|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |

|  |
| --- |
| **Nepean Blue Mountains - Aged Care****2022/23 - 2026/27****Activity Summary View** |

 |  |  |
|  |  |  |  |
|  |

|  |
| --- |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |

|  |
| --- |
| **AC-CF - 6 - 2024-25 Care Finder ACH Transition** |

 |  |

 |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Metadata** |

 |  |

 |
|  |
| **Applicable Schedule \***  |
| Aged Care |
| **Activity Prefix \***  |
| AC-CF |
| **Activity Number \*** |
| 6 |
| **Activity Title \***  |
| 2024-25 Care Finder ACH Transition |
| **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 aim of this activity is to transition existing ACH providers program (with the exception of hoarding and squalor services) to the Care Finder program and establish and maintain a care finder network in the NBM region that:o provides specialist and intensive assistance to help people in the care findertarget population to understand and access aged care and connect with otherrelevant supports in the communityo addresses the specific local needs of their region in relation to care findersupporto is supported to build their knowledge and skillso is an integrated part of the local aged care systemo collects data and information to support an evaluation of the care finder program• support and promote continuous improvement of the care finder program• support improved integration between the health, aged care and other systems at thelocal level within the context of the care finder program. |
| **Description of Activity \***  |
| A needs assessment has been undertaken to inform the mix and focus for care finders in the NBM region. The needs assessment has demonstrated the importance for care finders to be physically located within each of the four LGAs in the NBM region. Two of the four ACH providers are commissioned and cover areas within the region. The providers have completed the transition and further expanded their services to deliver care finder as well as transition from ACH services. The transitioned organisations have their own intake processes. Providers participate in bi-monthly community of practice meetings facilitated by the NBMPHN and undertake all mandatory and required training and additional identified training will be delivered through workshops as part of the community of practice process.The NBMPHN continue to work closely with the care finder organisations to integrate the care finder program into the aged care system. This will be achieved through leveraging existing relationships and engagement with relevant networks and inter-agencies raising awareness of the care finder program and role. Care finder referral pathways will be developed and published within HealthPathways, accessible through our My Health Connector website (https://myhealthconnector.com.au), consistent messaging and promotion across the region and engagement of key stakeholders in local government, health including primary health care providers, non-government organisations and other stakeholders engaged with the target population groups. |
| **Needs Assessment Priorities \*** |
| **Needs Assessment** |
| Needs Assessment 2021/22 - 2023/24 |
| **Priorities** |
|

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| **Priority** | **Page reference** |
| Address the need for culturally appropriate Services | 302 |
| Commission services to improve coordination of care | 255 |
| Workforce Capacity Including Skills and Training – identified need for basic mental health training for mainstream services, including Centrelink, Housing, Police, employers, and community organisatio | 285 |

 |  |

 |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Demographics** |

 |  |

 |
|  |
| **Target Population Cohort**  |
| The care finder target population is people who are eligible for aged care services in NBM region 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-facein Services Australia service centres) and access aged care services and/or• access other relevant supports in the community.Reasons for requiring intensive support may include:• isolation or no support person (e.g. carer, family or representative) who they arecomfortable to act on their behalf and/or who is willing and able to support them toaccess aged care services via My Aged Care• communication barriers, including limited literacy skills• difficulty processing information to make decisions• resistance to engage with aged care for any reason and their safety is at immediaterisk or they may end up in a crisis situation within (approximately) the next year• past experiences that mean they are hesitant to engage with aged care, institutions orgovernment. |
| **In Scope AOD Treatment Type \*** |
|  |
| **Indigenous Specific \*** |
| No |
| **Indigenous Specific Comments**  |
|  |
| **Coverage**  |
| **Whole Region**  |
| Yes |
|  |
|  |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Consultation and Collaboration** |

 |  |

 |
|  |
| **Consultation**  |
| As part of the needs assessment stakeholders were engaged and consulted to identify the key target population groups in the NBM region, these stakeholders included: Local Government, Womens Health Centre, NSW Police, Aged and Community Care providers, ACH providers, housing providers, disability providers, Local Health District, Community Health Centres, community service organisations and primary health care providers. |
| **Collaboration**  |
| Local Health District and Hawkesbury Hospital- building awareness of the care finder program, referral and promotion of the program in the region.Local Government- facilitation of the interagency meetings and engagement to ensure that care finder is integrated in the aged care system.Primary health care providers including pharmacy, general practice, allied health and aged care providers - referral, implementation and embedding into the health system through access to healthpathways. |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Milestone Details/Duration** |

