



# CHIC Partnership Councils

Memberships &  
Funded Projects

<b>FORMER NORTHERN AREA PARTNERSHIPS .....</b>	<b>4</b>
MACKAY .....	4
1. <i>PIK Project (Podiatry, Insulin Initiation and Kidney - Integration of Diabetes Service) (M01)</i> .....	4
TOWNSVILLE .....	4
1. <i>Integrated Health Partnerships – extending the reach (T01)</i> .....	5
NORTH WEST QUEENSLAND CHIC COUNCIL FORMED 9TH NOVEMBER 2008 .....	6
CAIRNS & HINTERLAND .....	6
1. <i>Community Physical Activity (Circus Skills) and Nutrition Program (CH01)</i> .....	6
2. <i>Tableland Diabetes Prevention and Early Detection Management Plan (CH02)</i> .....	7
3. <i>Yellow Envelope and Aged Care Information Transfer Project (CH03)</i> .....	7
4. <i>Changing practice with Chronic Disease self management – investing in Health Coaching (CH04)</i> .....	7
5. <i>Social, Emotional, Behavioural and Mental Health Pathways in School Age Children (CH05)</i> .....	8
6. <i>School Screening Project (CY06)</i> .....	8
CAPE YORK .....	9
1. <i>Standardised referral /pathways for those consumers with Chronic Disease lifestyle illnesses for all Primary Health Care Centres in Cape York (CY01)</i> .....	9
2. <i>Primary health care service co-ordination and integration at a local level (CY02)</i> .....	10
3. <i>Interagency Filing Procedure (CY03)</i> .....	10
4. <i>Barriers to Service Coordination with Multiple Primary Healthcare Service Providers (CY04)</i> .....	11
TORRES STRAIT – NOT YET FORMED – ONGOING NEGOTIATIONS .....	12
<b>FORMER CENTRAL AREA PARTNERSHIPS.....</b>	<b>13</b>
BRISBANE NORTHSIDE .....	13
1. <i>Strengthening Electronic Communication Capabilities (BN01)</i> .....	13
2. <i>Improved Falls Management &amp; Care of Patients in Brisbane’s Northside Community (BN02)</i> .....	14
3. <i>Regional Human Service Mapping System Taskforce Team/Community Information System (BN03)</i> .....	14
4. <i>Extension of Refugee Health Screening Clinic (BN04)</i> .....	14
5. <i>Minimising the Health Burden of Chronic Disease by Maximising Chronic Condition Self Management (BN05)</i> .....	15
6. <i>Chronic Disease Prevention and Self-Management Model in CALD population (BN06)</i> ....	15
7. <i>Enhancing Medication Titration in Patients with Heart Failure (BN07)</i> .....	15
8. <i>LIVE! And Re-Engerize Initiative (BN08)</i> .....	16
9. <i>Physical Activity Health Promotion Officer (BN09)</i> .....	16
SUNSHINE COAST & COOLOOLA.....	17
1. <i>Inter-professional learning, training and self-management capacity building framework for type 2 diabetes care (IPL Framework) (SCC01)</i> .....	17
2. <i>Primary Health Liaison Officer; Mental Health Executive Council (SCC02)</i> .....	17
WIDE BAY AND FRASER COAST .....	18
1. <i>Telehealth – new options for partnerships (WBFC01)</i> .....	18
2. <i>Avoidable Hospital Admissions Project (WBFC02)</i> .....	19
3. <i>Community Outreach Project (WBFC03)</i> .....	19
4. <i>General Practice Diabetic Services Improvement (WBFC04)</i> .....	19
CENTRAL QUEENSLAND .....	20
1. <i>Detoxification and Rehabilitation Services for Young People in Central Queensland (CQ01)</i> .....	20
2. <i>A comprehensive community screening program to improve prevention, screening and management of chronic diseases in adult residents of the Woorabinda Community (CQ02)</i> ...	21
3. <i>Rural Chronic/Complex Care Coordinators (CQ03)</i> .....	21
CENTRAL WEST.....	22
<b>FORMER SOUTHERN AREA PARTNERSHIPS .....</b>	<b>23</b>
SOUTHERN AREA ABORIGINAL AND TORRES STRAIT ISLANDER SPECIFIC PROJECTS .....	23

<b>1. Aboriginal and Torres Strait Islander Wellbeing in Far South West Queensland (ATSI01)</b>	23
SOUTH WEST PARTNERSHIP COUNCIL	24
<b>1. Scripts for Life (SW01)</b>	24
<b>2. Living Strong + (SW02)</b>	25
TOOWOOMBA AND DARLING DOWNS PARTNERSHIP COUNCIL	26
<b>1. Toowoomba Leg Club (TAAD01)</b>	26
<b>2. Healthy Piccaninny Program (TAAD02)</b>	26
<b>3. Southern Downs Suicide Prevention Project – Mental Health Training (TAADD03)</b>	26
<b>4. Mental Health Respite Skilling Project (TAAD04)</b>	26
<b>5. Healthy Kulila Kids (TAAD05)</b>	27
<b>6. Learning for Life (TAADD06)</b>	27
<b>7. Mapping of Community Services for the Darling Downs (TAAD07)</b>	28
<b>8. Connecting an Active Community (TAAD08)</b>	28
<b>9. Western Downs Healthy Communities (TAAD09)</b>	28
<b>10. Suicide Prevention Community Skilling (TAAD10)</b>	29
<b>11. Depression Resource, Peer Support and Education Program (TAAD11)</b>	29
<b>12. Link Between Chronic disease, Depression &amp; Substance Misuse (TAAD12)</b>	29
<b>13. Goondiwindi Healthy Community (TAAD13)</b>	29
WEST MORETON SOUTH BURNETT PARTNERSHIP COUNCIL	30
<b>1. Improved Coordination of Care to People with Type II Diabetes (WMSB01)</b>	30
SOUTHSIDE PARTNERSHIP COUNCIL	31
<b>1. Family Support Worker within BeauVisions Mental Health Community Support Service (SS01)</b>	31
<b>2. Mental Health Promotion Initiatives within the Bayside Area (SS02)</b>	32
<b>3. Comprehensive Evidence Based Model of Primary Care for People with Type II Diabetes (SS03)</b>	32
<b>4. Healthy Babies (SS04)</b>	32
<b>5. Bi-Lingual Health Promoter Project (SS05)</b>	33
<b>6. Inala and Surrounds Young Parent Consortium (SS06)</b>	33
<b>7. Coordination of the Living Well at Home Program across the Southern Health Service District (SS07)</b>	33
<b>8. Primary Connections in Mental Health (SS08)</b>	33
<b>9. Community Paediatric Complex Care (SS09)</b>	34
<b>10. HYPE! Hip Hop = Healthy – Street Dance for Logan Youth (SS10)</b>	34
<b>11. Independent Minds (SS11)</b>	35
GOLD COAST PRIMARY CARE PARTNERSHIP COUNCIL	36
<b>1. Phase One – Improving Health Outcomes for Young People and Their Families – Co-occurrence of Mental Illness and Alcohol and Other Drug Use (GC01)</b>	36
<b>2. Early Years Partnership: An early intervention and prevention initiative (GC02)</b>	36
<b>3. Service Access Partnership (GC03)</b>	37

