9 Resource Implications

The Queensland Refugee Health Service was allocated $1.08 million for establishment in 2007/08 and $1.2 million for implementation.

9.1 Establishment budget

The 2007/08 budget is allocated to planning and service establishment costs (refer table 8). Building infrastructure comprises a significant proportion of the budget as the hub is a new service that requires accommodation and fit-out. The hub building design, building works and fit out are estimated on the square metres required[23] and are allocated at the higher end of the estimated range as a budget risk management strategy. Therefore the Steering Committee identified a number of other priority items for expenditure if the hub building works have been overestimated (refer Table 9).

Table 8: 2007/08 Budget allocation Queensland refugee health service	
QRHS PLANNING	
QRHS planning August 2007-March 2008	124,394
PLAN IMPLEMENTATION	
Project officer to implement Service Plan March-Jun 08	24,426
IT infrastructure	
Medical Director software annual fee	1,848
Pracsoft software registration (once-off)	1,960
Pracsoft software annual subscription	1,150
MD/Pracsoft software set-up and staff training	9,300
Business analyst to develop database (3 months temp)	21,000
Development of health assessment template - electronic	2,000
Multifunctional copier/printer/fax/scanner for hub	15,000
Computer, laptop & printer purchase for hub & spokes	26,750
Building infrastructure	
Hub lease - pay in advance 3 years[24]	210,540
Hub - Building design work & fit for purpose assessment	75,000
Hub - Building works estimate (higher range)	364,772
Hub - Furniture and office fit-out estimate	50,000
Clinical equipment for hub and spokes	126,000
RESOURCES	
Assessment & immunisation personal record	10,000
GP desktop guide	3,000
GP desktop flip-chart	1,500
GP desktop CDrom	360
Translated resources on schistosomiasis	4,000
CAPACITY BUILDING	
QIRCH National Refugee Primary Health Care Conf sponsorship	5,000
Townsville GP training	2,000
TOTAL	**$1,080,000**

[23] This includes size requirements for the hub and the QIRCH Clinic

[24] From 2011 on, lease costs will need to be incorporated in annual budgets. To meet this cost, additional funding may be requested or labour costs reduced. As a risk management strategy, the AO7 coordinator is to be appointed on a three year contract.

BUDGET AVAILABLE	$1,080,000
PRIORITY ITEMS FOR EXPENDITURE IF HUB BUILDING COSTS ARE LOWER THAN PLANNED	
RESOURCES	
Print translated resource on health system (8 languages)	44,938
Assessment & immunisation personal record	30,000
GP desktop guide	3,000
GP desktop flip-chart	1,500
GP desktop cdrom	360
Translate & print TB brochures	22,000
CAPACITY BUILDING	
Townsville GP training	2,000
TOTAL	**$103,798**

Table 9: Priority items for expenditure if hub building costs are lower than planned

9.2 Implementation budget

The implementation budget for 2008/09, 2009/10 and 2010/11 is based on the following formulas and calculations which were applied to each hub and spoke location:

Budget item	Calculation/formula
Client number at each location	Based on actual settlement numbers in 2006/07. Future projections correspond closely.
Nursing hours	4.25 hours per adult to conduct health assessment (includes follow up referrals and phone calls) 2.75 hours per child to conduct health assessment 4 hours per week for meeting attendance and capacity building activities
Interpreter costs	1.5 hours per adult for health assessment with nurse 1 hour per child for health assessment with nurse 1 hour per person for health assessment with medical officer (where applicable) NB Cairns and Townsville use Doctors Priority Line for free telephone interpreting as there are no on-site interpreters available in the demand languages
Non-PBS medications	Based on medications list developed nationally, 'Conditions common to recent refugees and recommended treatments', applied to Queensland humanitarian entrants data and costed by Medicines and Pharmacy Services Unit (Attachment 10)
Income immunisation by nurses	$10.85 per immunisation through Medicare billing
Income health assessment by medical officers	$204 per health assessment through Medicare billing

Table 10: Formula and calculations in the 2008-11 budgets, Queensland Refugee Health Service

QUEENSLAND REFUGEE HEALTH SERVICE BUDGET 2008-2011	2008/09		2010/11		2011/12	
BRISBANE HUB - FUND MATER HEALTH SERVICES	**Expenditure**	**Income**	**Expenditure**	**Income**	**Expenditure**	**Income**
Statewide Function						
1FTE AO7	91,678		91,678		91,678	
.5FTE SMO	141,200		141,200		141,200	
oncosts	37,458		37,458		37,458	
computer levy	5,780		5,780		5,780	
Stationery/supplies	5,000		5,000		5,000	
Telephone/communication	2,000		2,000		2,000	
Non-PBS meds (state-wide)	43,379		43,379		43,379	
Resource development	9,477		9,477		9,477	
Car lease	10,000		10,000		10,000	
Travel/accom	7,500		7,500		7,500	
Evaluation	15,000		15,000		15,000	
SSP	3,300		3,300		3,300	
Sub-total State-wide Function	**$ 371,772**		**$ 371,772**		**$ 371,772**	
BRISBANE HUB - Health assessment clinic						
Staffing						
VMO sessions to see 934 entrants (see Note 1)	*$ 157,005*		*$ 157,005*		*$ 157,005*	
1NO2						
1NO4						
1FTE AO2						
sub-total staffing costs	214,768		214,768		214,768	
on costs	37,292		37,292		37,292	
non-labour						
Computer levy	10,060		10,060		10,060	
Telephone/communication	5,000		5,000		5,000	
Stationery/supplies	5,000		5,000		5,000	
Clinical supplies	10,000		10,000		10,000	
Interpreter services	150,387		150,387		150,387	

QUEENSLAND REFUGEE HEALTH SERVICE BUDGET 2008-2011	2008/09		2010/11		2011/12	
SSP	6,600		6,600		6,600	
Health assessment Item 714 MBS claims - Mater to retain		190,536		190,536		190,536
Immunisation by nurses		10,134		10,134		10,134
Sub-total Health assessment clinic	**$ 596,112**	**$ 200,670**	**$ 596,122**	**$ 200,670**	**$ 596,112**	**$ 200,670**
QIRCH (COMPLEX CASE MANAGEMENT FOR HUB)						
QIRCH operational costs (see Note 2)	**$ 25,000**		**$ 25,000**		**$ 25,000**	
BRISBANE NORTH SPOKE - FUND RCH HSD						
Staffing						
0.3 FTE NO2	22,564		22,564		22,564	
on costs	3,897		3,897		3,897	
Non-labour						
Printer levy	3,000		3,000		3,000	
Computer levy	2,250		2,250		2,250	
Stationery/supplies	1,000		1,000		1,000	
Telephone	1,000		1,000		1,000	
Clinical supplies	500		500		500	
Interpreter services	14,782		14,782		14,782	
Software annual fee	308		308		308	
SSP	660		660		660	
sub-total Brisbane North	**$ 49,961**		**$ 49,961**		**$ 49,961**	
LOGAN SPOKE - FUND SOUTHSIDE HSD						
Staffing						
1FTE NO2	75,213		75,213		75,213	
.5FTE AO2	21,210		21,210		21,210	
on costs	16,716		16,716		16,716	
Non-labour						
Computer levy	1,765		1,765		1,765	

QUEENSLAND REFUGEE HEALTH SERVICE BUDGET 2008-2011	2008/09		2010/11		2011/12	
Stationery/supplies	2,760		2,760		2,760	
Telephone	2,760		2,760		2,760	
Clinical supplies	1,000		1,000		1,000	
Car lease	8,000		8,000		8,000	
Interpreter services	29,134		29,134		29,134	
SSP	3,300		3,300		3,300	
sub-total Logan	**$ 161,858**		**$ 161,858**		**$ 161,858**	
TOOWOOMBA SPOKE - FUND TOOWOOMBA & DD HSD						
Staffing						
0.55 FTE NO2	41,366		41,366		41,366	
on costs	7,142		7,142		7,142	
Non-labour						
Computer levy	2,250		2,250		2,250	
Stationery/supplies	1,080		1,080		1,080	
Telephone	1,080		1,080		1,080	
Clinical supplies	500		500		500	
Interpreter services	21,646		21,646		21,646	
travel	500		500		500	
Software annual fee	308		308		308	
SSP	1,210		1,210		1,210	
sub-total Toowoomba	**$ 7,082**		**$ 77,082**		**$ 77,082**	
CAIRNS SPOKE - FUND GENERAL PRACTICE CAIRNS						
Staffing						
0.3FTE NO4	28,262		28,262		28,262	
on costs	4,898		4,898		4,898	
Non-labour						
Computer levy	2,250		2,250		2,250	
Stationery/supplies	1,000		1,000		1,000	