 |  |

 |
|  |
| **Activity Start Date**  |
| 30/06/2022 |
| **Activity End Date**  |
| 29/06/2025 |
| **Service Delivery Start Date** |
| 1 January 2023 |
| **Service Delivery End Date** |
| 30 June 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?**  |
| 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**  |
|  |
|  |
|  |
|  |

 |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |

|  |
| --- |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |

|  |
| --- |
| **AC-CF - 5 - 2024-25 Care Finder** |

 |  |

 |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Metadata** |

 |  |

 |
|  |
| **Applicable Schedule \***  |
| Aged Care |
| **Activity Prefix \***  |
| AC-CF |
| **Activity Number \*** |
| 5 |
| **Activity Title \***  |
| 2024-25 Care Finder |
| **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 aim of this activity is to establish and maintain a care finder network in the NBM region through supporting the transition of ACH providers and commissioning of additional care finders to undertake the following:o provide specialist and intensive assistance to help people in the care findertarget population to understand and access aged care and connect with otherrelevant supports in the communityo address the specific local needs of their region in relation to care findersupporto support to build their knowledge and skillso integrate care finders into part of the local aged care systemo collects data and information to support an evaluation of the care finder program• support and promote continuous improvement of the care finder program• support improved integration between the health, aged care and other systems at thelocal level within the context of the care finder program. |
| **Description of Activity \***  |
| A needs assessment has been undertaken to inform the mix and focus for care finders in the NBM region. The needs assessment demonstrated the importance for care finders to be physically located within each of the four LGAs in the NBM region. Care finders are commissioned in each LGA, two of the providers were ACH providers and expanded their service as care finders and another provider is delivering only as a care finder service without the transition. There are 7 Care Finders in the region with the program commissioned to three organisations. The commissioned organisations undertake their own intake of care finder clients. All providers participate in bi-monthly community of practice meetings facilitated by the NBMPHN and undertake all mandatory and required training with additional identified training will be delivered through workshops as part of the community of practice process.The NBMPHN works closely with the care finder organisations to integrate the care finder program into the aged care system which includes regular meetings with ACAT, LHD, aged care providers and other welfare and community providers in the region. This is achieved through leveraging existing relationships and engagement with relevant networks and inter-agencies raising awareness of the care finder program and role. Care finder referral pathways will be developed and published within HealthPathways, accessible through our My Health Connector website (https://myhealthconnector.com.au), consistent messaging and promotion across the region and engagement of key stakeholders in local government, health including primary health care providers, non-government organisations and other stakeholders engaged with the target population groups. |
| **Needs Assessment Priorities \*** |
| **Needs Assessment** |
| Needs Assessment 2021/22 - 2023/24 |
| **Priorities** |
|

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| **Priority** | **Page reference** |
| Address the need for culturally appropriate Services | 302 |
| Workforce Capacity Including Skills and Training – identified need for basic mental health training for mainstream services, including Centrelink, Housing, Police, employers, and community organisation | 285 |
| Maintain and promote utilisation of a health needs prioritisation framework incorporating social disadvantage and equity | 264 |

 |  |

 |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Demographics** |

 |  |

 |
|  |
| **Target Population Cohort**  |
| The care finder target population is people who are eligible for aged care services in NBM region 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-facein Services Australia service centres) and access aged care services and/or• access other relevant supports in the community.Reasons for requiring intensive support may include:• isolation or no support person (e.g. carer, family or representative) who they arecomfortable to act on their behalf and/or who is willing and able to support them toaccess aged care services via My Aged Care• communication barriers, including limited literacy skills• difficulty processing information to make decisions• resistance to engage with aged care for any reason and their safety is at immediaterisk or they may end up in a crisis situation within (approximately) the next year• past experiences that mean they are hesitant to engage with aged care, institutions orgovernment. |
| **In Scope AOD Treatment Type \*** |
|  |
| **Indigenous Specific \*** |
| No |
| **Indigenous Specific Comments**  |
|  |
| **Coverage**  |
| **Whole Region**  |
| Yes |
|  |
|  |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Consultation and Collaboration** |