# Former Northern Area Partnerships

## ***Mackay***

### **Management**

Chair	Dr Helen Archibald
Auspecting Organisation - Secretariat	Mackay Division of General Practice
CHIC Facilitator	Ms Mandy Laverack 07 4953 4491

### **Membership**

Qld Health – Hospitals in the Mackay Health Service District  
Central QLD Rural Division of General Practice  
Group of Private Allied Health Providers  
Local pharmacist  
Private GPs  
QH - Mackay Community Health  
Mackay Division of General Practice  
Aboriginal and Torres Strait Islander Community Health Service Inc Mackay  
Blue Care  
Oz Care  
RSL Care  
Mackay Division of General Practice  
Consumer Reference Group

## **Service Delivery and Innovation Projects**

### **1. PIK Project (Podiatry, Insulin Initiation and Kidney - Integration of Diabetes Service) (M01)**

**Project Lead Agency:** Mackay Division of General Practice

**Contact Phone:** (07) 4953 4491

**Description:** This project aims to improve collaboration and coordination of services between partners and joint planning in the Mackay, Whitsunday and Moranbah regions with three major service improvements:

- i) increased podiatry services by providing a high and medium risk foot clinic
- ii) diabetes team assessment and multidisciplinary team care assistance for patients who would benefit from the initiation of insulin; and
- iii) a diabetes educator service for patients with diabetes who have Stage 1 or Stage 2 kidney disease as determined by the eGFR <60 and/or micro albumin urea (laboratory proven).

The project's outcome will be an improved quality of life for patients with diabetes and a reduction in avoidable hospital admissions from the target population.

Target population – people diagnosed with diabetes living in Moranbah, Whitsunday and Mackay region.

## ***Townsville***

### **Management**

Chair	Mr Brendan Walsh
Auspecting Organisation – Secretariat	Townsville General Practice Network
CHIC Facilitator	Dr Tracy Cheffins 07 4725 8915

### **Membership**

Qld Health – GP Liaison committee  
Private GPs  
Private Allied Health Providers  
Integrated Health Care Partnerships (IHCP) team  
Townsville General Practice Network  
Queensland Health Medical  
Queensland Health Allied Health  
Non Government Health Organisations – CHAG Agencies Spiritus, OZ care

## **Service Delivery and Innovation Projects**

### **1. Integrated Health Partnerships – extending the reach (T01)**

**Project Lead Agency:** Townsville General Practice Network

**Contact Phone:** 07 4725 8915

**Description:** Extending the reach of the existing Integrated Healthcare Partnership program by the inclusion of patients at earlier stages of the disease process. The aim is to provide a complete range of allied health services to each patient and include more community based preventative strategies in the programme. Additionally the aim is to investigate provision of additional services using funds from private health insurance sector.

Achieving this will involve the identification of patients before they become frequent hospital attendees. Intervention to receive more community based treatment via assessment by a GP. Service coordinators will assess the multi-disciplinary care requirements of each patient and proceed to arrange appointments, specialist referrals and visits, and ensure the subsequent information is provided to GP.

Target population – Patients diagnosed with chronic disease requiring multi disciplinary care to keep them out of hospital.

## ***North West Queensland CHIC Council formed 9th November 2008***

### **Management**

Chair	Not yet appointed
Auspecting Organisation - Secretariat	James Cook University Mount Isa Centre for Rural and Remote Health (MICRRH)
CHIC Facilitator	Jenny Hayside 07 4744 7913

### **Membership**

North West Queensland Primary Healthcare (Division of General Practice)  
Queensland Health – Director of Primary Healthcare  
Queensland Ambulance  
Aboriginal Medical Service  
Bluecare  
North Queensland Council of Social Services  
Oxfam

## **Service Delivery and Innovation Projects**

### ***Cairns & Hinterland***

#### **Management**

Chair	Mrs Barbara Cunningham
Auspecting Organisation - Secretariat	Far North Queensland Division Rural Division of General Practice
CHIC Facilitator	Julie Eaton 07 4042 7333

#### **Membership**

Wuchopperen and Midin Aboriginal Medical Services  
Mooroobool Wellbeing Centre  
Cairns Regional Council  
Education Queensland  
TANKS Art Centre  
Consumer Advocate  
Cairns Police Citizens Youth Club  
General Practice Cairns  
Private Allied Health Professions  
Queensland Health  
Pharmacy Guild  
James Cook University  
Peace and Harmony in West Cairns

## **Service Delivery and Innovation Projects**

### **1. Community Physical Activity (Circus Skills) and Nutrition Program (CH01)**

**Project Lead Agency:** Cairns Regional Council

**Contact Phone:** (07) 4032 6602

**Description:** Phase 1 2007-2008 Cirque du School, Phase 2 – Carrot on a stick  
This program builds on the Circus de School food and fun project which is running in Western and Southern Schools in Cairns and takes it into the community. The program will be expanded and will cover physical activity – through circus skills, nutrition, social/emotional wellbeing and oral health. Outcomes of the project will be strengthened partnerships in the Cairns urban area through engaging with children, youth and their families in a local community health promotion program, which addresses behavioural risk factors for developing

chronic diseases - such as increasing physical activity, improving poor nutritional habits, increase fruit and vegetable intake, decrease sugar drinks, oral health and hygiene, and improved mental wellbeing. A presentation of circus skills and preparation of affordable healthy meal with families concludes the program.

Target population – Children and youth in Cairns who are disengaged with the education system and do not participate in mainstream physical activity.

## **2. Tableland Diabetes Prevention and Early Detection Management Plan (CH02)**

**Project Lead Agency:** Far North Queensland Rural Division of General Practice

**Contact Phone:** 07 4042 7333

**Description:** The purpose of the Phase 1 scoping and project plan report is to gain a clear direction forward on prevention, early detection and management of diabetes strategies across all health service providers in the Tablelands.

Target population – people in the Tablelands geographical area that are at risk of developing diabetes, have been identified as having early markers for diabetes and those with diabetes.

Phase 2 application is expected 2009-2010 round of funding.

## **3. Yellow Envelope and Aged Care Information Transfer Project (CH03)**

**Project Lead Agency:** Far North Queensland Rural Division of General Practice

**Contact Phone:** 07 4042 7333

**Description:** This project aims to improve the continuity of care for aged care residents transferred between Residential Aged Care Facilities and Hospitals throughout the Cairns and Hinterland Health Service District. 5000 Yellow Envelopes will be printed and training presented to relevant staff in acute and Residential Aged Care Facilities in their use. The outcome will be standardisation of documents to and from acute facilities and Residential Aged Care Facilities using a simple communication tool – the Yellow Envelope.

Target population – people living in residential aged care facilities, their service providers and their carers.