QUEENSLAND REFUGEE HEALTH SERVICE BUDGET 2008-2011	2008/09		2010/11		2011/12	
Telephone	1,000		1,000		1,000	
Clinical supplies	500		500		500	
Travel	1,000		1,000		1,000	
Mileage	500		500		500	
Interpreter services	0		0		0	
Software annual fee	308		308		308	
Admin fee General Practice Cairns (10%)	3,971		3,971		3,971	
sub-total Cairns	**$ 3,689**		**$ 43,689**		**$ 43,689**	
TOWNSVILLE SPOKE - FUND JAMES COOK UNIVERSITY						
Staffing						
0.2FTE NO4	18,842		18,842		18,842	
on costs	3,265		3,265		3,265	
Non-labour						
Computer levy	2,250		2,250		2,250	
Stationery/supplies	1,000		1,000		1,000	
Telephone	1,000		1,000		1,000	
Clinical supplies	500		500		500	
Mileage	500		500		500	
Software annual fee	308		308		308	
Interpreter services	0		0		0	
Travel	1,000		1,000		1,000	
Admin fee JCU (10%)	2,866		2,866		2,866	
sub-total Townsville	**$ 31,531**		**$ 31,531**		**$ 31,531**	
TOTAL EXPENDITURE ALLOCATED *(less cost of VMOs)*	**$ 1,200,000**		**$ 1,200,010**		**$ 1,200,000**	
TOTAL EXPENDITURE & INCOME	**$ 1,357,005**	**$ 200,670**	**$ 1,357,015**	**$ 200,670**	**$ 1,357,005**	**$ 200,670**
TOTAL SURPLUS AVAIL TO REINVEST IN REFUGEE HEALTH (Note 3)		**$ 43,665**		**$ 43,665**		**$ 43,665**

Budget explanatory notes:

Note 1 VMO sessions: Based on $168.10 per hour, Medical VMO FRACGP/Voc 3rd Yr, VMO Wage Rates Lattice system multiplied by 1 hour appointments for 934 humanitarian entrants per year.

Note 2 QIRCH Clinic operational costs: QIRCH Clinic will provide complex health coordination services for the hub. The ongoing funding commitment by St Vincent's and Holy Spirit Health, Queensland Health (recurrent funding and nine hours nursing hours provided by Southside Health Service District[25]) and Mater Health Services is required. However, the QIRCH sessional GPs currently donate whole or part of their Medicare earnings to the clinic to pay for operational costs. By ensuring that the QIRCH Clinic continues its operations in a sustainable way and not rely on volunteers, the operational costs are provided through this budget. It is a cost saving to pay for QIRCH Clinic's operational costs ($25,000), rather than allocating funds for complex health coordination to the hub, which would cost $158.759 (1.8 NO2 positions)

Note 3 Surplus available to reinvest into refugee health: the requirement for Mater Health Services to reinvest the operating surplus back into the refugee health service will be stipulated in the service agreement between Queensland Health and Mater Health Services.

[25] **Southside Health Service District has advised that the nine hours of nursing will be temporarily discontinued during the office relocation of Mt Gravatt Community Health Centre staff and will then be reassessed. However, the District has indicated that it values the long term partnership with QIRCH Clinic.**

10 Implementation and evaluation plan

10.1 Implementation plan

The following strategies concern the establishment of the service.

Strategies	Output	Target	Who is responsible
Establish an ongoing Statewide Advisory Committee and terms of reference, with membership including general practitioners, non government organisations and Queensland Health representatives	Statewide Advisory Committee established	July 2008	Statewide Coordinator
	Statewide Advisory Committee Terms of reference agreed	September 2008	Statewide Coordinator
Establish governance for the Service Queensland Health and at hub and spoke locations	Queensland Health contract management unit identified	July 2008	Project Sponsor
	Hub and spoke governance arrangements established	July 2008	Queensland Health Multicultural Program[26]
Establish clinical advisory committee	Clinical advisory committee established	July 2008	Statewide Coordinator
Monitor and report on the agreed deliverables achieved by the hub and spokes	Data collection tools are established	July 2008	Queensland Health Multicultural Program
	Service establishment indicators in the evaluation plan reported to contract management unit on a quarterly basis	First report Sep 2008	Statewide Coordinator
Appoint a statewide coordinator for the Queensland Refugee Health Service	Statewide Coordinator appointed	July 2008	Mater Health Services
Facilitate regular networking and communication processes between spokes	Email group established. Collaborative mechanisms between hub and spokes established	August 2008	Statewide Coordinator
Develop, implement and review consistent, standardised clinical and other protocols	Standardised health assessment template implemented	from July 2008	Queensland Health Multicultural Program

[26] **The Principal Project Officer (Refugee Health) position within the Queensland Health Multicultural Program has been extended April to June 2008 to undertake implementation and service establishment activities.**

Strategies	Output	Target	Who is responsible
	Clinical protocols developed	August 2008	Hub Medical officer together with Clinical Advisory Committee
Provide training and education on refugee health to service providers involved in the program	GP refugee health resources are disseminated widely in the hub and spoke areas	July – December 2008	Hub and spokes
Establish clinics	Clinical equipment purchased	June 2008	Queensland Health Multicultural Program together with hub and spokes
	Interim accommodation for hub established	June 2008	Mater Health Services
	Accommodation for hub fitted out	December 2008	Mater Health Services
	Hub Medical Officer, nurses, GPs and admin staff recruited	July 2008	Mater Health Services
	Spoke nurses and admin staff recruited	July 2008	Spokes: Southside HSD Royal Children's Hospital & HSD Toowoomba & Darling Downs HSD General Practice Cairns James Cook University
Pre-arrival planning is in place	Protocols for responding to health alerts in place	July 2008	Queensland Health Multicultural Program
Develop a process to manage the health requirements of group arrivals	Protocols for responding to large group arrivals in place	September 2008	Statewide Coordinator

Strategies	Output	Target	Who is responsible
Regular liaison with community GPs and Divisions of General Practice and other health services	Referral processes to community GPs established	August 2008	Nursing staff in hub and spokes
	Referral processes to other health services established	August 2008	Nursing staff in hub and spokes
Facilitate complex health case coordination and ongoing care with local services	Nurse appointed to provide complex case coordination (Logan, Brisbane North, Toowoomba, Cairns and Townsville)	July 2008	Spokes (as above)
Collect data on health conditions of assessed patients and analyse service provider training needs in managing these conditions	Develop database	July 2008	Mater Health Services[27]
	Capacity to collect information on health conditions in the database	July 2008	Mater Health Services
Collect data on client and service provider satisfaction with the service	Satisfaction surveys developed	Oct 2008	Statewide Coordinator

10.2 Evaluation plan

10.2.1 Evaluation purpose

To identify if the service is effective and efficient - if all eligible humanitarian entrants and asylum seekers have timely access to the service

10.2.2 Key audiences

Priority audiences
Funding body – Queensland Health
Department of Immigration and Citizenship
Integrated Humanitarian Settlement Strategy services
Community leaders
Service providers involved with the QRHS

Other interested stakeholders
State governments
General public

10.2.3 Reporting framework

There are three components to the evaluation:

- service establishment outputs
- service operational outputs
- service operational outcomes.

[27] **Mater Health Services will employ a business analyst to develop the database for the service**

The reporting framework for the evaluation plan is shown in figure 11.

EVALUATION COMPONENTS		FREQUENCY	FROM	TO
Service establishment	Service establishment outputs	One-off reporting	Statewide Coordinator	Queensland Health
Service operations	Service outputs	Quarterly	Hub, spokes	Statewide Coordinator
	Service outcomes	Six monthly	Statewide Coordinator	Queensland Health

Figure 11: Queensland Refugee Health Service - reporting framework

10.2.3 Service establishment outputs

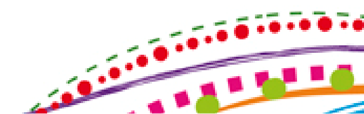
Output	Target	Who is responsible
Statewide Advisory Committee established	July 2008	Statewide Coordinator
Statewide Advisory Committee Terms of reference agreed	September 2008	Statewide Coordinator
QH contract management unit identified	July 2008	Project Sponsor
Hub and spoke governance arrangements established	July 2008	Queensland Health Multicultural Program
Clinical advisory committee established	July 2008	Statewide Coordinator
Data collection tools are established	July 2008	Queensland Health Multicultural Program
Service establishment indicators in the Evaluation plan reported to contract management unit on a quarterly basis	First report September 2008	Statewide Coordinator
Statewide Coordinator appointed	July 2008	Mater Health Services
Email group established. Collaborative mechanisms between hub and spokes established	August 2008	Statewide Coordinator
Standardised health assessment template implemented	from July 2008	Queensland Health Multicultural Program
Clinical protocols developed	October2008	Hub Medical officer together with Clinical Advisory Committee
GP refugee health resources are disseminated widely in the hub and spoke areas	July – December 2008	Hub and spokes
Clinical equipment purchased	June 2008	Queensland Health Multicultural Program together with hub and spokes
Accommodation for hub fitted out	December 2008	Mater Health Services

Output	Target	Who is responsible
Hub Medical Officer, nurses, GPs and admin staff recruited	July 2008	Mater Health Services
Spoke nurses and admin staff recruited	July 2008	Hub and spokes
Protocols for responding to health alerts in place	July 2008	Queensland Health Multicultural Program
Protocols for responding to large group arrivals in place	September 2008	Statewide Coordinator
Referral processes to community GPs established	August 2008	Nursing staff in hub and spokes
Referral processes to other health services established	August 2008	Nursing staff in hub and spokes
Nurse appointed to provide complex case coordination (Logan, Brisbane North, Toowoomba, Cairns and Townsville)	July 2008	Hub and spokes
Develop database	July 2008	Queensland Health Multicultural Program
Capacity to collect information on health conditions in the database	July 2008	Queensland Health Multicultural Program
Satisfaction surveys developed	Oct 2008	Statewide Coordinator

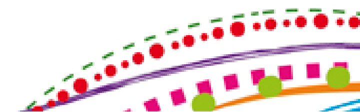
10.2.5 Service operation outputs

Outputs are reported by the hub and spokes to the Statewide Coordinator on a quarterly basis. The outputs and targets will be the basis of the service agreements between Queensland Health and the hub and spoke services.