 |  |

 |
|  |
| **Consultation**  |
| As part of the needs assessment stakeholders were engaged and consulted to identify the key target population groups in the NBM region, these stakeholders included: Local Government, Women’s Health Centre, NSW Police, Aged and Community Care providers, ACH providers, housing providers, disability providers, Local Health District, Community Health Centres, community service organisations and primary health care providers. |
| **Collaboration**  |
| Local Health District and Hawkesbury Hospital- building awareness of the care finder program, referral and promotion of the program in the region.Local Government- facilitation of the interagency meetings and engagement to ensure that care finder is integrated in the aged care system.Primary health care providers including pharmacy, general practice, allied health and aged care providers - referral, implementation and embedding into the health system through access to healthpathways. |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Milestone Details/Duration** |

 |  |

 |
|  |
| **Activity Start Date**  |
| 30/06/2022 |
| **Activity End Date**  |
| 29/06/2025 |
| **Service Delivery Start Date** |
| 1 January 2023 |
| **Service Delivery End Date** |
| 30 June 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):** Yes**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**  |
|  |
|  |
|  |
|  |
|

|  |  |
| --- | --- |
|  |  |
|  |  |

 |

 |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |

|  |
| --- |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |

|  |
| --- |
| **AC-EI - 3 - 2024-25 Early Intervention Initiatives** |

 |  |

 |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Metadata** |

 |  |

 |
|  |
| **Applicable Schedule \***  |
| Aged Care |
| **Activity Prefix \***  |
| AC-EI |
| **Activity Number \*** |
| 3 |
| **Activity Title \***  |
| 2024-25 Early Intervention Initiatives |
| **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 aim of this activity is to commission early intervention initiatives to support healthy ageing and the ongoing management of chronic conditions for older people in the Nepean Blue Mountains Region and increase awareness of the commissioned initiatives for primary health care through channels such as HealthPathways. |
| **Description of Activity \***  |
| The targeted interventions commissioned across the region enable access for older people to improve the management of chronic health conditions and will enhance existing healthy ageing programs where relevant. The initiatives include the following:- Quality improvement collaborative initiatives implemented in general practice to focus on improved management of chronic conditions for older people including social connection and social prescribing to reduce functional decline;- 6 intergenerational programs across the region to enhance function, reduce decline of mobility, improve social connection and opportunities to be involved in the community;- commission a mobile OT service to support older people to maintain their function and quality of life assisting them to remain at home for longer through improving access to OT assessment and referral for required services in the Lithgow LGA; - commission general practices to provide health connector services across the region improving access to services for older people through navigation and social prescribing- Commission Wellbeing Connectors in the region to provide additional support for older people (who are not eligible for care finder services) to access services to maintain their function and activities of daily living and improve their social connection to keep them well and at home for longer - Commission Community Connector Points to provide navigation and service information support for older people in frequented points across the region ie Neighbourhood Centres, Libraries and Community Centres.- delivery of 4 medicine literacy workshops for consumers delivered by a pharmacist across the region to improve health literacy and knowledge, understanding and confidence about medicines for older people.The above commissioned services are being evaluated through the following methods:Intergenerational Care Programs- will utilise the Geriatric Depression Scale and the Leuven Scale to measure QoL pre- and post- intervention. This program is being formally evaluated through an independent evaluator.• Expansion of Connector Points across the region- qualitative and quantitative feedback will be received via commissioned providers.• Implementation of the Healthy Ageing Interventions Program in general practice- utilising the Model for Improvement with general practices focusing on the 5 M's - medication, mentation, mobility, matters and malnutrition in general practice. 10 practices are participating and will be focusing on each of the 5 M's at the learning workshops to increase capacity in general practice and undertake proactive best practice care to reduce functional decline in the older person and keep them healthy and at home for longer.• Mobile Occupational Therapy (OT) service- the Edmonton Frailty Scale will be used as the key measure of frailty and QoL for the Mobile OT program and outcome reporting.- Wellbeing Connectors - will be required to report on the outcome of referrals including case studies and improved QoL and wellbeing score through the WHO Wellbeing Index.- Health Connectors - will be required to report on the outcome of referrals including case studies and improved QoL and wellbeing score through the WHO Wellbeing Index.These activities will also provide education to primary health care providers to improve access for older Australians to appropriate psychosocial, health, social and welfare supports.Educational resources will be made available to family members or carers on how to manage an older person’s health. Practice nurses and general practitioners (GPs) participating in the Healthy Ageing Interventions Program will undertake several formal and informal training opportunities with associated education resources provided. Participating practice nurses will undertake Health Connector training, The Advance Project’s eLearning course for General Practice Nurses, online palliative care training, and courses offered by Dementia Training Australia. Participating GPs will undertake The Advance Project’s eLearning course for GPs, attend palliative care ‘grand rounds’, and courses offered by Dementia Training Australia.The facilitators from each Intergenerational service provider completed the online intergenerational training course though the Australian Institute of Intergenerational Practice (AIIP). In addition, there are several CPD events delivered across the funding period for allied health, GPs and practice nurses to access including Dementia Care (including diagnosis and referral pathways); frailty and identification of functional decline in older people and the importance of social connectedness in older adults.The programs are promoted through HealthPathways, newspapers and social media, Practice News (PHN communications channels) and website. |
| **Needs Assessment Priorities \*** |
| **Needs Assessment** |
| Needs Assessment 2021/22 - 2023/24 |
| **Priorities** |
|