## **4. Changing practice with Chronic Disease self management – investing in Health Coaching (CH04)**

**Project Lead Agency:** General Practice Cairns

**Contact Phone:** 07 4080 1500

**Description** The *Queensland Strategy for Chronic Disease 2005-2015* recognises that chronic disease accounts for more than one third of all deaths in the State and over 70% of the total health expenditure. This project will allow for 60 participants from both government and non government agencies to participate in a training investment on health coaching. Health Coaching Australia (HCA) defines health coaching as a clinical health intervention to be used only by qualified health professionals, to facilitate lifestyle risk factor reduction and support self management in people with chronic health conditions. There will be 3 workshops with 20 participants at each workshop. The purpose of this course is to provide the participating health professionals with techniques to assist individuals with chronic disease/s to address their barriers and more effectively engage in health behaviour change. Thereby improving the health status of the individual by encouraging, empowering, enabling them to become active partners with their care providers in the management of their health

## **5. Social, Emotional, Behavioural and Mental Health Pathways in School Age Children (CH05)**

**Project Lead Agency:** General Practice Cairns

**Contact Phone:** 07 4080 1500

**Description:** Social, emotional, behavioural and mental health issues in school age children are increasingly common. They present in many different forms to members of the primary health care team and to community partners such as Education Queensland and the Cairns Regional Council. Truancy, vandalism and drug abuse are all consequences of behavioural and mental health issues that we are aware of in day to day life. There are many government and non-government agencies and private sector stakeholders that strive to assist these young people when they, or their family, present for help. To maximise the assistance that all community partners can provide, knowledge of, and access to, available resources, including medical treatment, is vital. The aim of the project is to improve access to services through; consolidating and disseminating information, documenting referral pathways; and building capacity through increased knowledge and understanding of the multiple partners involved in the project. It is further envisaged that under Phase II of this Project, the provision of a service delivery map will form the basis for developing protocols for service delivery and coordination between service providers

## **6. School Screening Project (CY06)**

**Project Lead Agency:** Wuchopperen Health Services Limited

**Contact Phone:** 07 4080 1000

**Description:** The School Screening Project will provide comprehensive primary health care for students through implementation child & Adult health checks annually at schools; make an assessment of the child's physical, psychological and social well being and also what preventative health care, education and other assistance is required to improve their overall health and well being.

## **Cape York**

### **Management**

Chair	Ms Karen Jacobs
Auspecting Organisation - Secretariat	Queensland Health
CHIC Facilitator	Ms Karen Jacobs 07 4090 6248

### **Membership**

Cape York Health Service District  
Far North Queensland Rural Division of General Practice (FNQRDGP)  
Royal Flying Doctors Service  
Apunipima – Cape York Health Council  
Cook Shire Council  
Queensland Ambulance Service  
Community Nutritionist  
Brisbane Indigenous Media Association (BIMA)  
Indigenous Health Coordinator Cape York  
Director, Mental Health and ATODS, Cape York Health Service District  
Director, Primary Health Care, Cape York Health Service District  
Tropical Population Health Network, Queensland Health

## **Service Delivery and Innovation Projects**

### **1. Standardised referral /pathways for those consumers with Chronic Disease lifestyle illnesses for all Primary Health Care Centres in Cape York (CY01)**

**Project Lead Agency:** Apunipima – Cape York Health Council

**Contact Phone:** 07 4081 5600

**Description:** This initiative is aimed at enhancing service co-ordination and shared service delivery by targeting the reduction of risk factors and providing better primary clinical care. This will lead to a reduction in avoidable hospital admissions, inappropriate referrals to outpatient visiting services and improved quality of life. This project aligns to the CHIC principles of improving efficiency and access and service delivery through integrated collaborative practice.

Target population – A population of 12,000 people spread over an area of 156,000 square kilometres serviced by the Cape York Health Service District.

No further funding sought for this project in round 2 as project was completed.

## **2. Primary health care service co-ordination and integration at a local level (CY02)**

**Project Lead Agency:** Apunipima – Cape York Health Council

**Contact Phone:** 07 4081 5600

**Description:** At a community level the introduction of new *Improved Primary Health Care Initiatives* have been met with a variety of responses due to their uncertainty of the programs delivered through the Primary Health Care Centre. A solid community familiarisation and a good understanding of roles have assisted greatly in the integration of programs and referral processes across the service provider platforms in a number of locations. However, overall feedback from communities indicate that there is still considerable confusion and a lack of understanding around the initiative's purpose and how it coordinates or integrates with existing services.

This initiative is aimed at enhancing service co-ordination, integration and local collaboration in the delivery of primary health care, which aligns to the CHIC principles of improving efficiency, access and service delivery through integrated collaborative practice. This project consists of a series of cluster based workshops across Cape York to seek input from local communities, service providers and key stakeholders for collaborative action

Target population – A population of 12,000 people spread over an area of 156,000 square kilometres serviced by the Cape York Health Service District.

## **3. Interagency Filing Procedure (CY03)**

**Project Lead Agency:** Apunipima – Cape York Health Council

**Contact Phone:** 07 4081 5600

**Description:** The purpose of this project is to develop a single interagency procedure for medical record filing order which will apply to all clients. As a result of the project we expect to see records retained within Cape York Health Service Facilities which are accessible to the multiple partners in health service provision across the Cape. This interagency procedure for medical record filing and order will be based on principles of patient safety and quality. It will also include a register of all current forms contributing to Medical Record and an interagency process for approval of new forms and order within the Medical Record. There will also be time spent with clinicians on enhancing the knowledge on how to locate specific health information with the Medical Record.

#### **4. Barriers to Service Coordination with Multiple Primary Healthcare Service Providers (CY04)**

**Project Lead Agency:** Far North Queensland Rural Division of General Practice

**Contact Phone:** 07 4042 7333

**Description:** Cape York Health Service District (CYHSD) incorporates two regional towns (Cooktown and Weipa) and ten remote communities (Hope Vale, Wujal Wujal, Laura, Kowanyama, Pormpuraaw, Aurukun, Lockhart River, Coen, Napranum and Mapoon) with a predominantly Indigenous population. The region is serviced by multiple government and non-government organisations (i.e. Apunipima, Far North Qld Rural Division of General Practice, Royal Flying Doctor Service and Qld Health) who are funded by both State and Australian governments to provide an extensive range of health services. Since 2005, there has been a significant increase in funding for health service provision to the region particularly in the areas of chronic disease, maternal and child health, mental health and drug and alcohol services. While the increased funding has been welcomed, it has resulted in a more complex service environment where integration and co-ordination of services is difficult to achieve. To address this, service providers and funders are together seeking to engage an external consultant to undertake a review of the current service environment to identify the barriers that prevent or block effective and efficient service provision. The review will also include recommendations on how to address these barriers. The consultancy will take into consideration the views and opinions of contracted service providers, community health centre staff, community members and funders. The final report will be presented back to the Cape York Regional Health Forum (CYRHF) and the Cape York Primary Health Care Partnership Council (CYPHCPC) for action by key partner organisations

## ***Torres Strait – not yet formed – ongoing negotiations***

### **Management**

Chair

Auspecting Organisation -

Secretariat

CHIC Facilitator

### **Membership**

In principle agreement obtained from – RFDS

Apunipima – Cape York Health Council

Queensland Ambulance

## **Service Delivery and Innovation Projects**

# Former Central Area Partnerships

## ***Brisbane Northside***

### **Management**

Chair	Abbe Anderson
Auspecting Organisation – Secretariat	GPpartners
CHIC Facilitator	Shelley Kleinhans / Kate Drinkwater 07 3630 7300

### **Membership**

Northside HSD  
RBWH HSD  
RCH HSD  
OzCare  
Blue Care  
Spiritus  
Southern Cross Care  
Aboriginal and Islander Community Health Services (AICHS) Brisbane  
GPpartners  
Moreton Bay General Practice Network (formerly RBCDGP)  
Private General Practitioners

## **Service Delivery and Innovation Projects**

### **1. Strengthening Electronic Communication Capabilities (BN01)**

**Project Lead Agency:** GPpartners

**Contact Phone:** 07 3630 7300

**Description:** This initiative aims at building the capacity for improved communication strategies between healthcare providers to improve patient care and management against all the identified areas within the CHIC guidelines (chronic and complex disease, child health, mental health, drug and alcohol, intervention strategies). GPpartners and the Redcliffe Brisbane Caboolture Division of General Practice will employ staff to roll out the preferred secure electronic communication software solution selected through the Department of Health and Ageing's Managed Health Network funded in Healthcare evaluation.

