities *

Needs Assessment

2023_Refresh_BrisbaneNorthPHN_HNA

Priorities

Priority	Page reference
Aged Care	70

Activity Demographics

Target Population Cohort

This activity is targeted at older people (65+) living with chronic disease including First Nations people over 50 years of age.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

A First Nations program has been commissioned from an ACCHO to connect older people with chronic conditions to health resources and social networks.

First Nations representative/s will be approached at each stage of the project to ensure cultural appropriateness of outputs (e.g. services, information, education). Specific resources and education will be developed for Aboriginal and Torres Strait Islander people over the age of 50 years, where appropriate based on advice from First Nations representatives.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

A consultant was hired for a scoping analysis to determine the direction of the project. The consultant held consultations with organisations, community members, key stakeholders and health professionals, in addition to utilising the PHN needs assessment and a literature review.

All contracts with service providers have a requirement for co-design and community consultations.

Collaboration

Additional consultations with older people, providers and other stakeholders will be held as required. Stakeholders will have opportunities to give feedback and will participate in ongoing evaluation.

A Community of Practice has been established for intergenerational program service providers. The Australian Institute of Intergenerational Practice will provide support and expertise to the Community of Practice.

An overarching Early Interventions Community of practice will be established to ensure collaboration between projects and foster cross-program referrals and co-ordination.

Activity Milestone Details/Duration

Activity Start Date

31/08/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/09/2022

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

A consultant was hired for a scoping analysis to determine the direction of the project. The consultant held consultations with organisations, community members, key stakeholders and health professionals, in addition to utilising the PHN needs assessment and a literature review.

Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27
Early Intervention - Interest	$0.00	$0.00	$0.00	$0.00	$0.00
Early Intervention	$0.00	$784,993.10	$491,630.82	$0.00	$0.00

Totals

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27	Total
Early Intervention - Interest	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Early Intervention	$0.00	$784,993.10	$491,630.82	$0.00	$0.00	$1,276,623.92
Total	$0.00	$784,993.10	$491,630.82	$0.00	$0.00	$1,276,623.92

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

Summary of activity changes for Department

Activity Status

Ready for Submission

AC-EI - 1001 - Early intervention initiatives to support healthy ageing - Operational

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-EI

Activity Number *

1001

Activity Title *

Early intervention initiatives to support healthy ageing - Operational

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The activity represents the operational component of Early Intervention initiatives only

Description of Activity *

The activity represents the operational component of Early Intervention initiatives only

Needs Assessment Priorities *

Needs Assessment

2023_Refresh_BrisbaneNorthPHN_HNA

Priorities

Priority	Page reference
Aged Care	70

Activity Demographics

Target Population Cohort

The activity represents the operational component of Early Intervention initiatives only

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The activity represents the operational component of Early Intervention initiatives only

Collaboration

The activity represents the operational component of Early Intervention initiatives only

Activity Milestone Details/Duration

Activity Start Date

31/08/2022

Activity End Date

29/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Is this activity the result of a previous co-design process?

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

Has this activity previously been co-commissioned or joint-commissioned?

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments

Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27
Early Intervention - Interest	$0.00	$0.00	$0.00	$0.00	$0.00
Early Intervention	$0.00	$28,636.36	$28,636.36	$0.00	$0.00

Totals

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27	Total
Early Intervention - Interest	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Early Intervention	$0.00	$28,636.36	$28,636.36	$0.00	$0.00	$57,272.72
Total	$0.00	$28,636.36	$28,636.36	$0.00	$0.00	$57,272.72

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

Summary of activity changes for Department

Activity Status

Ready for Submission

AC-VARACF - 1001 - Telehealth availability and use in RACFs - Operational

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-VARACF

Activity Number *

1001

Activity Title *

Telehealth availability and use in RACFs - Operational

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

Timely access to primary health care professionals, whether through face-to-face consultation or telehealth, is recognised as an issue for many Residential Aged Care Facilities (RACFs), that in some cases can lead to potentially preventable hospitalisations. RACFs require adequate telehealth facilities to support access to virtual consultations for their residents.
The need for RACF residents to have access to appropriate support from their health care team has been highlighted during the recent COVID 19 pandemic and in the Royal Commission into Aged Care Quality and Safety report.