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| **Priority** | **Page reference** |
| Address the need for culturally appropriate Services | 302 |
| Support general practice with Quality improvement initiatives | 250 |
| Commission services to improve coordination of care | 255 |
| Continue to support consumer awareness | 262 |
| Address social isolation and stigma | 290 |
| Continue ongoing education and training to build capacity | 242 |

 |  |

 |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Demographics** |

 |  |

 |
|  |
| **Target Population Cohort**  |
| Older people in the NBM region |
| **In Scope AOD Treatment Type \*** |
|  |
| **Indigenous Specific \*** |
| No |
| **Indigenous Specific Comments**  |
|  |
| **Coverage**  |
| **Whole Region**  |
| Yes |
|  |
|  |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Consultation and Collaboration** |

 |  |

 |
|  |
| **Consultation**  |
| The NBMPHN Healthy Ageing Steering Committee will assist to inform the co-design and commissioning process. The Health Ageing Steering Committee include the follow representatives:PHN Healthy Ageing team Head of Geriatric Medicine LHDVirtual Aged Care Team Nurse PractitionerGPPractice Nurse- Health ConnectorConsumerPharmacyRACF Care ManagerNSW AmbulanceMulticultural health and Aboriginal health |
| **Collaboration**  |
| Consumers; primary health care professionals including GPs and Practice Nurses; NBMLHD Primary Care and Community Health; Allied Health; Local Government; aged and community services; Aboriginal Medical Service; Aboriginal community services; Aboriginal Health; Nepean Multicultural Access, ACON, SydWest and NDIA, NBMLHD Disability Advisor.These stakeholders will be involved in the co-design process and design the target initiatives that are to be commissioned.Research to inform these services and consultation included:NBMPHN undertook a comprehensive literature review relating to models of early intervention in older people, in alignment with the analysis of data to ensure an understanding of the current community profile for older people in the Nepean Blue Mountains region. To ensure that both a quantitative and qualitative approach was undertaken a series of community consultations and expert interviews to understand the specific needs, gaps and circumstances relating to early intervention in older adults across our region.The consultation process utilised a combination of methods including surveys, face-to-face and virtual sessions, forums and advisory committee engagement. The range of stakeholders engaged in this process included representatives from other PHNs, health professionals working in the aged care sector including geriatricians, GPs, Practice Nurses, Allied Health Professionals, community, and health consumers. The aim of these consultations was to determine the area of focus for the funding and scope potential service models for the Early Intervention (EI) Initiative.Information was gathered from the following sources to assist the consultation process, which included, but was not limited to the following:• Nepean Blue Mountains Primary Health Network Needs Assessment 2021 and 2022.• Service mapping conducted to identify existing services and programs available to older adults in our region to reduce duplication.• The Early Intervention Consultation and Commissioning Recommendation Report 2021.• Improving Social Connections for Older Australians - Evaluation Report University of Wollongong.• Primary Care consultations – GPs, Geriatricians, RACH providers, community health representatives, Regional Assessment Teams and Healthy Ageing Advisory Committee members.• Academic literature informed the planning of the identified EI Initiatives and consideration of the outcomes expected from the commissioned activities. |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Milestone Details/Duration** |