## **2. Improved Falls Management & Care of Patients in Brisbane's Northside Community (BN02)**

**Project Lead Agency:** Royal Brisbane & Women's Hospital HSD

**Contact Phone:** (07) 3636 8111

**Description:** This project is designed to develop and trial a model for long term sustained use by Royal Brisbane and Women's Hospital and Northside community service providers and partners which will improve the identification and community referral of fallers/potential fallers who present to hospital or present elsewhere in the health system after having fallen. The model will utilise a range of falls resources that have already been established within the Northside and other districts to ensure a comprehensive response to meet the needs of fallers/potential fallers.

## **3. Regional Human Service Mapping System Taskforce Team/Community Information System (BN03)**

**Project Lead Agency:** Population Health, Brisbane North/Brisbane Northside Health Promotion Unit

**Contact Phone:** 07 3624 1111

**Description:** This project will create a centralised information data source to increase everybody's access to potential partners, planners, clinicians and providers, as well as enhance their knowledge of health and well being services.

## **4. Extension of Refugee Health Screening Clinic (BN04)**

**Project Lead Agency:** Community Child Health Service Royal Children's Hospital HSD

**Contact Phone:** 07 3250 8513

**Description:** Through designated health screening centres this project will expand existing services, increasing access for refugee families and improved linkages between the screening service and other services to which refugees are referred. The project will develop and trial a model of refugee health screening that will be complementary to other similar services being established in other sites around the State.

## **5. Minimising the Health Burden of Chronic Disease by Maximising Chronic Condition Self Management (BN05)**

**Project Lead Agency:** Moreton Bay General Practice Network

**Contact Phone:** 07 3284 5155

**Description:** The purpose of this project is to improve in the Deception Bay area, the capacity of allied health providers, pharmacists, general practitioners and Practice Nurses to work more effectively together to provide better patient centred care, through improved collaboration, improved coordination of primary health care services and through a more thorough understanding of the roles of each provider. This will be enabled through a two day training program aimed at educating the various health providers in the principles of chronic disease management, chronic disease self-management, motivational interviewing techniques and stages of change. The program will be conducted by the Inter-Professional Clinic University of Qld.

## **6. Chronic Disease Prevention and Self-Management Model in CALD population (BN06)**

**Project Lead Agency:** Ethnic Communities Council of Queensland (ECCQ)

**Contact Phone:** 07 3844 9166

**Description:** The aim of this project is to trial an integrated healthy lifestyle; health prevention education; and self-management program over a three year period from 2008-11. With a focus on primary and secondary prevention, ECCQ's evidence-based Chronic Disease management program for Culturally and Linguistically Diverse (CALD) communities will aim to encourage behaviour change and promote health and wellbeing. The program has incorporated information on nutrition, physical activity behaviours, and depression as co-morbidities of chronic disease. Community-based multicultural community health workers will deliver program service to communities.

**Target Population:** The program will be suitable for the CALD population living in the North Brisbane region.

## **7. Enhancing Medication Titration in Patients with Heart Failure (BN07)**

**Project Lead Agency:** Metro North, The Prince Charles Hospital

**Contact Phone:** 07 3139 5031

**Description:** This project aims to improve the initiation and optimal dosage of 3 major heart failure medications for patients post discharge from hospital. There is a strong evidence to suggest that maximal tolerated doses of ACE inhibitors (or angiotensin receptor blockers if ACE inhibitors are contraindicated or not tolerated) and Beta Blockers along with adjustment of diuretic dose will reduce heart failure admissions to hospitals.

### **8. LIVE! And Re-Energize Initiative (BN08)**

**Project Lead Agency:** Moreton Bay General Practice Network

**Contact Phone:**

**Description:** The project looks to minimise the health burden of chronic disease and promote preventative health and self management techniques and to contribute to a decrease in the prevalence of complications due to existing chronic disease in the Moreton Bay General Practice Network (MBGPN) population. MBGPN aims to do this through the use of two programs, LIVE! And Re-Energize. The LIVE! Program focuses to altering lifestyles to prevent future chronic disease, while the Re-Energize program focuses specifically on patients at 'high risk' of developing Type 2 Diabetes.

### **9. Physical Activity Health Promotion Officer (BN09)**

**Project Lead Agency:** Primary and Community Health Service, Queensland Health

**Contact Phone:** 07 3139 4119

**Description:** The project aims to employ a HPI Physical Activity Health Promotion Officer. The purpose of this position will be to assist the Chronic Disease Coordinator in further developing activities to address the burden of chronic disease and its effects on the Aboriginal and Torres Strait Islander community. The position will facilitate future growth of the Chronic Disease Team projects to the Northern of the Metro North Health Service District. This project will review the current Isobel Intervention and Prevention Program. The project will increase physical activities and health promotion programs. The project will address the need for health prevention information and education by developing specifically designed resources to address the needs of Aboriginal and Torres Strait Islander peoples.

## **Sunshine Coast & Cooloola**

### **Management**

Chair	Dr Peter Dobson
Auspecting Organisation – Secretariat	Sunshine Coast Division of General Practice
CHIC Facilitator	Jenny Morcom 07 5456 8888

### **Membership**

Sunshine Coast & Cooloola Health Service District  
Population Health, Sunshine Coast  
Sunshine Coast Division of General Practice  
North Coast Aboriginal Corporation for Community Health  
Blue Care (as CHAG rep)

## **Service Delivery and Innovation Projects**

### **1. Inter-professional learning, training and self-management capacity building framework for type 2 diabetes care (IPL Framework) (SCC01)**

**Project Lead Agency:** Sunshine Coast Division of General Practice

**Contact Phone:** 07 5456 8888

**Description:** The strategic goal of this plan is to optimise the care provided within the community for the benefit of the patient with type 2 diabetes and reduce the burden of management on the acute and tertiary sector (SCDGP CLPI Report, 2008). Strategically building cross-sector practitioner development and capacity to provide treatment and care and self-management capability that reflects the ideals of primary health care that is patient-centred, convenient, easily accessible and affordable (Rogers & Veale, 2000) is the preliminary step towards achieving this goal and reorienting service delivery locally.

### **2. Primary Health Liaison Officer; Mental Health Executive Council (SCC02)**

**Project Lead Agency:** Sunshine Coast Division of General Practice

**Contact Phone:** 07 5456 8888

**Description:** This proposal is a compilation of two analogous programs to affect change at the interface between hospital and primary care. They both feature relationship development, improved communication, continuity of patient care, care coordination and enhancing referral, discharge and share care processes. One focuses on the in scope chronic disease, type 2 diabetes in the first instance and Aboriginal and Torres Strait Islander (Indigenous) population and will be referred to within this document as the Primary Health Liaison officer (PHLO) program. The other one endorses and supports the Mental Health Executive Council (MHEC) to focus on strategic interface developments with mental health arena.