OUTPUTS	Numerator (N) and Denominator (D)	Target	Data source	How collected	Who collects	When to collect
Links with local groups maintained by Statewide Advisory Committee	n/a	100%	Statewide Coordinator report	Minutes of Statewide Advisory Committee	Statewide Coordinator	Quarterly
Hub and spokes provide quarterly reports to Statewide Coordinator Statewide Coordinator reports to contract management unit every six months.	n/a	100%	Statewide Coordinator report	Hub/Spoke report to Statewide Coordinator	Statewide Coordinator	Quarterly
Minimum one face-to-face meeting annually	Number of site visits each year	1	Statewide Coordinator report	Statewide Coordinator report	Statewide Coordinator	Quarterly
Minimum one site visit per year each by Statewide Coordinator and Medical Officer to spokes	Number face to face meetings each year	2 per site	Statewide Coordinator report	Statewide Coordinator report	Statewide Coordinator	Quarterly
Quarterly teleconferences facilitated by Statewide Coordinator	Number teleconferences each year	4	Statewide Coordinator report	Statewide Coordinator report	Statewide Coordinator	Quarterly
Clinical advisory committee meets bi-monthly to lead development, implementation and review of clinical protocols in 2008-09 and meets as	Number of meetings in 2008-09	6	Statewide Coordinator report	Statewide Coordinator report	Statewide Coordinator	Quarterly



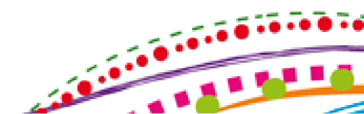
OUTPUTS	Numerator (N) and Denominator (D)	Target	Data source	How collected	Who collects	When to collect
required thereafter						
Participation in state and national forums to ensure protocols reflect contemporary best practice	Number of forums attended per year /Number of forums per year	n/a	Statewide Coordinator report	Statewide Coordinator report	Statewide Coordinator	Quarterly
GP training is developed and conducted in collaboration with local GP divisions	N: Number GP training sessions conducted in hub and spoke locations D:Total number of GP divisions in hub and spoke locations	1 per Division	Statewide Coordinator report	Statewide Coordinator report	Statewide Coordinator	Quarterly
Regular liaison between statewide coordinator, nurses and IHSS services to plan appointments, including responses to health alerts	N: Number of issues resolved D: Number of issues listed on Issues Register	100% resolved	Issues register	Statewide Coordinator report	Statewide Coordinator	Quarterly
Standardised nursing health assessment template is used	n/a	100%	Statewide Coordinator report	Statewide Coordinator report	Statewide Coordinator	Quarterly
Immunisation catch up provided where required	N: Number of assessed patients fully immunised D: Number of assessed patients	100%	Database Aust Childhood Immunisation Register (under 8) Vivas Qld Register	Nurse checks with Registers Statewide Coordinator report	Nurses; Statewide Coordinator	Annual check with Registers Quarterly – numbers immunised



OUTPUTS	Numerator (N) and Denominator (D)	Target	Data source	How collected	Who collects	When to collect
MBS billing of immunisation	N: MBS immunisation billing revenue received D: Potential MBS immunisation billing revenue (number of medicare eligible assessed patients immunised X MBS item fee)	100%	Pracsoft	Patient record	Nurses; Statewide coordinator	Quarterly
Visiting Medical Officers or general practitioners undertake medical assessment and review of all hub clients with MBS billing of Item 714	N: Number of humanitarian entrants and asylum seekers who received a medical assessment and review in quarter in hub D: Number of humanitarian entrants and asylum seekers arriving in quarter in hub service area	100%	Database	Database entries	Medical officer/nurses	Quarterly
	N: MBS Item 714 billing revenue received D: Potential MBS	100%	Pracsoft	Patient record	Medical officer/nurses	Quarterly

OUTPUTS	Numerator (N) and Denominator (D)	Target	Data source	How collected	Who collects	When to collect
	Item 714 billing revenue (number of medicare eligible assessed patients X MBS item fee)					
Medical Officers continue providing medical assessment and review (Brisbane North, Toowoomba) of all clients	N: Number of humanitarian entrants and asylum seekers who received a medical assessment and review in quarter in spoke location D: Number of humanitarian entrants and asylum seekers arriving in quarter in spoke location	100%	Database	Spoke database entries	Medical officer/nurses	Quarterly
Referral processes to community GPs to undertake medical assessment and review are in place (Logan, Cairns, Townsville) of all clients	Referral processes in place	By July 08 in each location	Statewide Coordinator report	Hub/Spoke report to Statewide Coordinator	Statewide Coordinator	Quarterly
Number of referrals to providers other than GPs	N: Number health conditions requiring referral in spoke/hub location D: Number of new	100%	Database	Hub and spoke database entries	Medical officer/nurses	Quarterly

OUTPUTS	Numerator (N) and Denominator (D)	Target	Data source	How collected	Who collects	When to collect
	referrals made in spoke/hub location					
Patient files are exported electronically to community GPs	N: Number of electronic referrals to community GPs D: Number of total referrals to GPs	75%	Database	Hub and spoke database entries	Nurses Statewide Coordinator	Quarterly
All newly arrived humanitarian entrants are referred to a community general practitioner for ongoing care	N: Number of referrals to community GPs in spoke/hub D: Number of new arrivals in spoke/hub location	100%	Database	Hub and spoke database entries	Nurses; Statewide coordinator	Quarterly
All asylum seekers are referred to a general practitioner willing to waive fees for ongoing care	N: Number of asylum seekers referred to GPs in quarter D: total number of asylum seekers seen in quarter	100%	Database	Hub and spoke database entries	Nurses; Statewide coordinator	Quarterly
Number of GPs in referral networks is maintained and/or increased	N: Number of GPs in referral networks in service location D: total number of GPs in service location	Increases over time	Database	Hub and spoke database entries	Nurses; Statewide coordinator	Quarterly



OUTPUTS	Numerator (N) and Denominator (D)	Target	Data source	How collected	Who collects	When to collect
GPs and other health service providers are provided education and training on refugee health	N: Number of GPs participating in training D: Number of GPs in the area		Training and resources report		Nurses; Statewide coordinator Statewide MO	
Number of clients requiring complex health case coordination monitored per service against 25% projected need	N: Number of patients requiring complex health case coordination in quarter D: Total number of patients in quarter	25%	Database	Hub and spoke database entries	Nurses; Statewide coordinator	Quarterly
Number of hours required for complex health case coordination monitored per client against 10 hours projected need	N: Number of hours required for complex health case coordination in quarter D: Total number of patients with complex health requirements in quarter	10 hours per patient	Database	Hub and spoke database entries	Nurses; Statewide coordinator	Quarterly
Number of referrals for complex health cases	N: Number of referrals made D: Total number of complex cases	More than 5 referrals	Database	Hub and spoke database entries	Nurses Statewide Coordinator	Quarterly
Frequency of health conditions among assessed patients (eg. Schistosomiasis) by	n/a	4 reports per year	Database	Hub and spoke database entries	Nurses; Statewide	Quarterly

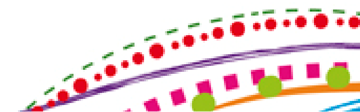
OUTPUTS	Numerator (N) and Denominator (D)	Target	Data source	How collected	Who collects	When to collect
country of origin over time. (Note: information will need to be de-identified to meet privacy requirements).					coordinator	
Interpreters are used as needed	N: Number of clients where an interpreter was used D: Total clients		Database	Hub and spoke database entries	Nurses; Statewide coordinator	Quarterly
The majority of patients assessed through the service and service providers involved with the service satisfied with the service.	Majority satisfied	Majority (note may be qualitative)	Satisfaction survey	Client focus groups; provider survey	Statewide Coordinator	Annually

10.2.6 Service operational outcomes

The Statewide Coordinator reports on the service outcomes to Queensland Health six monthly.