 |  |

 |
|  |
| **Activity Start Date**  |
| 31/12/2021 |
| **Activity End Date**  |
| 29/06/2025 |
| **Service Delivery Start Date** |
| June 2023 |
| **Service Delivery End Date** |
| 30 June 2024 |
| **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):** Yes**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**  |
| This activity will be implemented through a co-design approach with consumers, primary health care providers, aged and community care stakeholders, local government and key peak groups including representation from diverse population groups (Aboriginal and Torres Strait Islander, CALD, LGBTIQ+ and disability). The co-design identified key issues including management chronic disease conditions for older people in the NBM region to reduce avoidable hospital admissions; challenges to access OT services in the region and social isolation. |
|  |

 |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |

|  |
| --- |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |

|  |
| --- |
| **AC-VARACF - 1 - 2024-25 Aged Care Virtual Access RACF Operations** |

 |  |

 |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Metadata** |

 |  |

 |
|  |
| **Applicable Schedule \***  |
| Aged Care |
| **Activity Prefix \***  |
| AC-VARACF |
| **Activity Number \*** |
| 1 |
| **Activity Title \***  |
| 2024-25 Aged Care Virtual Access RACF Operations |
| **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 aim of the activity is to support RACFs to increase the availability and use of telehealth and digital health technologies to support access to virtual consultations for aged care residents. |
| **Description of Activity \***  |
| To achieve the aim we will work closely with participating RACFs:- build on the completed baseline assessment of current digital and telehealth capabilities in their facility through assessment of meaningful use and confidence using digital tools;- continue to work with the Care Manager/s on their digital health capability plan to address the interoperability gaps identified in the baseline survey;- continue to implement the plan including: required technology, the development and initiation of training and support resources for staff based on identified training needs; - continue to work with the Care Managers to encourage the use of My Health Record and Australian Immunisation Register through the initiation of PRODA of HPOS to enhance the transfer of care and resident health care information;- Continue to deliver training to staff in RACFs to improve capability to use digital health technologies and assess the training outcomes through post assessment. |
| **Needs Assessment Priorities \*** |
| **Needs Assessment** |
| Needs Assessment 2021/22 - 2023/24 |
| **Priorities** |
|

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| **Priority** | **Page reference** |
| Increase and enhance meaningful use of My Health Record | 243 |
| Enhance video Telehealth uptake | 243 |
| Expand the uptake of My Health Record across the primary and secondary care | 244 |
| Increase access to Primary Care services within RACFs including via telehealth | 267 |

 |  |

 |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Demographics** |

 |  |

 |
|  |
| **Target Population Cohort**  |
| Residential Aged Care Facilities, Residents, primary healthcare professionals and clinicians |
| **In Scope AOD Treatment Type \*** |
|  |
| **Indigenous Specific \*** |
| No |
| **Indigenous Specific Comments**  |
|  |
| **Coverage**  |
| **Whole Region**  |
| Yes |
|  |
|  |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Consultation and Collaboration** |

 |  |

 |
|  |
| **Consultation**  |
| NBM LHD - Virtual Aged Care Team and Digital Health TeamRACF Care Managers and StaffDiverse groups - Aboriginal and Torres Strait Islander, LGBTIQ+, CALD, and disability |
| **Collaboration**  |
| NBM LHD - Virtual Aged Care Team and Digital Health Team - inform and ensure there is not duplication.RACF Care Managers and Staff - involved in the design and implementation of the activityAustralian Digital Health Agency |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Milestone Details/Duration** |

 |  |

 |
|  |
| **Activity Start Date**  |
| 31/12/2021 |
| **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 |

 |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |

|  |
| --- |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |

|  |
| --- |
| **AC-AHARACF - 2 - 2024-25 Enhance After Hours Support for RACFs** |