To address this need, the Department of Health and Aged Care (DoHAC) have provided funding to support participating RACFs to have access to appropriate telehealth facilities and equipment to enable residents to virtually consult when needed with their primary health care professionals, specialists, and other clinicians.
This work will be undertaken in consideration of the individual needs of each RACF in the North Brisbane Region as they each will have different levels of telehealth capacity and capability. This will include ensuring the telehealth consult technology implemented into RACF's will be compatible with technology used by health care providers in the region as well as being aligned with recognised telehealth standards.

Through this activity, the PHN aims to:
• assist RACFs to have appropriate telehealth facilities and equipment to enable their residents to virtually consult when needed with their primary health care professionals, specialists and other clinicians.

• provide training to RACFs staff to support them to have the capabilities to assist their residents in accessing virtual consultation services.
• encourage increased use of My Health Record by RACFs, to improve the availability and secure transfer of resident's health care information between RACFs, primary care and acute care settings
• consult with Queensland Health to ensure the service complements efforts underway by the State government

Description of Activity *

This three year activity to enhance the availability and use of telehealth for RACF residents to ensure they receive the right care at the right time in the right place will include:
- an individual assessment of each RACF's current telehealth capability to inform the development of individualised plans

- provision of a telehealth grant to purchase telehealth equipment or improve internet connectivity (22/23 FY only)

- business process support to assist with the implementation of telehealth as part of routine care consults

- Education/training in the use of telehealth during clinical consults

- Increasing the awareness and benefits of using My Health Record

- Evaluation of the activities

This work will be supported by the following existing and previous activities, designed to promote collaborative practice and increased use of My Health Record (MHR) within residential aged care including:
• Residential aged care collaboratives (existing)
• Implementing My Health Record in a RACF pilot project (previous).

Needs Assessment Priorities *

Needs Assessment

2023_Refresh_BrisbaneNorthPHN_HNA

Priorities

Priority	Page reference
Aged Care	70
Service System	72

Activity Demographics

Target Population Cohort

The target audience for this activity is staff working in residential aged care facilities.
This activity aims to improve the health outcomes for all people living in Residential Aged Care Facilities.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Co-design and Co-commissioning activities include:

- A collective approach to engaging with the corporate office of larger aged care organisations with multiple RACFs was jointly undertaken with other QLD PHN to minimise duplication and gain an understanding of their organisations' broader telehealth strategies (FY22/23)
- A select number of RACFs were involved in the development and trialling of the Telehealth Capability Assessment Tool (FY22/23)
- A select number of RACFs were involved in the development and trialling of Business Support Process activities (FY22/23)
- Regular meetings with QNT PHN's to share practices that have supported the design and implementation of the telehealth project (FY22/23 & 23/24)
- Collaborating with other PHNs to co-commission the development of the Telehealth Training modules (FY22/23 & 23/24).

Collaboration

The scoping of the approach and ongoing collaboration will be undertaken regularly with established Residential Aged Care Collaboratives in our region, selected interested RACF stakeholders and the Metro North Residential Aged Care District Assessment and Referral Service (RADAR) team.

This will ensure that the work being delivered will meet the needs of the RACF's as well increasing the likelihood of participation in understanding the benefits that enhanced telehealth access will have on their resident care. There was a collective approach to engaging the RACF's who are operated by larger organisations with other QLD PHN's. This enabled a broader understanding of the larger organisations' telehealth strategies to ensure that any work undertaken with individual RACFs is consistent with the larger organisation's strategy and preferences in relation to engagement with PHNs.

Activity Milestone Details/Duration

Activity Start Date

31/03/2022

Activity End Date

29/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

Yes

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

- A collective approach to engaging with the corporate office of larger aged care organisations with multiple RACFs was jointly undertaken with other QLD PHN to minimise duplication and gain an understanding of their organisations' broader telehealth strategies (FY22/23)
- A select number of RACFs were involved in the development and trialling of the Telehealth Capability Assessment Tool (FY22/23)
- A select number of RACFs were involved in the development and trialling of Business Support Process activities (FY22/23)
- Regular meetings with QNT PHN's to share practices that have supported the design and implementation of the telehealth project (FY22/23 & 23/24)
- Collaborating with other PHNs to co-commission the development of the Telehealth Training modules (FY22/23 & 23/24).

Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27
Virtual Access in RACFs - Interest	$0.00	$0.00	$0.00	$0.00	$0.00
Virtual Access in RACFs	$0.00	$410,825.07	$195,100.19	$0.00	$0.00

Totals

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27	Total
Virtual Access in RACFs - Interest	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Virtual Access in RACFs	$0.00	$410,825.07	$195,100.19	$0.00	$0.00	$605,925.26
Total	$0.00	$410,825.07	$195,100.19	$0.00	$0.00	$605,925.26

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

Summary of activity changes for Department

Activity Status

Ready for Submission

AC-AHARACF - 1000 - Enhanced After Hours Support for RACF's

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-AHARACF

Activity Number *

1000

Activity Title *

Enhanced After Hours Support for RACF's

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

Older people living in Residential Aged Care Facilities (RACFs) are a vulnerable, frail, and complex population with unique care needs. RACF residents can experience rapid health deterioration during the after-hours period, but immediate transfer to hospital is not always clinically necessary. Although the Emergency Department (ED) is specialised in providing acute care, it is recognised that this environment can be distressing for an older person and their family and a stay in hospital can lead to complications for a frail older person.

The decision to transfer a resident to ED is often complex and influenced by many factors including the skills and confidence of nursing staff, GP availability (particularly after hours) as well as access to a clear and current advance health directive outlining the persons wishes and preferences for care.

To help reduce unnecessary hospital presentations, the Department of Health and Aged Care have provided funding to PHN's under the Aged Care Initiative, to address awareness or utilisation issues of out of hours services among participating RACFs in the Brisbane North region.

In line with the overarching outcomes for the Aged Care Funding initiative, to reduce potentially preventable hospitalisations among RACF residents, this activity aims to improve access to timely and appropriate medical care and advice after hours and include:

• Increased staff awareness of out of hours services available
• Improved after hours planning & implementation
• Increased confidence of staff to access appropriate care after hours for residents
• Increased engagement between RACF staff and other Health professionals
• Enhanced access to general practitioners

Description of Activity *

Discussions with Metro North Health, Primary Health Care providers and key findings from the Brisbane North PHN's After-Hours Needs Assessment (March 2020) have identified gaps in the provision of after-hours care for the region's communities. These gaps were especially identified in the northern end of the catchment and included residents in residential aged care facilities. This can result in care being delayed and/or unnecessary presentations to the Emergency Departments for conditions that are non-urgent. There are many and complex patient, service and system issues that contribute to this problem.

In understanding the broader and localised issues relating to the need for effective out of hours plans within the Brisbane North region, this PHN will undertake activities as outlined by DOHAC to ensure people living in RACFs have access to appropriate care in the out of hours period.

To ensure people living in RACFs have access to appropriate care in the out of hours period, this PHN will undertake the following activities:
• Conduct a survey to identify whether RACFs in the region have an after hours action plan

• Provide guidance to assist participating RACFs to develop and implement after-hours action plans
• Educate participating RACFs in out of hours health care options
• Encourage implementation of digital medical records
• Support engagement between RACFs and other Health Professionals through quarterly facilitation of the TPCH and Caboolture Residential aged care collaboratives
• Provide access to relevant resources and tools to support the implementation of after-hours plans
• Maintain a stock of clinical handover Yellow Envelopes to enable distribution to RACF and hospitals to enable effective transfer of resident information
• Provision of regular reporting

This work will be supported by the following existing activities, designed to promote collaborative practice within residential aged care and improve transition of care in the Brisbane North region:
• Residential aged care collaboratives
• Improving transition of care training
• Distribution of Yellow envelope handover tool

Needs Assessment Priorities *

Needs Assessment

2023_Refresh_BrisbaneNorthPHN_HNA

Priorities

Priority	Page reference
Aged Care	70

Activity Demographics

Target Population Cohort

This activity is specifically for people living in Residential Aged Care Facilities including people over 50 who identify as First Nations people.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Recent and ongoing consultation with members of the RACF Collaboratives are informing the early and ongoing development of the activity. Strengthening the existing RACF collaboratives will also play a key role in increasing cross sector engagement between health professionals working in aged care, which is a key objective of this activity. In the delivery of this activity, our Aged Care team will also be working closely with our Primary Care and Integration teams who bring sector knowledge, GP connections and experience of afterhours needs. Consultation with our Clinical Council has, and will continue to be, undertaken as appropriate.