## **Wide Bay and Fraser Coast**

### **Management**

Chair	Ms Kylie Slack
Auspecting Organisation – Secretariat	GP Links
CHIC Facilitator	Cyleece Feher 07 4151 0814

### **Membership**

Core membership i.e. Signatories to Partnership Agreement:

Fraser Coast Health Service District  
Wide Bay Health Service District  
GP Links (formerly Wide Bay Division of General Practice)  
Blue Care (as CHAG rep)  
Bundaberg Indigenous Wellbeing Centre

Reps from other forums/initiatives are invited to attend and receive all correspondence:

HeadSpace Agencies – Fraser Coast Integrated Mental Health Service, Lifeline, Youthcare, Fraser Coast Training Employment Support Service, Kids Intervention Prevention Program, Hervey Bay City Council, Maryborough City Council, DETA, Dept Child Safety.  
ABHI Stakeholders – St Stephen’s Hospital, Mater Hospital, Friendlies Hospital, private psychologist, Bundaberg Aboriginal & Torres Strait Islander Health Action Group, Indigenous Health Advisory Council, More Allied Health Services.

## **Service Delivery and Innovation Projects**

### **1. Telehealth – new options for partnerships (WBFC01)**

**Project Lead Agency:** GP Links

**Contact Phone:** 07 4151 0814

**Description:** This project will provide two telehealth machines, one based at GP Links and one based at Gayndah Community Health. The telehealth machines will facilitate access to health services to the rural communities using a different medium other than face to face visitation. It is envisaged that the telehealth services will be used for a range of services including the delivery of group health promotion, 1:1 consultations, consultation for some of the complex and chronic condition patients, Retro Net (a Lifeline Domestic Violence and family counselling service) and other types of consultations that lend themselves to this medium.

## **2. Avoidable Hospital Admissions Project (WBFC02)**

**Project Lead Agency:** GP Links

**Contact Phone:** 07 4151 0814

**Description:** The aim of this project is to facilitate improvements in co-ordinated care of patients with chronic diseases such as COPD and Chronic Cardiac Disease who are likely to readmit to hospital during the course of their illness. The project is an integrated and collaborative project involving public hospitals and community agencies to address patients with cardiac and COPD issues that have a high volume of unplanned and frequent re-presentations to hospital. This project will utilise a Patient-Centred Care Coordinator to directly provide, plan and organise patient care in collaboration with other services in an integrated Case Management Plan.

## **3. Community Outreach Project (WBFC03)**

**Project Lead Agency:** Bridges Aligned Services

**Contact Phone:** (07) 4154 2300

**Description:** This project aims to minimise the harm (including mental illness, intentional self-harm, suicide and chronic disease) caused and/or affected by drug and alcohol misuse in Bundaberg. The project will:

- Increase the capacity of families and community members to provide effective interventions and accurate information to people who misuse substances;
- Provide evidence-based psychosocial interventions for people who misuse substances and their families;
- Establish outreach clinics in a variety of locations that meet the needs of people who misuse substances and their families; and
- Ensure holistic and integrated care solutions for people with a dual diagnosis or complex needs.

## **4. General Practice Diabetic Services Improvement (WBFC04)**

**Project Lead Agency:** GP Links Wide Bay

**Contact Phone:** 07 4151 0814

**Description:** The purpose of this project is to improve the health outcomes for diabetic patients within the whole of the Wide Bay Fraser Coast region by prototyping best practice, sustainable practice based diabetic clinics that will be serve as, and be promoted, as a model for all general practices within the region. The aims of the project are:

- Increased workforce capacity of Diabetes Educators
- Improved health outcomes for patients
- Improved patients' understanding of their health
- Increased efficiency in use of GP's time
- A coordinated approach to diabetes management

## **Central Queensland**

### **Management**

Chair	Ms Leonie Dooley
Auspecting Organisation – Secretariat	Capricornia Division of General Practice
CHC Facilitator	Ben Norden 07 4921 7708

### **Membership**

Bidgerdii Community Health Service  
Capricornia Division of General Practice  
Central Qld HSD  
Central Queensland Rural Division of General Practice  
Central Queensland University  
Consumer rep (Heart Foundation)  
OzCare (Extended Care Forum Rep)  
Hillcrest Private Hospital  
Mater Private Hospital  
Population Health, Central Area Health Service

### **Service Delivery and Innovation Projects**

#### **1. Detoxification and Rehabilitation Services for Young People in Central Queensland (CQ01)**

**Project Lead Agency:** Darumbal Community Youth Service

**Contact Phone:** 07 4922 6180

**Description:** This project is seeking to identify the need for youth specific detoxification and rehabilitation services in Central Qld along with identifying the cultural, social and environmental factors that place young people into 'at risk' situations for overdose, misuse and/or loss of life.

The aim of the project is to gather all available data to develop a report on the need for detoxification and rehabilitation services for young people in Central Queensland.

## **2. A comprehensive community screening program to improve prevention, screening and management of chronic diseases in adult residents of the Woorabinda Community (CQ02)**

**Project Lead Agency:** Central Queensland Health Service District

**Contact Phone:** 07 4920 6211

**Description:** This project will plan, develop, implement and review a comprehensive population screen of all adults in Woorabinda for chronic disease risk factors, disease processes and established disease.

The aims of the project are to:

- Plan, develop, implement and review the population screen;
- Obtain baseline data on chronic disease levels and establish processes for regular patient review;
- Further develop a more coordinated approach to targeted interventions aimed at the risk factors and diseases found to be most prevalent; and
- Utilise existing technology to identify strengths and weaknesses regarding data management.

Target Population: All residents of Woorabinda over the age of 15 years.

## **3. Rural Chronic/Complex Care Coordinators (CQ03)**

**Project Lead Agency:** Central Queensland Rural Division of General Practice Assn. Inc.

**Contact Phone:** 07 4992 5544

**Description:** This project will address the issues surrounding the low usage of the Medicare funded Chronic Disease initiatives. The CHIC funding will fund the formal implementation of a pilot to address issues identified as part of the Gap analysis undertaken to identify areas where there is a lack of co-ordinated care. The project will allow the Division to employ one Full Time Employee in the role of Chronic/Complex Care Coordinator. This project will fund the provision of equipment and resources necessary to fulfil this role and the development of educational and networking activities. The services provided will integrate services available locally, through Community Providers and Queensland Health, and will assist the patients to access services provided regionally.

## **Central West**

### **Management**

Chair	Ms Jill Koeneman
Auspecting Organisation – Secretariat	North & West Queensland Primary Healthcare
CHIC Facilitator	Sue Haines 07 4658 0859

### **Membership**

Spiritus  
Blue Care  
Anglicare  
Home and Community Care  
North & West Queensland Primary Health Care  
Royal Flying Doctor Service  
Central West Health Service District  
Population Health, Central West Population Health Service

### **Service Delivery and Innovation Projects**

## **Former Southern Area Partnerships**

### ***Southern Area Aboriginal and Torres Strait Islander Specific Projects***

#### **1. Aboriginal and Torres Strait Islander Wellbeing in Far South West Queensland (ATSI01)**

**Project Lead Agency:** Charleville & Western Areas Aboriginal & Torres Strait Islander Corporation for Health (CWAATSICH)

**Contact Phone:** 07 4654 3277

**Description:** CWAATSICH, Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services, and Roma Therapy Centre aim to compliment current Chronic Disease intervention in the Aboriginal Medical Services in St George, Charleville, Cunnamulla and Roma. To achieve this outcome the project intends to recruit a clinician that will perform the role of a chronic disease team leader, working in a clinical capacity, liaison officer between partners and key stakeholders and mentor of Aboriginal Health Workers. The CHIC Service Delivery and Innovation Funding is a part contribution to this project. Additional funding for this project is being provided under the Chronic Disease Program.