Summary of service outcomes						
	Numerator (N) and Denominator (D)	**Target**	**Data source**	**How collected**	**Who collects**	**When to collect**
1. Humanitarian entrants receive an assessment within specified time frames						
Refugees receive a nursing health assessment within four weeks of arrival	N: Number of refugees who received a nursing assessment in the period D: Number of refugees arriving in the period N: Number of refugees who received a nursing assessment within four weeks of arrival D: Number of refugees who received a nursing assessment in the period	90%	Database	Hub and spoke database entries	Nursing staff	Quarterly
SHP entrants receive a nursing health assessment within four weeks of arrival SHP entrants receive a nursing health assessment within eight weeks of arrival	N: Number of SHP who received a nursing assessment in the period D: Number of SHP arriving in the period N: Number of SHP entrants who received a nursing assessment within four weeks of arrival D: Number of SHP entrants who received a nursing assessment in the quarter N: Number of SHP entrants who received a nursing assessment within	75% 25%	Database	Hub and spoke database entries	Nursing staff	Quarterly

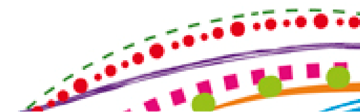
Summary of service outcomes						
	Numerator (N) and Denominator (D)	**Target**	**Data source**	**How collected**	**Who collects**	**When to collect**
	eight weeks of arrival D: Number of SHP entrants who received a nursing assessment in the quarter					
Humanitarian entrants receive timely medical assessment after the nursing assessment, within two weeks in the hub and within four weeks in the spokes	N: Number of humanitarian entrants who received a medical assessment in the period D: Number of humanitarian entrants arriving in the period N: Number of Hub clients who received a medical assessment within 2 weeks of the nursing assessment D: Number of Hub clients who received a medical assessment in the period N: Number of spoke clients who received a medical assessment within 4 weeks of the nursing assessment D: Number of spoke clients who received a medical assessment in the period	100% 100% for hub clinic 100% for spokes	Database HIC (uptake of Item 714)	Hub and spoke database entries HIC search	Nursing staff Statewide Coordinator	Quarterly
2. The service receives income commensurate with services provided that can be billed to Medicare						
Hub receives minimum of $10,000 income annually from nurse MBS billings	N: Number of clients immunised D: Number of MBS claims for immunisation	100%	Database Pracsoft billing	Statewide Coordinator report	Statewide Coordinator	Quarterly
Hub and spokes receive income	N: Number of medicare eligible clients	100%	Database	Statewide	Statewide	Quarterly



Summary of service outcomes						
	Numerator (N) and Denominator (D)	**Target**	**Data source**	**How collected**	**Who collects**	**When to collect**
commensurate with medical services that can be billed to Medicare or facility fees paid by GPs	assessed D: Number of MBS claims for assessment		Pracsoft billing	Coordinator report	Coordinator	
3. Humanitarian entrants and asylum seekers are referred to health services including community general practitioners for ongoing care						
Humanitarian entrants and asylum seekers are referred to health service providers reflecting their health conditions and needs	N: Number and type of referrals D: Health needs and conditions requiring referral	100%	Medical Director	Medical Director reports	Nursing staff	Quarterly
Newly arrived humanitarian entrants are referred to a community general practitioner for ongoing care	N: Number of GP referrals made D: Number of newly arrived humanitarian entrants seen	100%	Medical Director	Medical Director reports	Nursing staff	Quarterly
Asylum seekers are referred to a general practitioner willing to waive fees for ongoing care	N: Number of GP referrals made D: Number of asylum seekers seen	100%	Medical Director	Medical Director reports	Nursing staff	Quarterly
Humanitarian entrants and asylum seekers stay with a general practitioner for ongoing care	N: Number of GP referrals made D: Number of humanitarian entrants and asylum seekers with same GP post three months (analysed separately)	100% Note: not all GPs will provide this info.	Survey	Survey GPs and clients	Statewide Coordinator	Six monthly
4. Humanitarian entrants and asylum seekers receive complex health case coordination						
Humanitarian entrants and asylum seekers with complex	N: Number of humanitarian entrants and asylum seekers receiving complex	25%	Database	Hub and spoke	Nursing staff Statewide	Quarterly

Summary of service outcomes						
	Numerator (N) and Denominator (D)	**Target**	**Data source**	**How collected**	**Who collects**	**When to collect**
health issues receive complex health case coordination (up to ten hours)[28]	health case coordination D: Total number of humanitarian entrants and asylum seekers			database entries	Coordinator	
	N: Number of hours complex health case coordination received D: Number of complex health cases	10 hours	Database	Hub and spoke database entries	Nursing staff Statewide Coordinator	Quarterly
5. The frequency of health conditions identified by the service is commensurate with the country of origin of humanitarian entrants and asylum seekers						
Frequency of health conditions among assessed clients by country of origin over time	N: Number of health conditions identified among humanitarian entrants and asylum seekers D: Number of humanitarian entrants and asylum seekers from particular country groups	Relevant to the literature	Database	Hub and spoke database entries	Nursing staff Statewide Coordinator	Quarterly
6. Clients and service providers are satisfied with the service						
The majority of clients assessed through the service are satisfied with the service	N: Number of satisfied clients D: Total number of clients involved with the service	75%[29]	Satisfaction survey	Client focus groups	Statewide Coordinator	Annually

[28] The budget allows for 10 hours for 25% of clients. In practice, some will require more and some less than 10 hours.
[29] This may be a qualitative measure



Summary of service outcomes						
	Numerator (N) and Denominator (D)	**Target**	**Data source**	**How collected**	**Who collects**	**When to collect**
The majority of service providers are satisfied in the service	N: Number of satisfied service providers D: Total number of service providers involved with the service	75%[30]	Satisfaction survey	Survey	Statewide Coordinator	

[30] **This may be a qualitative measure**

10.3 Distribution, feedback and revision of Service Plan

The Service Plan was distributed to the Steering Committee for feedback. This final Service Plan includes the comments provided. When the Service Plan is approved, it is planned that a summary format be distributed to the key stakeholders.

10.4 Risk assessment

Strengths:

- Is recurrently funded
- Planning process had very high level of engagement with key stakeholders
- Has support from key stakeholders.

Weaknesses:

- Resource allocation is inadequate for a dedicated GP liaison role. Barriers currently exist for referral of refugee patients to community GPs, such as: a lack of community GPs willing to bulk-bill patients; reluctance by some GPs to use interpreters, inability of most practices to have longer appointments times
- Relies on willingness of GPs to accept refugee patients when current practice indicates there are significant barriers to refugees gaining GP access
- Key stakeholders in non-government organisations and community leaders have strongly advocated for the service to be available for humanitarian entrants who have settled longer than six months. Resource allocation is only adequate to service newly arrived humanitarian entrants and asylum seekers.

11. Attachments

Attachment 1. Past service planning – outcomes of December 2006 Refugee Health Planning Workshop

Purpose of Workshop

- The purpose of the workshop was to map the current process for refugees to access appropriate health services throughout their settlement period, identify gaps and duplications in the process, and propose solutions to improve the process.

Process Map

- The process of refugee health service access was mapped for refugees from pre-arrival to completion of settlement – refer to attached process map (at end of attachment) developed from the workshop.

Identified Gaps

- No integration and co-ordination of services
- No-one owns the process - who is responsible?; too much buck-passing
- Risk management – who is managing the risk?
- Poor data collection – no ED data
- Little health information sharing
- No record of previous health services
- Access to interpreters is limited
- Pre-screening gaps
- Informal assessments being performed
- Access to specialists in regional areas is limited
- Difficulties in some instances to get GP's to accept refugees, especially large families
- Screening process
  - how information is shared
  - immunisation, pre-departure and on arrival
- Very limited pre-departure and post arrival education regarding health system and health records
- Few measures for preventative health
- Inappropriate admissions
- Very little training for health providers – none in some regions.

Duplication

- Presenting multiple times eg: hospitals, GP's in different places
- Repeated assessments – some informal assessments and formal
- Repeated tests/immunisations.

Solutions

- Ensure availability of relevant medications
- Education on refugee issues
  - develop education packages for general practice and other health professionals.
- Education for refugees

- Specific knowledge – how health system works and how to access – key resource for IHSS.
- Consistent offshore screening and improved information sharing of screening results
- Strategy on Health information – "same importance as passport" (need to address privacy issues)
    - Need shared health records – web based would be nice.
- Use of a non-government body/agency to develop and maintain links and conduct education sessions with General Practice, nurses and other health professionals, as would be more effective in achieving engagement and capacity building than a government agency
- There needs to be a clear understanding of public and primary health roles and the expectations of those roles in the management and coordination of refugee health services
    - Public health should be managed by Queensland Health through centralised assessment, treatment and management of health care, and should be located in areas of settlement
    - Coordination role should be central and should collect and disseminate information on health needs of arrivals, develop and implement strategic plans for refugee health care services, and provide support for regional areas
    - Service needs a statewide clinical director (MO) to oversee and provide clinical expertise and mentoring
    - Needs to include linkages to General Practice
    - Community Health nurses to provide assessments to new arrivals
    - Co-location of services would improve access to services for refugees.
- Regular community and sector meetings
- Possibility of developing an ID card
- Development and implementation of health promotion strategies.

Process Mapping Refugee Health

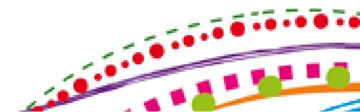
Immigration
officer

OIM
DIMA

Offshore
(Refugee 200
Visa)

Refugee s

Pre departure
screening



Attachment 2: Terms of reference of Steering Committee

1. BACKGROUND

A Statewide Refugee Health Service (SRHS) was funded in June 2007. It aims to implement a coordinated statewide health service for refugees, special humanitarian entrants and asylum seekers. Through a hub and spoke service model, it will provide:

- Standard initial health assessments, including public health screening and catch-up vaccination schedules
- Coordination of short term health management with additional support for complex cases, and
- Referral to existing services for continuing care.