Collaboration

Key to the successful design and implementation of this activity will be the ongoing collaboration and information sharing with Metro North Health, GPs and residential aged care to ensure alignment with RACF outreach, virtual health and hospital avoidance programs. Use of our RACF Collaboratives to guide the design of activities will ensure that they are relevant and useful to their intended audience.

In the establishment and implementation of this project, the PHN will continue to collaborate with key stakeholders to ensure this intervention meets the needs of all stakeholders. Activity and progress will be managed by the PHNs Care Coordination Projects Team and guided by the stakeholder representatives as part of the established RACF collaboratives and the Metro North RADAR team.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2022

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: Yes
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

No

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27
After Hours Access in RACFs - Interest	$0.00	$0.00	$0.00	$0.00	$0.00
After Hours Access in RACFs	$0.00	$228,002.04	$130,066.79	$0.00	$0.00

Totals

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27	Total
After Hours Access in RACFs - Interest	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
After Hours Access in RACFs	$0.00	$228,002.04	$130,066.79	$0.00	$0.00	$358,068.83
Total	$0.00	$228,002.04	$130,066.79	$0.00	$0.00	$358,068.83

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

Summary of activity changes for Department

Activity Status

Ready for Submission

AC-CF - 1000 - Care Finder Program

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

1000

Activity Title *

Care Finder Program

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The care finder program will provide specialist and intensive assistance to help people to understand and access aged care and connect with other relevant supports in the community. Care finders will target senior Australians who need intensive support who could otherwise fall through the cracks.

The aged care system is complex and some people find it more difficult than others to navigate and access the services they need.

The Legislated Review of Aged Care 2017 identified that a common recommendation from stakeholders was to provide a face-to-face presence in the community for people who require extra support to access My Aged Care and the aged care system. In response to recommendations made in the Legislated Review, the aged care system navigator trials were announced in the 2018-29 Budget. The trials have been testing different ways of helping people to understand and engage with the aged care system. Findings from the trials will inform the design of the care finder program.

The Royal Commission into Aged Care Quality and Safety heard throughout its enquiry that aged care needs to have a much greater face-to-face presence. It recommended a workforce of care finders to be funded to provide face-to-face support to help people to navigate and access aged care.

The care finder program was announced by the Commonwealth Government in the 2021-22 Budget as part of the Connecting

Senior Australians to Aged Care Services measure and will be delivered through PHNs.

The intended outcomes of the care finder program are to improve outcomes for people in the care finder target population, including:

- improved coordination of support when seeking to access aged care
- improved understanding of aged care services and how to access them
- improved openness or willingness to engage with the aged care system
- increased care finder workforce capability to meet client needs
- increased rates of access to aged care services and connections with other relevant supports
- increased rates of staying connected to the services they need post service commencement
- improve integration between the health, aged care and other systems at the local level within the context of the care finder program.

Description of Activity *

This activity is to establish and maintain a network of care finders to provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the community.

Details of activities to address opportunities to enhance integration between the health, aged care and other systems at the local level are as follows:

The PHN has:
• recruited PHN staff to undertake commissioning of care finder activities;
• built a tendering strategy based on findings from the care finder Supplementary Needs Assessment;
• contracted existing Australian Council on Healthcare (ACH) providers and supported the transition of ACH services to care finder;
• tendered and commissioned care finder services for the region based on identified local needs via an open tender Two general providers for the whole target population (one in Moreton Bay region and one in the Brisbane region) and five specialist providers to support specific priority populations.

The number of care finder organisations for this activity is as follows:
Six services, including one consortium model of 3 organisations, were funded to provide care finder services in the PHN region. Informed by findings of supplementary needs assessment. There was consideration of both geographical focus and priority population focus to support the region.

The services are:
• Footprints who were funded for two components - Homelessness and risk of homelessness, and the Moreton Bay sub-region components (generalist).
• Communify (who are the lead of a consortium which include QPP for HIV support and Micah for homelessness) for the Brisbane sub-region (generalist).
• Micah for Forgotten Australians/Care Leavers (priority population)
• QC for LGBTI Health for the LGBTI+ population (priority population)
• World Wellness Group for culturally and linguistically diverse population (priority population)
• Ozcare for Homeless/risk of homeless (They were transitioned from a previous homelessness/risk of homelessness funding (ACH), similar to Footprints Homelessness component- tender was not required)

B) Geographic coverage of care finder services and any locations being prioritised for care finder support:
Geographic focused general services were tendered to support all care finder target population in two sub-regions that the PHN was divided into- the Brisbane sub-region and Moreton Bay sub-region. Two services were contracted to support the geographic focus.