## ***South West Partnership Council***

### **Management**

Chair	Brenda Tait
Auspicng Organisation – Secretariat	RHealth
CHIC Facilitator	Jennie Waters 07 4658 0859

### **Membership**

South West Health Service District (3 delegates)  
R Health (2 delegates)  
Royal Flying Doctors Service Charleville  
Charleville and Western Districts Corporation for Community Health  
Goondir Health Service  
Cunnamulla Aboriginal Corporation for Health  
Spiritus Roma  
Maranoa Health Enhancement Program  
South West Healthy Communities Program  
Other people may be invited to provide expert advice to the Partnership Council, as required.

## **Service Delivery and Innovation Projects**

### **1. Scripts for Life (SW01)**

**Project Lead Agency:** RHealth

**Contact Phone:** 07 4638 1377

**Description:** This project will develop, implement, monitor and evaluate a prescription and referral program to support community members in the Murweh, Quilpie, Paroo and Bulloo Shires to enhance their health through lifestyle change. A Project Officer will tailor existing tools, develop locally relevant resources and provide support to health service providers. The project is based on the existing national *Lifescrpts Initiative* implemented through Divisions of General Practice.

## **2. Living Strong + (SW02)**

**Project Lead Agency:** Goondir Health Services

**Contact Phone:** 07 4662 6147

**Description:** Living Strong + is a group-based healthy lifestyle program for Aboriginal and Torres Strait Islander people which will support and encourage participants to make healthy lifestyle choices. The program will improve communication and involvement between community members and health services. Living Strong + will allow early identification and intervention for clients with chronic disease and will empower clients through education and self-management strategies. Living Strong + will incorporate St George and Dirranbandi Health Service Providers, organisations and consumers/community actively involved in planning and developing program delivery.

## ***Toowoomba and Darling Downs Partnership Council***

### **Management**

Chair	Mary Coman
Auspicng Organisation – Secretariat	GP Connections
CHIC Facilitator	Andrea Frost 07 4688 2000

### **Membership**

Toowoomba and Darling Downs Health Service District (3 delegates)  
GP Connections (2 delegates)  
R Health (2 delegates)  
Goondir Health Service  
Carbal Aboriginal and Torres Strait Islander Community Controlled Medical Centre  
Lifeline Darling Downs Region  
Department of Communities Darling Downs Region  
Other people may be invited to provide expert advice to the Partnership Council, as required.

## **Service Delivery and Innovation Projects**

### **1. Toowoomba Leg Club (TAAD01)**

**Project Lead Agency:** Ozcare

**Contact Phone:** 07 3028 9157

**Description:** Leg Club is a unique, evidence based model of community based leg ulcer care. It incorporates expert wound care in a community owned, social environment. The Club would run initially once a week. Research into the model has demonstrated the cost effectiveness and clinical effectiveness of this model. The social interaction enables a self management approach and empowers the client to become an active participant in leg care and chronic illness. Opportunities exist in this setting to provide additional education on chronic disease management, healthy eating, and active lifestyle.

### **2. Healthy Piccaninny Program (TAAD02)**

**Project Lead Agency:** Carbal Aboriginal and Torres Strait Islander Community Controlled Medical Centre

**Contact Phone:** 07 4616 6877

**Description:** The Healthy Piccaninny Program is a 12 month program which aims to provide Aboriginal and Torres Strait Islander women and their families with information, education, social and emotional wellbeing as well as enabling access and referrals to culturally appropriate services within the community.

### **3. Southern Downs Suicide Prevention Project – Mental Health Training (TAAD03)**

**Project Lead Agency:** RHealth for Southern Downs Suicide Prevention Taskforce

**Contact Phone:** 07 4660 3901

**Description:** This project will reduce the number of those at risk of suicide or self harm by increasing the capacity of communities in the Southern Downs region to deal with and address local mental health issues. This will be achieved by the training of at least four Mental Health First Aid Facilitators and subsequently utilising their skills for ongoing education and networking to reduce inappropriate referrals and maximise understanding and support.

### **4. Mental Health Respite Skilling Project (TAAD04)**

**Project Lead Agency:** Blue Care for the Commonwealth Respite and Carelink Centre Darling Downs South West Queensland

**Contact Phone:** 1800 052 222 ([ja.ryan@bluecare.org.au](mailto:ja.ryan@bluecare.org.au))

**Description:** This project will enable new and existing support workers to undertake training (Mental Health First Aid) and influence cultural change within services.

### **5. Healthy Kulila Kids (TAAD05)**

**Project Lead Agency:** Carbal Aboriginal and Torres Strait Islander Community Controlled Medical Centre

**Contact Phone:** 07 4639 4461

**Description:** This project aims to demonstrate, through weekly sessions, healthy lifestyle choices and skills to the children at Kulila Indigenous Kindergarten and their care givers. Skill and information to include healthy nutrition choices (including culturally appropriate resources for caregivers) healthy activity, hygiene and health checks.

### **6. Learning for Life (TAAD06)**

**Project Lead Agency:** Carbal Aboriginal and Torres Strait Islander Community Controlled Medical Centre (TADD06)

**Contact Phone:** 07 4639 4461

**Description:** This project aims to demonstrate, through weekly sessions, healthy lifestyle choices and skills to the children at Aboriginal and Torres Strait Islander and Special Needs children at Rockville State Schools and their care givers. Skill and information to include healthy nutrition choices (including culturally appropriate resources for caregivers) healthy activity, hygiene and health checks.

## **7. Mapping of Community Services for the Darling Downs (TAAD07)**

**Project Lead Agency:** GP Connections

**Contact Phone:** 07 4688 2000

**Description:** This project expands the current mapping survey of community services from a Toowoomba focus, to include the flow of patients from Northern and Southern Downs. It will also indicate gaps in access to services.

## **8. Connecting an Active Community (TAAD08)**

**Project Lead Agency:** Roma Therapy Centre

**Contact Phone:** 07 4622 4322

**Description:** The Roma Therapy Centre will coordinate and implement an integrated multidisciplinary approach that provides exercise, dietetics, and physiotherapy to identified target groups. Connecting an Active Community will compliment and support clinical services through intervention and gap filling via ongoing non-clinical support that influences healthy lifestyle choices in line with evidenced based health promotion. This support will be delivered in group and individual sessions. To achieve positive, sustainable outcomes, the program will operate across the continuum of care in small rural and remote communities, providing access to services that educate and promote lifestyle choices ensuring sustainable benefits to individuals and the local community.