2. PURPOSE

The purpose of the Steering Committee is to oversee the development of the Statewide Refugee Health Service Plan, for endorsement by the Assistant General Manager, Southern Area Health Services.

3. SCOPE

The SRHS Plan will define the functions and protocols of the service, who will be involved, and at what time, where services will be funded and by what funding arrangements.

4. COMPOSITION OF MEMBERSHIP

Membership will comprise representatives of key organisations involved in the arrival and health assessment process for refugees, special humanitarian entrants and asylum seekers. 'Hub' and 'Spoke' service areas will be represented. The membership is at Attachment 1.

5. OPERATING PRINCIPLES and OPERATING GUIDELINES

Members will bring to the group knowledge and experience of their agencies in relation to the early and ongoing health care for refugees, special humanitarian entrants and asylum seekers.

Members are expected to actively participate in Steering Committee meetings and provide a proxy or written comments on agenda items for circulation before each meeting.

Members are also expected to brief senior management within their agencies on progress and ensure that their contribution is representational of respective work areas. The promotion of the SRHS plan to respective work areas is a part of this process.

The Steering Committee will be chaired by the Manager, Queensland Health Multicultural Program. The Steering Committee will be a forum for discussion on progress and future actions.

5.1 Management of agenda

The Queensland Health Multicultural Program will develop the agenda for the Steering Committee in consultation with members.

5.2 Meetings

The Steering Committee will meet monthly during the first 4 months then as needed.

5.3 Agenda papers and related material

Agenda papers and related information will be provided to Steering Committee members one week prior to each meeting.

Minutes of meetings will be provided to all members for comment within one week. Members can make comment within one week of receiving the minutes. If no or minor comments are received, the minutes will be taken as endorsed by the Steering Committee. If substantial comments are received, amendments will be made and minutes recirculated for comment within one week. If no comments are received, the minutes will be taken as endorsed. If additional comments are received, the minutes will be endorsed at the next Steering Committee meeting.

A Quorum is one half of the number of members plus one.

All records and documentation will be maintained by the Queensland Health Multicultural Program.

6. TERM OF APPOINTMENT

Members of the Steering Committee will be appointed until February 2008. The Steering Committee will not continue after the endorsement of the Service Plan, planned for February 2008.

If a member is no longer able to commit to undertaking the work of the Steering Committee, the member should advise the Chair of the Steering Committee and provide a nomination for a replacement member from their organisation/work area.

7. FINANCIAL ARRANGEMENTS

Expenses incurred in organising meetings, such as venue and catering will be administered and met by the Queensland Health Multicultural Program. Expenses incurred by agencies' involvement in the Steering Committee, such as staff time, will be met by the respective agency.

Attachment 3: Membership of the Steering Committee

Representative agency	Contact
Queensland Health Multicultural Program	Ellen Hawes (chair) Marina Chand Ana Maria Holas (October – Dec 2007) Sarah Grealy (Dec 2008 – March 2008)
Statewide Population Health Unit	David Logan
Brisbane South Population Health Unit	Dr Brad McCall
Mater Health Services	Jeff Potter
Southside Health Service District	Brett Bricknell
Northside Health Service District	Sandy Jamieson
Toowoomba Health Service District	Dr John Hooper
Townsville Health Service District	Lyam Morris
Royal Children's Hospital and Health Service District	Jan Pratt
Cairns Health Service District	Graham Sanderson
Department of Immigration and Citizenship	Heather Sayner
Multicultural Development Agency	Leanne Tuipulotu
Communicable Diseases	Dr Frank Beard
General Practice Qld	Christine Kardash (SEAGP) Dr Alison Stewart
Policy Branch, Queensland Health	Sandra Eyre
Queensland Transcultural Mental Health Centre	Rita Prasad-Ildes
Community Health Action Group	Lorella Piazzetta (September – December 2007) Wayne Sanderson (December 2007 – March 2008)
Queensland Program of Assistance to Survivors of Torture and Trauma	Tracy Worrall

Attachment 4: Terms of reference of reference groups

1. BACKGROUND

A Statewide Refugee Health Service (SRHS) was funded in June 2007. It aims to implement a coordinated statewide health service for refugees, special humanitarian entrants and asylum seekers. Through a hub and spoke service model, it will provide:

- Standard initial health assessments, including public health screening and catch-up vaccination schedules
- Coordination of short term health management with additional support for complex cases, and
- Referral to existing services for continuing care.

The model is expected to be implemented in the geographical areas of highest refugee settlement, namely Brisbane, Logan, Toowoomba, Cairns and Townsville. A Reference Group will be established in each geographical area to provide advice and contribute to the planning of the proposed clinics and services as they apply to that region.

1. ROLE & PURPOSE

The overall purpose of the Reference Group is to advise the Steering Committee that oversees the development of the Statewide Refugee Health Service Plan, on local issues that should be considered in the development of the Plan and to contribute to local planning of the proposed service as it applies to their region.

The Reference Group will:

- Act as an advisory group to the Steering Committee on local issues that should be considered in the development of the Plan
- Provide advice on the functions, roles, location, protocols, processes (what, who, where, how), governance arrangements and funding arrangements of the proposed service locally
- Provide a forum for discussion of the key issues around establishing a refugee health service in the local area and take these issues back to the Steering Committee and representative agencies
- Provide local input into the development of the Plan in relation to the spoke service
- Provide an avenue for client/community input into the planning process of the service
- Undertake community consultation on the proposed service for the local area.

2. COMPOSITION OF MEMBERSHIP

Membership will comprise representatives of key organisations involved in the arrival and health assessment process for refugees, special humanitarian entrants and asylum seekers. The minimum representation should include:

- Project Manager, Queensland Health Multicultural Program
- Local Health Service District representative
- Local IHSS service provider
- Other relevant settlement service provider
- Local GP Division
- Refugee health service provider/clinic
- Population health representative

- Community health representatives
- At least two community/client representatives.

3. OPERATING PRINCIPLES and OPERATING GUIDELINES

Members will bring to the group knowledge and experience of their agencies/communities in relation to the early and ongoing health care for refugees, special humanitarian entrants and asylum seekers.

Members are expected to actively participate in Reference Group meetings.

Members from organisations are expected to brief senior management within their agencies on progress and ensure that their contribution is representational of respective work areas.

Members from communities are expected to informally consult within their communities to ensure their contribution is shared by others in their community.

The Reference Group will be chaired by a representative of the Steering Committee.

4. MEETINGS

4.1 Management of agenda

The Queensland Health Multicultural Program in conjunction with the Chair will develop the agenda for the Reference Group in consultation with members.

4.2 Meetings

The Reference Group will meet monthly during the first 4 months then as needed.

4.3 Agenda papers and related material

Agenda papers and related information will be provided to Reference Group members one week prior to each meeting.

Minutes of meetings will be provided to all members for comment within one week. Members can make comment within one week of receiving the minutes. Minutes will then be endorsed.

As the Reference Group is not a decision making body, a quorum is not required for meetings to proceed.

All records and documentation will be maintained by the Queensland Health Multicultural Program.

5. TERM OF APPOINTMENT

Members of the Reference Group will be appointed until February 2008. The Reference Group will not continue after the endorsement of the Service Plan, planned for February 2008.

6. FINANCIAL ARRANGEMENTS

Expenses incurred in organising meetings, such as venue and catering will be administered and met by the Queensland Health Multicultural Program. Expenses incurred by agencies' involvement in the Reference Group, such as staff time, will be met by the respective agency.

Funding is available for community consultation and consumer representation at meetings. This funding is to be allocated and managed by one member agency that will undertake the community/consumer consultation. This agency will be appointed by the Reference Group and approved by the Queensland Health Multicultural Program, Queensland Health.