C) Specific sub-group(s) of the care finder target population being prioritised for care finder support: Specialist services were tendered to support specific priority populations across the whole Brisbane North PHN region. The priority populations tendered for, as informed by the Supplementary Needs Assessment for the region, were Forgotten Australians/Care Leavers, people who identify as LGBTIQ+ and people from culturally and linguistically diverse backgrounds.
The two ACH services were tendered as specialist services to support homeless or at risk of homelessness care finder population across the PHN region.

Given the rollout of the Trusted Indigenous Facilitator (now Elder Support) program we were informed about at the time, no specialist service was tendered with a First Nations focus. First Nations people who are within the care finder target population will be able to choose whether to receive support from a care finder or Trusted Indigenous Facilitator if both are available.

D) Activities in which the PHN has participated to enhance integration between the health, aged care and other systems at the local level include:
• Presented at Regional Assessment Service information sessions to provide ongoing updates about the roll out of care finder support in the Brisbane North PHN region;
• Presented at June 2022 and March 2023 Aged Care Forums in Caboolture about the Brisbane North PHN care finder program;
• Attendance at Kilcoy Inter-agency meetings.
• Included care finder program details in Aged Care GP resource- https://d1jydvs1x4rbvt.cloudfront.net/downloads/BNPHN_BSPHN_Aged_Care_System_Resource_For_GPs_Mar23.pdf
• Promotion of care finder services across various social media platforms as they commence service provision;
• Inviting Intermediary organisations to attend Brisbane North PHN care finder network meetings in order to foster networking, knowledge sharing and explore linkages including potential referral pathways. Current intermediary organisation attendees include The Metro North HHS Director of Social Work and the Team Care Coordination team.

The PHN has, and will continue to:
• develop community of practice meetings with care finder organisations to support the establishment and continuous improvement of the care finder program;
• develop, implement and maintain processes to meet data collection and reporting requirements;
• build awareness of the care finder program through ongoing promotion of care finder services across various social media platforms and newsletters targeting GP's, hospitals, intermediary and community organisations, and community members;
• identify and address opportunities to enhance integration between health, aged care and other systems at the local level, including:

1. Presenting at Information sessions across multiple sectors including aged care and linked sectors;
2. Ongoing attendance at regional Inter-agency meetings such as the Kilcoy Inter-agency meeting;
3. Continuing to support regular introductions of care finder services to intermediary services across health, aged care and other systems at the local level;
4. Continuing to facilitate networking and introductions between intermediary organisations in health, aged care, and other systems, and care finder service providers.

• Inviting a relevant stakeholder from the health, aged care, or other system to share details of their service, support referrals to and from care finders and network with care finders services at the bi-monthly Brisbane North care finder network meetings, and Care finder CoP meetings hosted by Brisbane North PHN;
• Coordinating presentations by or about care finder services at relevant stakeholder events;
• Coordinating promotion of care finder services at relevant stakeholder events.
• Undertaking other activities as they present to support enhance integration between health, aged care and other systems at the local level.

Needs Assessment Priorities *

Needs Assessment

2023_Refresh_BrisbaneNorthPHN_HNA

Priorities

Priority	Page reference
Aged Care	70
Service System	72
Aboriginal & Torres Strait Islander Health	67

Activity Demographics

Target Population Cohort

The care finder target population is people who are eligible for aged care services and have one or more reasons for requiring intensive support to: - interact with My Aged Care and access aged care services and/or - access other relevant supports in the community.

Target Population is aimed at people: - 65 years or older (or 50 years or older for Aboriginal and/or Torres Strait Islander people) or - 50 years or older (or 45 years or older for Aboriginal and/or Torres Strait Islander people) and on a low income and homeless or at risk of homelessness.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

The Trusted Indigenous Facilitators program is being rolled out in 2023 and will offer a similar service to care finders. They will be located in Aboriginal Community Controlled Health Services, Indigenous aged care providers or community hubs and will support any Aboriginal and/or Torres Strait Islander person who needs their help. Older Aboriginal and Torres Strait Islander peoples who are within the care finder target population will be able to choose whether to receive support from a care finder or Trusted Indigenous Facilitator, if both are available.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Community consultation was a crucial stage in developing the Supplementary Needs Assessment that guided development of the program.