## **9. Western Downs Healthy Communities (TAAD09)**

**Project Lead Agency:** Dalby Regional Council

**Contact Phone:** 07 4672 1100

**Description:** The project will provide support to further develop and refine a partnership approach with local government, state and federally funded agencies and community organisations within the Western Downs region that will improve health lifestyle for the benefit of local communities. The WDHC model will use the best and most relevant aspects of a plethora of examples of Healthy Communities strategies that are currently being implemented across southern metropolitan and rural Queensland, eg. Southern Downs Health Community, Chinchilla Health Active Partnership, Active Roma, South Burnett Health Communities, Get Active Gold Coast, which are all partnership approaches to improving local environments for the benefit of health by encouraging great community involvement and great cooperation between different sectors of the community, industry and government.

### **10. Suicide Prevention Community Skilling (TAAD10)**

**Project Lead Agency:** Care Goondiwindi

**Contact Phone:** 07 4671 0700

**Description:** This project is to support the broader strategic direction of the Southern Downs Suicide Prevention Taskforce (SDSPT) furthering the original 'Mental Health Training' project. This project, though providing low cost subsidized Mental Health First Aid (MHFA) training to community members, would reduce the numbers of those at risk of suicide or self-harm as well as increase the capacity of communities in the Southern Downs region to deal with and address local mental health issues, through providing training to skill community members at low cost. Funding over two years will help embed the capacity for cultural change within the local communities regarding people with mental health issues who reside in the community.

### **11. Depression Resource, Peer Support and Education Program (TAAD11)**

**Project Lead Agency:** Depression Support Network (Toowoomba) Inc

**Contact Phone:** 07 4639 3983

**Description:** This project will provide peer support to people with depression, provide education to individuals, carers and communities, maintain drop-in resource centre and increase opening hours, network and collaborate with other agencies and provide advocacy to individuals who are suffering from depression.

### **12. Link Between Chronic Disease, Depression & Substance Misuse – Working together to bring about change! (TAAD12)**

**Project Lead Agency:** Goondir Aboriginal & Torres Strait Islander Health Services

**Contact Phone:** 07 4662 6147

**Description:** This project is to improve the capacity of Goondir staff members to appropriately and holistically assist Indigenous clients and their families to modify or change their behaviour across a number of health issues that negatively interact whilst to contribute to building partnerships across the ATODs sector on the Northern Downs.

### **13. Goondiwindi Healthy Community (TAAD13)**

**Project Lead Agency:** Queensland Policy Citizens Youth Welfare Association

**Contact Phone:** 07 4671 5677

**Description:** This project will be based on the Healthy Cities model, which is a cooperative approach to improving urban and rural environments for health by encouraging greater community involvement and greater cooperation between different sectors of the community, industry and government. The project utilises a range of inter-related strategies which focus on environmental supports to health-enhancing behaviours.

## **West Moreton South Burnett Partnership Council**

### **Management**

Chair	Myrtle Green
Auspic Organisation - Secretariat	West Moreton South Burnett Health Service District
CHIC Facilitator	Christina Barron 07 4638 1377

### **Membership**

West Moreton South Burnett Health Service District (WMSBHSD) (6 delegates)  
Ipswich and West Moreton Division of General Practice (IWMDGP) (3 delegates)  
Southern Queensland Rural Division of General Practice (SQRDGP) (3 delegates)  
St Andrews Hospital (2 delegates)  
Ipswich City Council – Community and Cultural Services Manager  
University of Queensland – Professor of Nursing  
Blue Care representative  
Ozcare representative  
Queensland Ambulance Service representative  
Population Health - Manager  
Kambu Medical Centre – Chief Executive Officer  
Bremer TAFE representative  
Local AMA representative  
Health Community Council representative  
Consumer representative  
Other people may be invited from time to time to provide expert advice to the Partnership Council as required.

### **Service Delivery and Innovation Projects**

#### **1. Improved Coordination of Care to People with Type II Diabetes (WMSB01)**

**Project Lead Agency:** Ipswich and West Moreton Division of General Practice

**Contact Phone:** 07 3813 7017

**Description:** The project aims to improve the coordination of care to people with Type II diabetes, through improved local partnerships and joint planning. Both Ipswich and West Moreton Division of General Practice and RHealth will partner with Ipswich Community Health Service (West Moreton South Burnett Health Service District) to build on the successes of the diabetes model, establishing sustainability and extending the model to other chronic disease areas such as Heart Failure and Lung Disease.

## **Southside Partnership Council**

### **Management**

Chair	Christine Kardash
Auspecting Organisation - Secretariat	SouthEast Primary HealthCare Network Ltd
CHIC Facilitator	Helen Elliot 07 3840 6150

### **Membership**

CEO, SouthEast Primary HealthCare Network Ltd  
Executive Director, Community and Primary Health, Southside Health Service District  
Queensland Health  
CEO, SouthEast Primary HealthCare Network Ltd  
Director, Allied Health, Mater Health Services shared position with Director, Allied Health  
Princess Alexandra Hospital  
Chair, Bayside Health Community Council  
Director, Southern Area Population Health, Queensland Health  
CEO, Multicultural Development Association Inc.  
Area Community Care Manager, Spiritus  
CEO, Alcohol and Drug Foundation – Queensland  
Councillor, Beaudesert Shire Council

## **Service Delivery and Innovation Projects**

### **1. Family Support Worker within BeauVisions Mental Health Community Support Service (SS01)**

**Project Lead Agency:** Centacare St Mary's Community Services

**Contact Phone:** 07 5541 1653

**Description:** A Family Support Worker will be employed within the BeauVisions Mental Health Community Support Service to work with parent clients and their children to improve relationships by educating and re-educating parents on how better to manage their symptoms and the impacts of these on their children, whilst also renewing and developing their parental skills. The Family Support Worker will also develop a specific parenting skills training program/regime with a focus on the effects of mental illness. This program can then be used to up-skill relevant organisational (and partner agency) staff as well as the general community to ensure the sustainability of the project and ultimately the ongoing outcomes for parent clients and their children.

## **2. Mental Health Promotion Initiatives within the Bayside Area (SS02)**

**Project Lead Agency:** South East Alliance of General Practice (Brisbane) Ltd

**Contact Phone:** 07 3840 6150

**Description:** The scope of this project is to improve the positive mental health and well being of young people in Bayside with the use of mental health promotion initiatives; and to improve networks between schools and local mental health service and primary care providers. This will be achieved by a range of strategies targeting both the individual and community.

## **3. Comprehensive Evidence Based Model of Primary Care for People with Type II Diabetes (SS03)**

**Project Lead Agency:** South East Alliance of General Practice (Brisbane) Ltd

**Contact Phone:** 07 3840 6150

**Description:** This project will support general practices from the SEAGP to implement a comprehensive, evidence based model of primary care that involves collaboratively working with Brisbane Southside Community Health diabetes services, Health Services diabetes services, private specialists and allied health providers of diabetes services in the local area. General Practice will be supported to manage patients with chronic disease in the primary care setting. Secondary care providers will provide support to General Practice through formal evidence based shared care and mentoring which meet the needs of all stakeholders. People with Type II Diabetes will have increased access to services within their usual care setting.

## **4. Healthy Babies (SS04)**

**Project Lead Agency:** Queensland University of Technology

**Contact Phone:** 07 3138 5806

**Description:** The project aims to increase exclusive breastfeeding rates, decrease the inappropriate introduction of solids in accordance with the Australian Dietary Guidelines and the World Health Organisation (WHO) breastfeeding targets, and thus decrease hospitalisation rates for gastroenteritis and other illness associated with the inappropriate use of artificial feeds and the early introduction to solids.