 |  |

 |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Metadata** |

 |  |

 |
|  |
| **Applicable Schedule \***  |
| Aged Care |
| **Activity Prefix \***  |
| AC-AHARACF |
| **Activity Number \*** |
| 2 |
| **Activity Title \***  |
| 2024-25 Enhance After Hours Support for RACFs |
| **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 aim of this activity is to enhance after hours support for RACHs to reduce transfer to hospital in the after hours period. This will be achieved through the development of after hours plans and procedures appropriate for their facility. |
| **Description of Activity \***  |
| To achieve the aim we will continue to work closely with participating RACHs:• to ensure all RACHs have an after-hours action plan in place. The PHN have undertaken change management plans with the RACHs to facilitate and embed the implementation of after-hours action plans.• The after-hours action plan review identifies areas of risk mitigation to reduce the incidence of reliance on after hours services. This included the delivery of the following training opportunities and any additional training associated with hospital frequency to maintain competency in aged care staff to care for patients in the after hours period:o Intravenous Cannulationo Urinary Catheterisationo ISBAR handover education with the Australian College of Nursing.• NBMPHN has developed and continues to deliver an education package which includes the following: After-hours, telehealth, and My Health Record. The training topics include, but are not limited to: benefits of telehealth, concerns for using telehealth, preparing for telehealth services, MBS terms, using Healthdirect, advance care planning, Health Pathways, clinical governance, My Health Record, after-hours care and secure messaging;• continue to work in consultation with the Care Manager, clinical staff, residents GPs an appropriate after hours care plan, including access to up to date digital medical records to keep the plan up to date;• implement any new inclusions in the plan including: continuous training and development of staff and support resources for staff based on after-hours health care options and processes including increasing access to RACH staff to training and education to improve capacity and reduce the need for hospital transfer.- RACHs have received a copy of the ‘minimum documentation standards’ which reflects the funding and clinical obligations that need to be recorded. NBMPHN meets regularly with the RACHs using this time to raise the ‘minimum documentation standards’ template and reiterate support with the change management process. RACHs continue to review their documentation quality ‘in house’. |
| **Needs Assessment Priorities \*** |
| **Needs Assessment** |
| Needs Assessment 2021/22 - 2023/24 |
| **Priorities** |
|

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| **Priority** | **Page reference** |
| Improve Access to after-hours primary care | 239 |
| Enhance video Telehealth uptake | 243 |
| Expand the uptake of My Health Record across the primary and secondary care | 244 |
| Increase access to Primary Care services within RACFs including via telehealth | 267 |
| Skills and Training Capacity | 276 |
| Improve access for people at end of life to support and services to die at home if that is their preferred place, through improved integration and coordination of services | 265 |

 |  |

 |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Demographics** |

 |  |

 |
|  |
| **Target Population Cohort**  |
| Residential Aged Care Facilities, primary health care providers and residents and families of residential aged care facilities |
| **In Scope AOD Treatment Type \*** |
|  |
| **Indigenous Specific \*** |
| No |
| **Indigenous Specific Comments**  |
|  |
| **Coverage**  |
| **Whole Region**  |
| Yes |
|  |
|  |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Consultation and Collaboration** |

 |  |

 |
|  |
| **Consultation**  |
| The NBMPHN Healthy Ageing Steering Committee will assist to inform the work undertaken in this activity. The Health Ageing Steering Committee include the follow representatives:PHN Healthy Ageing team Head of Geriatric Medicine LHDVirtual Aged Care Team Nurse PractitionerDiverse groups - Aboriginal and Torres Strait Islander, LGBTIQ+, CALD, and disability GPPractice Nurse- Health ConnectorConsumerPharmacyRACF Care ManagerNSW Ambulance |
| **Collaboration**  |
| Residential Aged Care Facilities - design and implementationGeneral Practitioners and other primary health care providers - design and implementationNBMLHD Virtual Aged Care Team - informing the work |
|  |
|  |
|

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |

|  |
| --- |
| **Activity Milestone Details/Duration** |

 |  |

 |
|  |
| **Activity Start Date**  |
| 30/11/2021 |
| **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 |

 |  |