Attachment 5: Membership of the reference groups

Brisbane reference group membership

Jan Pratt Nursing Director Primary Care Program Community Child Health Royal Children's Hospital and Health Service District (Chair)	Sandy Jamieson, Community Health Service Joe Debattista, Zonal Sexual Health Coordinator Sexual Health Service Northside HSD
Renae Heatley, Women's and Newborn Service Alison Dickinson, Oral Health Royal Brisbane and Women's Hospital	Caroline Austin International Programs /Community Partnerships Manager Australian Red Cross
Jorg Buchberger, Refugee Settlement Service Manager Ruby Cruz, Case Coordinator The Multicultural Development Association (MDA)	Ms Susan Hoy Community & Hospital Program Coordinator GP Partners
Tracy Worrall, Director Sally Stewart, Manager of Community Services The Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)	Claire Brolan Coordinator QIRCH Clinic
Margot Salmon Refugee Claimants Support Centre	Dr Rod Davison Public Health Physician Central Public Health Unit – Brisbane North
Naomi Kikkawa, RCH HSD Bozica Stumfold, Northside HSD Miwa Okochi, PAH HSD Multicultural Mental Health Coordinators	Robyn Penny CNC Liaison Primary Care Program Community Child Health Royal Children's Hospital and Health Service District
Terry O'Brien Clinical Nurse Consultant Queensland Tuberculosis Control Centre (SAPHS)	Jan Noakes Refugee Services St. Vincent de Paul Society
Adele Rice Principal Milpera State High School	Sugee Kannangara Manager of Settlement Grants Program Inala Community House
Ruth Rowan Community Health Action Group	Christine Kardash Chief Executive Officer South East Alliance of General Practice
Dermot Dorgan Coordinator The Romero Centre	Jeannie Mok, Coordinator Say Samone Multicultural Community Centre
Dr. Brad McCall Public Health Medical Officer Brisbane Southside Population Health	Dee Jeffrey South Brisbane Community Health Service
Lalita Lakshmi Multicultural Policy Officer Queensland Council of Social Services	Mark Storrs Brisbane South Division of GPs
Nick Pouchkareff Refugee Health Project Southside Health Service District	Debbie Cowan Project Officer Partnerships Initiative Chronic Disease Place Based Initiative

Logan reference group membership

The Logan Refugee Health Network undertook the functions of the reference group for the Statewide Refugee Health Service planning.

Brett Bricknell (Chair) Project Manager District Consolidation Project Southside Health Service District	Libby Wort Clinical Nurse Consultant Community Child Health
Nick Pouchkareff Refugee Health Project Southside Health Service District	Debbie Cowan Project Officer Partnerships Initiative Chronic Disease Place Based Initiative
Margaret Neil Manager Settlement Services ACCESS Services Inc.	Mary Asickob Torture/trauma counselling program Access Inc.
Donna Chatfield Logan City Council	Narelle Fernandez Clinical Nurse Community Health
Fazil Rostam District Multicultural Health Coordinator Southside Health Service District	Harriet Aitken GP Liaison Officer Chronic Disease Place Based Initiative
Clifford Soo Multicultural Mental Health Coordinator Bayside Mental Health Service Southside	Zhihong Gu Health Program Coordinator The Ethnic Communities Council of Queensland
Claire Brolan Coordinator QIRCH Clinic	Louise D Youth and Family Service
Glenda Magill Clinical Nurse Community Health	Dee Jefrey South Brisbane Community Health Service
Narelle Lehmann Child Health	Sylvia Penhaligon General Practice Logan Area Network
Heather Sayner and Jukka Ilpola Manager Settlement Programs and Planning Department of Immigration and Citizenship	Dr Kari Jarvinen Brisbane Southside Population Health Unit
Karen Grimley Multicultural Mental Health Coordinator Beenleigh Mental Health	Lamar Brown Logan City Council Cultural Diversity Project Officer
Carolyn Sherwell Acting CNC PAAC Nursing	

Toowoomba reference group membership

The Toowoomba and Darling Downs Multicultural Health Advisory Committee undertook reference group functions.

Amutha Kandasamy Community Nutritionist Queensland Health	Ans van Erp Cunningham Centre
Beverly Rule RN, Emergency Department	Christine Duncan Midwife, Toowoomba Health Service
R Cleary University Southern Queensland	Elizabeth jones Toowoomba City Council
Janet Baines Health Information Services	Jennifer Withnall QPASTT
Joy Olsen RN, Kobi House	Joyanne Clark Mercy Family Services
Julie Crosbie Adult Mental Health	Nadia Campbell Social Worker
Mary Coman Community and Allied Health	Penny Parker Social Worker, Community Health
Neil Parker Public Health Medical Officer, Darling Downs Population Health Unit	Sandy Hilder Staff Development, Training and Support Unit
Robyn Crisp Mercy Family Services	Terri Flanagan Organisational Improvement Unit
Sue Schmidt Social Worker, Allied Health	Dr John Hooper Director of Public Health

Cairns reference group membership

Local Health Service District representative (Chair)	Graham Sanderson Manager Specialist Clinics Cairns Health Service District
Local IHSS service provider	Martin Mettmann Manager Settlement Services Centacare Cairns
Local GP Division	Bernie Triggs Manager General Practice Cairns
Population health representative	Dianne Brookes Juliet Esmonde Public Health Nurses Tropical Population Health Unit
Local Health Service District representative – community health	Ulli Schuhmacher Social worker Westcourt Community Health Centre
General Practitioner	Dr Mark McKinnon
Multicultural Mental Health Coordinator	Wendy Zerner
Interpreter Quality Officer, Queensland Health	Libby Sterling

Townsville reference group membership

Local Health Service District representative (Chair)	Lyam Morris (Chair) Townsville Health Service District
Local IHSS service provider	Meg Davis & Gabe Cairns Coordinator and IHSS worker Townsville Multicultural Support Group
Local GP Division	Megan Williams (September – November 2007) Program Coordinator/ Practice Support Townsville Division of General Practice Carol Nolan (December 2007 – March 2008) Programs Manager Townsville Division of General Practice
Population health representative	Dr Steven Donohue Public Health Physician
Other settlement services	Angela Beggs Assistant Director Townsville Migrant Resource Centre
Community representatives	Nazifeh Yousefi Community representative Jeremiah Deng Community representative Moses Agogbel Community representative
Multicultural Mental Health Coordinator	Veronica Johnson Multicultural Mental Health Coordinator
Townsville Base Hospital	Dr Claire Stewart
Oral Health Services	Charmaine Knox

Attachment 6: Planning framework

PROPOSED REFUGEE JOURNEY—STATEWIDE REFUGEE HEALTH SERVICE

Pre-arrival planning	Arrival	Initial assessment & link to GP	Referral/coordination of health services	Exit
What: Who: How: Where: When:	What: Who: How: Where: When:	What: Who: How: Where: When:	What: Who: How: Where: When:	What: Who: How: Where: When:
Staff: Dollars: ICT: Capital works:	Staff: Dollars: ICT: Capital works:	Staff: Dollars: ICT: Capital works:	Staff: Dollars: ICT: Capital works:	Staff: Dollars: ICT: Capital works:

GOVERNANCE

COMPONENT	REPORTS TO	AGENCY RESPONSIBLE
Statewide Refugee Health Service		
Statewide Hub		
Spokes:		
Brisbane		
Cairns		
Logan		
Toowoomba		
Townsville		

FUNDING ARRANGEMENTS Funding provided annually to

Resource allocations (funding provided)

Funding period

Attachment 7: Hub and QIRCH Clinic organisational chart

Statewide Refugee Health Service—
Hub & QIRCH Clinic organisational chart

Accountability
Professional supervision

Accountable to Mater Health Services

HUB STATEWIDE

SMO

A07

HUB CLINICAL

N04

GPs

N02

A02

Accountable to Mater Health Services

QIRCH CLINIC

A04

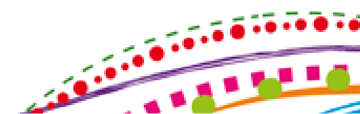
N02

A02

GPs

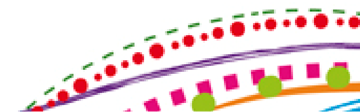
Attachment 8: Proposed refugee health journeys for each location

1. Brisbane Refugee Health Assessment Clinic
2. Brisbane North Refugee Health Clinic
3. Cairns Refugee Health Service
4. Logan Refugee Health Service
5. Toowoomba Refugee Health Service
6. Townsville Refugee Health Service