## **5. Bi-Lingual Health Promoter Project (SS05)**

**Project Lead Agency:** Griffith University

**Contact Phone:** 07 3382 1202

**Description:** The Bi-Lingual Health Promoter project addresses the lack of access to services among CALD communities. It uses a collaborative community-based approach to consultation to recruit local bi-lingual community members who will be trained and supported to act as health promoters. By virtue of their background and position in the community, the Health Promoters will draw on their existing community linkages in a culturally appropriate way to act as a bridge between the communities and the health system. They will advocate for improved access, ensure that local communities are consulted appropriately and support them in their interpretation and use of health services.

## **6. Inala and Surrounds Young Parent Consortium (SS06)**

**Project Lead Agency:** Spiritus (Early Parent Centre)

**Contact Phone:** 07 3723 6633

**Description:** This project will build on and enhance the services currently being provided to young parents at the Spiritus Early Parent Centre based in Inala, to offer a comprehensive and integrated model of service delivery in a safe, non-threatening and information environment outside of hospital and government facilities. The project will coordinate currently fragmented services and the forming of the consortium will increase service coordination to better meet the needs of young parents and offer a more diverse range of outreach service from conception to early childhood. The project will improve the capacity of existing services, particularly child health to engage high risk clients including people from culturally and linguistically diverse populations and Aboriginal and Torres Strait Islander peoples.

## **7. Coordination of the Living Well at Home Program across the Southern Health Service District (SS07)**

**Project Lead Agency:** Mater Misericordiae Health Services Brisbane Limited

**Contact Phone:** 07 3163 1760

**Description:** This project aims to build on previous collaborative work done between ARCH (Annerley Road Community Health) Home care services and DAART (Domiciliary Allied Health Acute care and Rehabilitation Team). This project will expand the program to promote health and independence and increase partnership between various across the health service district by:

- Packaging the program into a format that will allow other service providers to implement the model across the Brisbane Health Service district including domestic service providers and allied health teams;
- Development and delivery of an education program for staff, General Practitioners and community stakeholders to create a climate of change in service delivery of domestic assistance;
- Organising a trial equipment store for services and clients to access via liaison with manufacturers; and
- Ensuring the longevity of the program by setting up formal networks of Living Well At Home Program providers in the community.

## **8. Primary Connections in Mental Health (SS08)**

**Project Lead Agency:** SouthEast Primary HealthCare Network

**Contact Phone:** 07 3290 3733

**Description:** This pilot project aims to strengthen connections between primary care and mental health and increase collaboration between key partners in Logan. A primary health

care worker (mental health) situated in the community setting and within general practice, provides a unique method to achieve this goal. The primary health care worker (mental health) will act as an interface between patients, hospital, public mental health services and primary health care for those patients discharged from the Logan Hospital, adult mental health units.

### **9. Community Paediatric Complex Care (SS09)**

**Project Lead Agency:** Mater Health Services, DAART Paediatrics

**Contact Phone:** 07 3163 1760

**Description:** The project aims to develop, implement and evaluate an enhanced model of care for children/young people with chronic/complex care needs and their families which integrates their care between hospital and home and provides a more sustainable delivery of service within the community.

### **10. HYPE! Hip Hop = Healthy – Street Dance for Logan Youth (SS10)**

**Project Lead Agency:** Griffith University – Logan Campus

**Contact Phone:** 07 3382 1487

**Description:** This project aims to use *street* dance to engage Logan's culturally diverse and predominantly low income school population to participate in a holistic health program. The specific aim of the project includes: to implement a long term, culturally relevant physical activity program that utilises street dance to encourage physical activity participation, to increase physical activity participation, to increase participant's self esteem, connectedness and social competence through project participation, to implement a health eating intervention for participants, to improve health eating patterns among participants, to increase participants understanding of the impact of alcohol, tobacco and other drugs on health status and to integrate diverse ethnic groups (e.g. Pacific Islander cultures) into dance and health eating.

### **11. Independent Minds (SS11)**

**Project Lead Agency:** Jimboomba Community Care Association Inc (JCAA)

**Contact Phone:** 07 5547 9797

**Description:** Independent Minds aims to provide an early intervention and prevention program to alcohol, tobacco and other drug issues for youth between the ages 11 to 18. Independent Minds will build in improving service integration and developing a streamline service for young people in the local area.

## **Gold Coast Primary Care Partnership Council**

### **Management**

Chair	Matt Carrodus
Auspecting Organisation - Secretariat	Gold Coast Division of General Practice
CHIC Facilitator	Marcia Dwonczyk 07 5507 7777

### **Membership**

Executive Director, Community, Allied, Rehabilitation and Aged Services, Queensland Health  
HACC Area Manager, Queensland Health  
Regional Manager, Bluecare  
Area Manager, RSL Care  
Assistant Regional Manager (Southern Region), OzCare  
Manager Service Development, Spiritus  
Disability Services Queensland  
Regional Planner, Department of Communities  
CEO, Gold Coast Division of General Practice  
Manager, Mental Health Services, Queensland Health  
Gold Coast Health Service District Health Community Council  
Assistant Manager, Health Services Branch, Department of Health and Ageing  
Manager, Social Planning and Research, Gold Coast City Council  
Director Health Promotion, Gold Coast Population Health  
Board Member, Gold Coast Division of General Practice  
Director, Community and Child Health, Queensland Health  
Representative TBA, Kalwun Health Service (Community Controlled Health Service)

### **Service Delivery and Innovation Projects**

#### **1. Phase One – Improving Health Outcomes for Young People and Their Families – Co-occurrence of Mental Illness and Alcohol and Other Drug Use (GC01)**

**Project Lead Agency:** Gold Coast Division of General Practice

**Contact Phone:** 07 5507 7777

**Description:** The purpose of the project is to undertake a planning and investigation phase to improve health outcomes of young people (0-25) by targeting the complex nature of the interaction between alcohol and other drug use/ misuse and mental health issues and their families from promotion of positive health and wellbeing (eg resilience) through to prevention, early intervention, crisis intervention, management and ongoing support for those with complex needs.

#### **2. Early Years Partnership: An early intervention and prevention initiative (GC02)**

**Project Lead Agency:** The Benevolent Society and Gold Coast Division of General Practice

**Contact Phone:** 07 5578 1346 or 07 5507 7777

**Description:** This project is being undertaken to develop universal support for promoting strong, healthy children as well as early identification and intervention for those children identified as vulnerable or at risk. The project will target children 0-6 years old and their parents. The project will establish a GP collaborative through which the evidence based Reach out and Read program will be implemented, improve immunisation and provide clear pathways for appropriate early interventions.

### **3. Service Access Partnership (GC03)**

**Project Lead Agency:** Gold Coast Division of General Practice

**Contact Phone:** 07 5507 7777

**Description:**

This project is about achieving easy, timely, multidimensional information, access and engagement across stake holders. The goal of this project is to identify an approach to health service access that is sustainable, including not only the resources, but also built in incentives for the system to be kept up to date. The project will contribute to health partnerships in two ways – one in the development of the service access strategy and one in the implementation of the approach.