The PHN conducted stakeholder mapping activities to ensure this process was strategic and comprehensive and took a sample of key stakeholders across target care finder populations including:
• navigation services, local councils, ACH providers, community hubs, aged care providers, health services and professionals, GPs, peak bodies, and community groups/organisations,
• other organisations relevant to the care finder target population, service providers and target population consumers, and
• Brisbane North PHN's Clinical Council and Community Advisory Council.

The findings of the consultation assisted the PHN to:
• develop a plan for commissioning care finder services based on the identified local needs,
• identify criteria for service providers,
• commission care finder services,
• consider collaborations across PHN regions where care finder organisations deliver specialised services.

Collaboration

As the region's service provision accelerates, ongoing feedback from care finder organisations and their clients through suitable feedback channels such as the care finder community of practice, will be considered to support program enhancement.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2025

Other Relevant Milestones

23/24 Milestones have been met

24/25 Milestones:
• All organisations are expected to maintain full operational capacity until the expiration of the contract on June 2025.
• Organisations must meet quarterly and annual performance expectations during the length of their contract and promptly notify the PHN of any challenges.

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: Yes
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

As an organisation, the PHN is dedicated to being informed and led by community voices. Community consultation was a crucial stage in developing the Supplementary Needs Assessment that guided development of the program. A list of key potential stakeholders was identified for consultation. Given time constraints, a methodology was utilised that maximised coverage of stakeholders to best meet the objectives of the engagement.

The PHN conducted stakeholder mapping activities to ensure this process was strategic and comprehensive and took a sample of key stakeholders across target care finder populations including:
• navigation services, local councils, ACH providers, community hubs, aged care providers, health services and professionals, GPs, peak bodies, and community groups/organisations,
• other organisations relevant to the care finder target population, service providers and target population consumers, and
• Brisbane North PHN's Clinical Council and Community Advisory Council.

The findings of the consultation assisted the PHN to:
• develop a plan for commissioning care finder services based on the identified local needs,
• identify criteria for service providers,
• commission care finder services,
• consider collaborations across PHN regions where care finder organisations deliver specialised services.

As the region's service provision accelerates, ongoing feedback from care finder organisations and their clients through suitable feedback channels such as the care finder community of practice, will be considered to support program enhancement.

Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27
Care Finder Program - Interest	$0.00	$0.00	$0.00	$0.00	$0.00
Care Finder Program	$0.00	$1,935,106.21	$2,013,642.73	$0.00	$0.00

Totals

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27	Total
Care Finder Program - Interest	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Care Finder Program	$0.00	$1,935,106.21	$2,013,642.73	$0.00	$0.00	$3,948,748.94
Total	$0.00	$1,935,106.21	$2,013,642.73	$0.00	$0.00	$3,948,748.94

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

Summary of activity changes for Department

Activity Status

Ready for Submission

AC-CF - 1001 - Care Finder Program - Operational

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

1001

Activity Title *

Care Finder Program - Operational

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

This activity represents the Operational component of Care Finder only

Description of Activity *

This activity represents the Operational component of Care Finder only

Needs Assessment Priorities *

Needs Assessment

2023_Refresh_BrisbaneNorthPHN_HNA

Priorities

Priority	Page reference
Aged Care	70

Activity Demographics

Target Population Cohort

This activity represents the Operational component of Care Finder only

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

This activity represents the Operational component of Care Finder only

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

This activity represents the Operational component of Care Finder only

Collaboration

This activity represents the Operational component of Care Finder only

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Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/09/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Is this activity the result of a previous co-design process?

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

Has this activity previously been co-commissioned or joint-commissioned?

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments

Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27
Care Finder Program - Interest	$0.00	$0.00	$0.00	$0.00	$0.00
Care Finder Program	$0.00	$532,140.97	$271,451.00	$0.00	$0.00

Totals

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27	Total
Care Finder Program - Interest	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Care Finder Program	$0.00	$532,140.97	$271,451.00	$0.00	$0.00	$803,591.97
Total	$0.00	$532,140.97	$271,451.00	$0.00	$0.00	$803,591.97

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

Summary of activity changes for Department

Activity Status

Ready for Submission

AC-CF - 1100 - Supporting existing providers to transition to ACF

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

1100

Activity Title *

Supporting existing providers to transition to ACF

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The aged care system is complex and some people find it more difficult than others to navigate and access the services they need.