PROPOSED REFUGEE JOURNEY – BRISBANE REFUGEE HEALTH ASSESSMENT CLINIC				
PRE-ARRIVAL PLANNING	ARRIVAL	INITIAL ASSESSMENT & LINK TO GP	REFERRAL/COORDINATION OF HEALTH SERVICES	EXIT
WHAT	WHAT	WHAT	WHAT	WHAT
1. DIAC notifies MDA of subsequent month's arrivals 2. DIAC notifies MDA of arrival information. 3. MDA notifies Clinics of confirmed arrival details[31][32]. MDA to advise Clinics if Unaccompanied Minors included in newly arrived refugees. 4. Clinic appointment is arranged – MDA notified 5. Interpreter is booked by Clinic	1. Quick visual check, standard basic health questions asked. 2. If well go to accommodation. If unwell, go to hospital. 3. If there is a 24 hr health alert – to A&E 4. If a 48 hr health alert – to accommodation and taken to the hospital 5. If 72 hr health alert to accommodation and then to hospital within 72 hrs[33] 6. Client consent obtained to share health information with Clinic. If consent obtained, client and health manifest information forwarded to Clinic. 7. Client consent obtained to forward discharge summary from ED to the Clinic. If consent obtained, Clinic advised of ED visit. 8. Clinic to contact ED to obtain copy discharge summary 9. MDA notifies Clinic if language was incorrect in DIAC notification 10. Client registered on Clinic client database 11. Health Appointment made and MDA notified. 12. Client notified of health appointment, transport arranged 13. Clinic to contact Mercy Family Services to advise of health assessment appointment for unaccompanied minors. 14. MDA educates client re health system 15. 100% referral to QPASTT for mental health risk assessment. 16. For people arriving on 202 visas: a. MDA to contact proposer and advise of the Clinic; b. MDA to provide details to the Clinic; c. Clinic to make appointment and notify proposer; d. If 3 'do not attends' – Clinic to notify MDA. MDA to follow up with proposer.	1. Client is transported to Clinic 2. Nurse commences health assessment and organises initial blood tests. 3. Immunisation given/ catch-up templates completed 4. A VMO/GP review test results and completes health assessment. 5. Client registered on QRHS database 6. Link to community GP for routine health care 7. Referral to QIRCH for complex health care	1. Management plan completed for client 2. Summary of health assessment given to the client 3. Appropriate referrals made by Clinic (specialist, mental health, school based nursing, dental, maternity, sexual health etc). 4. Optometry referral by MDA 5. QPASTT contacted if trauma or mental health issues identified to confirm if already accepted as a client. 6. QH Mental Health team contacted if clinical diagnosis needed. 7. Copy of appointments given to the client and to MDA 8. Transport arranged for referral appointments 9. Client with complex health issues to referred to QIRCH 10. Relevant public health issues raised with QH Public Health.	1. Client advised that nurse withdrawing & how to contact if required 2. GP advised nurse withdrawing & how to contact if required 3. MDA advised of client exit 4. Client exit entered on QRHS database
WHO	WHO	WHO	WHO	WHO
1, 2 DIAC 3 MDA 4. Clinic, MDA 5. Clinic	1. MDA (Hub/ QH Public Health to create questions). 2-7, 9, 13-15, 16 a, b, e MDA 8, 10-12, MDA 16 c, d Clinic	1. MDA 2, 3, 5-7Nurse 4. GP/MO	1, 3, 10. MO/GP and Nurse 2, 5, 6, 9Nurse 7. Nurse/Administration Officer 4, 8 MDA	1, 2 - Nurse 3, 4 – Nurse or Admin Officer
HOW	HOW	HOW	HOW	HOW
1. Routine email notification 2. Email notification 3. MDA emails Clinic 4. Clinic appointment made and Clinic	1. Standardised questions to be developed by Hub and QH Public Health 2. MDA transports clients to home or hospital 3. MDA transports clients to hospital 4. MDA transports clients to home and takes client to the hospital the next day. 5. MDA transports clients to home. Takes client to hospital within 72	1. MDA staff or other settlement workers 2. Standardised health assessment template 3. Standard immunisation catch-up schedule	1. Standard template used (Part of Item 714). 2. Hand-held record completed (where used) and MD summary printed and put into the record. 3. Nurse contacts referral	1. Exit appointment 2. Prior to exit appointment being

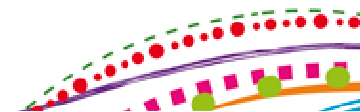
[31] Confirmed arrival information does not include names but should include overall number of arrivals, family group, date of arrival, gender, date of birth, country of origin, language spoken.
[32] Health information (where available in a health manifest) is not to be forwarded to the Clinic until consent has been obtained from the client (post arrival)
[33] A process for the Clinic potentially responding to health alerts needs to be developed.



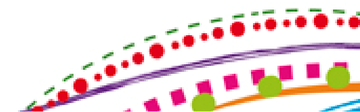
PROPOSED REFUGEE JOURNEY – BRISBANE REFUGEE HEALTH ASSESSMENT CLINIC				
PRE-ARRIVAL PLANNING	**ARRIVAL**	**INITIAL ASSESSMENT & LINK TO GP**	**REFERRAL/COORDINATION OF HEALTH SERVICES**	**EXIT**
contacts MDA worker 5. Nurse books interpreter on behalf of MO/GP – Dr Priority Line or via QH Interpreter System	hours. 6, 7, Signed consent for sharing health information. 8. Phone 9. Email 10. Clinic database 11. Clinic database/ email 12. Email 13. MDA client visit/ processes 14. MDA case management 15. MDA/QPASTT protocols 16 a. MDA process. b. Email. c. Letter/ phone call. d. Email/ phone call. e. MDA processes.	4. Standardised health assessment template or Medical Director 5. QRHS database 6. Health Assessment: a. Nurse calls the GP practice and forwards paperwork. B Nurse completes referral to QIRCH/ liaises with QIRCH Nurses 7. Nurse contacts GP, makes appointment and forwards papers. Nurse contacts MDA with GP/appointment details. MDA takes person to their first appointment.	organisations and makes appointments. 4. MDA makes appointment and takes client to the appointment. 5. Nurse contacts QPASTT 6. Nurse contacts QH mental health or QTMHC if necessary 7. Nurse gives a written copy of appointments to the client and emails MDA worker with appointments. 8. MDA arranges transport/ support to access referral appointment 9. Nurse to liaise with QIRCH for referral. 10. Nurse contacts Public Health when necessary	arranged b/w client and nurse 3. Nurse emails MDA 4. QRHS database
WHERE	**WHERE**	**WHERE**	**WHERE**	**WHERE**
1-4. n/a. 5. Clinic	1. Airport 2, 4, 5 Client accommodation/ hospital 3. Hospital/ Client accommodation 6, 7 Client accommodation /hospital/ MDA/Email 8, 11, 16c & d. Clinic 9, 10 MDA / email 12. n/a 13. MDA/ client contact 14. MDA/ client accommodation 15, 16 a, b, e MDA	1. Client accommodation to Clinic 2-7Clinic	1, 2, 3, 5,6,7, 9, 10 - Clinic 4, 8 – MDA	1, 2, 3, 4 – Clinic
WHEN	**WHEN**	**WHEN**	**WHEN**	**WHEN**
1. One month in advance 2. As soon as DIAC notifies MDA (1-7 days before arrival) 3. Within one day of arrival 4. Within two days of arrival 5. When appointment made (within three days of arrival)	1. Immediately on arrival 2-6 Asap after client arrives 7 Asap after client visit to ED 8 Asap after notified, prior to appointment 9, 10 Asap after client arrives 11 Within 3 days of being notified of client arrival 12 Within 3 days of being notified of client appt 13. Within 3 days of appt being made 14, 15 According to MDA contractual requirements 16 a. When receive notification from DIAC - prior to arrival. b. Prior to arrival. c. Within 5 working days of receiving notification from MDA. d. On third non-attendance. e. Within two weeks of notification.	1- 3 On appt. day 4 One week after initial appt. 5. Asap after first appointment 6 a. When medical review is complete (within 3 months). b. If complex health care identified at initial medical review. 7 When nursing assessment is complete.	As appropriate and relevant	1, 2, & 3 When health case mgt not needed. Within 3-6 months of registration. 4. Within 2 weeks of client exit

PROPOSED REFUGEE JOURNEY – BRISBANE NORTH REFUGEE HEALTH SERVICES				
PRE-ARRIVAL PLANNING	**ARRIVAL**	**INITIAL ASSESSMENT & LINK TO GP**	**REFERRAL/COORDINATION OF HEALTH SERVICES**	**EXIT**
WHAT	**WHAT**	**WHAT**	**WHAT**	**WHAT**
7. DIAC notifies MDA of subsequent month's arrivals 8. DIAC notifies MDA of arrival information. Where available health information is included in a health manifest. 9. MDA notifies Clinics of confirmed arrival details[34][35]. Clinic appointment is arranged – MDA notified 10. Interpreter is booked by Clinic	1. Quick visual check, standard basic health questions asked. 2. If well go to accommodation. If unwell, go to hospital. 3. If there is a 24 hr health alert – to A&E 4. If a 48 hr health alert – to accommodation and taken to the hospital 5. If 72 hr health alert to accommodation and then to hospital within 72 hrs[36] 6. Client consent obtained to share health information with Clinic. If consent obtained, client and health manifest information forwarded to Clinic. 7. Client consent obtained to forward discharge summary from ED to the Clinic. If consent obtained, Clinic advised of ED visit. 8. Clinic to contact ED to obtain copy discharge summary 9. MDA notifies Clinic if language was incorrect in DIAC notification 10. Client registered on Clinic client database 11. Health Appointment made and MDA notified. 12. Client notified of health appointment, transport arranged 13. Clinic to contact Mercy Family Services to advise of health assessment appointment for unaccompanied minors. 14. MDA educates client re health system 15. 100% referral to QPASTT for mental health risk assessment. 16. For people arriving on 202 visas: a. MDA to contact proposer and advise of the Clinic; b. MDA to provide details to the Clinic; c. Clinic to make appointment and notify proposer; d. If 3 'do not attends' – Clinic to notify MDA. MDA to follow up with proposer.	1. Client is transported to Clinic 2. Nurse commences health assessment 3. Immunisation given/ catch-up templates completed 4. VMO completes health assessment 5. Client registered on QRHS database 6. Client linked to GP	1. Hand-held Health Record completed with a management plan attached. Given to the client. 2. Appropriate referrals made by Clinic (specialist, mental health, school based nursing, dental, maternity, sexual health etc). 3. Optometry referral by MDA 4. QPASTT contacted if trauma or mental health issues identified to confirm if already accepted as a client. 5. QH Mental Health team contacted if clinical diagnosis needed. 6. Copy of appointments given to the client and to MDA 7. Transport arranged for referral appointments 8. Client with complex health issues to referred to QIRCH 9. Relevant public health issues raised with QH Public Health.	1. Client advised that nurse withdrawing & how to contact if required 2. GP advised nurse withdrawing & how to contact if required 3. MDA advised of client exit 4. Client exit entered on QRHS database
WHO	**WHO**	**WHO**	**WHO**	**WHO**
1, 2. DIAC, MDA 3. MDA, Clinic 4. Clinic, MDA 5. Clinic	1. MDA (Hub/ QH Public Health to create questions). 2-7, 9, 13-15, 16 a, b, e MDA 8, 10-12, MDA 16 c, d Clinic	1. MDA 2, 3, 5, 6 Nurse 4. GP/MO	1, 2. MO/GP and Nurse 3, 7 MDA 4, 5, 8, 9 Nurse 7. MDA	1, 2 - Nurse 3, 4 – Nurse or Admin Officer
HOW	**HOW**	**HOW**	**HOW**	**HOW**
1. Routine email notification 2. Email notification 3. MDA emails Clinic 4. Clinic appointment made and Clinic contacts MDA worker	1. Standardised questions to be developed by Hub and QH Public Health 2. MDA transports clients to home or hospital 3. MDA transports clients to hospital 4. MDA transports clients to home and takes client to the	1. MDA staff or other settlement workers 2. Standardised health assessment template 3. Standard immunisation	1. Hand-held record completed and summary printed and put into the record. 2. Nurse contacts referral organisations and makes	1. Exit appointment 2. Prior to exit appointment being arranged b/w client and nurse