The Legislated Review of Aged Care 2017 identified that a common recommendation from stakeholders was to provide a face-to-face presence in the community for people who require extra support to access My Aged Care and the aged care system. In response to recommendations made in the Legislated Review, the aged care system navigator trials were announced in the 2018-29 Budget. The trials have been testing different ways of helping people to understand and engage with the aged care system. Findings from the trials will inform the design of the care finder program.

The Royal Commission into Aged Care Quality and Safety heard throughout its enquiry that aged care needs to have a much greater face-to-face presence. It recommended a workforce of care finders to be funded to provide face-to-face support to help people to navigate and access aged care.

The care finder program was announced by the Commonwealth Government in the 2021-22 Budget as part of the Connecting Senior Australians to Aged Care Services measure and will be delivered through PHNs.

The care finder program will provide specialist and intensive assistance to help people to understand and access aged care and connect with other relevant supports in the community. Care finders will target senior Australians who need intensive support

who could otherwise fall through the cracks.

This particular activity is to ensure the transition of existing ACH service providers to the ACF program.

Description of Activity *

The previous ACH providers Footprints and OzCare were identified by the Department as receiving quarantined funds to support these two providers to transition to the ACF model. As the existing service model differed from the current ACF model, the PHN is playing an active role in supporting the shaping of their scope of work to the ACF model.

Care finders that have transitioned from ACH will be supported to continue providing specialist supports with a focus on assisting people who are homeless or at risk of homelessness. Both providers indicated their willingness to change to the ACF model and have been actively linked into the ACF network with the additional three ACF services.

The ACF network offers these two service providers support with the commencement of the program, including information sharing about reporting, training, workforce development and service delivery models. The PHN facilitates these meetings to foster open discussion about capacity issues and wait list management.

Needs Assessment Priorities *

Needs Assessment

2023_Refresh_BrisbaneNorthPHN_HNA

Priorities

Priority	Page reference
Aged Care	70

Activity Demographics

Target Population Cohort

The care finder target population is people who are eligible for aged care services and have one or more reasons for requiring intensive support to: - interact with My Aged Care (either through the website, contact centre or face-to-face in Services Australia service centres) and access aged care services and/or - access other relevant supports in the community.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

As an organisation, the PHN is dedicated to being informed and led by community voices. Community consultation was a crucial stage in developing the Supplementary Needs Assessment that guided development of the program. A list of key potential stakeholders was identified for consultation. Given time constraints, a methodology was utilised that maximised coverage of stakeholders to best meet the objectives of the engagement.

The PHN conducted stakeholder mapping activities to ensure this process was strategic and comprehensive and took a sample of key stakeholders across target care finder populations including:
• navigation services, local councils, ACH providers, community hubs, aged care providers, health services and professionals, GPs, peak bodies, and community groups/organisations,
• other organisations relevant to the care finder target population, service providers and target population consumers, and
• Brisbane North PHN's Clinical Council and Community Advisory Council.

Collaboration

The PHN has, and will continue to:
• develop community of practice meetings with care finder organisations to support the establishment and continuous improvement of the care finder program;
• develop, implement and maintain processes to meet data collection and reporting requirements;
• build awareness of the care finder program, and support the integration of the care finder network into the local aged care system;
• identify and address opportunities to enhance integration between health, aged care and other systems at the local level.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No

Continuing Service Provider / Contract Extension: No
Direct Engagement: Yes
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

No

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27
Care Finder Program - Interest	$0.00	$0.00	$0.00	$0.00	$0.00
Care Finder Program	$0.00	$659,498.79	$669,391.27	$0.00	$0.00

Totals

Funding Stream	FY 22 23	FY 23 24	FY 24 25	FY 25 26	FY 26 27	Total
Care Finder Program - Interest	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Care Finder Program	$0.00	$659,498.79	$669,391.27	$0.00	$0.00	$1,328,890.06
Total	$0.00	$659,498.79	$669,391.27	$0.00	$0.00	$1,328,890.06

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

Summary of activity changes for Department

Activity Status

Ready for Submission