[34] Confirmed arrival information should include overall number of arrivals, date of arrival, gender, date of birth, country of origin, language spoken.
[35] Health information (where available in a health manifest) is not to be forwarded to the Clinic until consent has been obtained from the client (post arrival)
[36] A process for the Clinic potentially responding to health alerts needs to be developed.

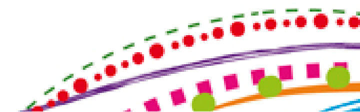


PROPOSED REFUGEE JOURNEY – BRISBANE NORTH REFUGEE HEALTH SERVICES				
PRE-ARRIVAL PLANNING	**ARRIVAL**	**INITIAL ASSESSMENT & LINK TO GP**	**REFERRAL/COORDINATION OF HEALTH SERVICES**	**EXIT**
5. Nurse books interpreter via QH Interpreter System	hospital the next day. 5. MDA transports clients to home. Takes client to hospital within 72 hours. 6, 7, Signed consent for sharing health information. 8. Phone 9. Email 10. Clinic database 11. Clinic database/ email 12. Email 13. MDA client visit/ processes 14. MDA case management 15. MDA/QPASTT protocols 16 a. MDA process. b. Email. c. Letter/ phone call. d. Email/ phone call. e. MDA processes.	catch-up schedule 4. Standardised health assessment template or Medical Director 5. QRHS database 6. Nurse contacts GP, makes appointment and forwards papers. Nurse contacts MDA with GP/appointment details. MDA takes person to their first appointment.	appointments. 3. MDA makes appointment and takes client to the appointment. 4. Nurse contacts QPASTT 5. Nurse contacts QH mental health or QTMHC if necessary 6. Nurse emails MDA worker with appointments 7. MDA arranges transport/ support to access referral appointment 8. Nurse to liaise with QIRCH for referral. 9. Nurse contacts Public Health when necessary	3. Nurse emails MDA 4. QRHS database
WHERE	**WHERE**	**WHERE**	**WHERE**	**WHERE**
1, 2, 3 - email 4. Email 5. Clinic	1. Airport 2, 4, 5 Client accommodation/ hospital 3. Hospital/ Client accommodation 6, 7 Client accommodation /hospital/ MDA/Email 8, 11. Clinic 9, 10 MDA / email 12. Clinic/email 13. MDA/ client contact 14. MDA/ client accommodation 15, 16 a, b, e MDA 16 c & d Clinic	1. Client accommodation to Clinic 2-7. Clinic	1, 2, 3, 5, 6, 7, 9, 10 Clinic 4, 8 MDA	1, 2, 3, 4 – Clinic
WHEN	**WHEN**	**WHEN**	**WHEN**	**WHEN**
1. One month in advance 2. As soon as DIAC notifies MDA (1-7 days before arrival) 3. Within one day of arrival 4. Within two days of arrival 5. When appointment made (within three days of arrival)	1. Immediately on arrival 2-6 Asap after client arrives 7 Asap after client visit to ED 8 Asap after notified, prior to appointment 9, 10 Asap after client arrives 11 Within 3 days of being notified of client arrival 12 Within 3 days of being notified of client appt 13. Within 3 days of being appt being made 14, 15 According to MDA contractual requirements 16 a. When receive notification from DIAC - prior to arrival. b. Prior to arrival. c. Within 5 working days of receiving notification from MDA. d. On third non-attendance. e. Within two weeks of notification.	1- 3 On appt. day 4 One week after initial appt. 5. Asap after first appointment 6 a. When medical review is complete (within 3 months). b. If complex health care identified at initial medical review. 7 When nursing assessment is complete.	As appropriate and relevant	1, 2, & 3 When health case mgt not needed. Within 3-6 months of registration. 4. Within 2 weeks of client exit



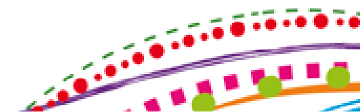
PROPOSED REFUGEE JOURNEY – CAIRNS REFUGEE HEALTH SERVICE				
PRE-ARRIVAL PLANNING	**ARRIVAL**	**INITIAL ASSESSMENT & LINK TO GP**	**REFERRAL/COORDINATION OF HEALTH SERVICES**	**EXIT**
WHAT	**WHAT**	**WHAT**	**WHAT**	**WHAT**
1. DIAC notifies Centacare/Nurse of subsequent month's arrivals 2. Centacare notifies nurse of confirmed arrival details[37][38] 3. GP appointment is arranged 4. Agreement b/w GP Cairns& GP practice finalised 5. Interpreter is booked 6. Transit provider notifies Centacare of person's health during transit and if language was incorrect in DIAC notification 7. Research camp/country conditions, health issues	1. If well go to accommodation. If unwell or a health alert, go to hospital. 2. Client consent obtained to share health information and to attend appointment. 3. Client notified of health appointment, transport arranged 4. Health education for client health 5. Centacare notifies nurse if language was incorrect in DIAC notification	1. Client is transported to GP 2. Client registered on GP practice client database 3. Nurse commences health assessment 4. Short consult with GP 5. GP completes health assessment 6. Client registered on QRHS database	1. Management plan completed with client 2. Appropriate referrals made 3. Transport arranged for referral appointments 4. Interpreters booked for referral appointments 5. Client is followed up by GP 6. Communication and reinforcement of instructions and general health education eg. first aid 7. Client data to be entered into Queensland Refugee Health Service database	1. Client advised that nurse withdrawing & how to contact if required (through Centacare) 2. GP advised nurse withdrawing & how to contact if required (trough GP Cairns) 3. Centacare advised of client exit 4. Client exit entered on QRHS database
WHO	**WHO**	**WHO**	**WHO**	**WHO**
1. DIAC 2. Centacare 3, 5, 7 Nurse 4. Cairns Division of General Practice/ GP practice 6. Transit provider	1, 2, 3, 4, 5 – all Centacare	1. Centacare 2. Nurse/practice staff 3, 6 Nurse 4, 5 GP	1, 2. GP and nurse 3, 5, 6, 7. Nurse. 4. Nurse/ Referral agency	1, 2, 3, 4 - nurse
HOW	**HOW**	**HOW**	**HOW**	**HOW**
1. Routine email notification 2. Email notification 3. Nurse makes GP appointment 4. Standard agreement sent 5. Nurse books Dr Priority Line/interpreter for GP 6. Telephone/ email 7. Contact network of refugee health nurses/hub	1. Centacare transports clients to hospital; discharge info to GP/nurse 2, 3, 4 Routine contact/info session 5. Email/phone call	1. Centacare staff or volunteers 2. Routine practice registration 3 & 5 Standardised health assessment template 4. GP appointment 6. QRHS database	1, 2 Part of Item 714 3. Nurse contacts Centacare or for immediate appointments arranges cab vouchers 4. Nurse contacts referral agency to book interpreter. 5. Nurse books client with GP 6. Client appt. with nurse 7. QHRS database	1. Exit appointment 2. & 3. Prior to exit appointment being arranged b/w client and nurse 4. QRHS database
WHERE	**WHERE**	**WHERE**	**WHERE**	**WHERE**
1, 2, 3, 6, 7 – n/a 3, 5. GP Practice	1. Cairns Hospital 2, 3, 4 Client accommodation or Centacare. 5. n/a	1, 2, 3, 4, 5– GP practice 6. GP Cairns/lap-top	1, 2, 3, 5, 6 GP practice 4. Referral agency 7. GP Cairns/ lap-top	1, 2, & 3 – GP Practice 4. JCU/lap-top
WHEN	**WHEN**	**WHEN**	**WHEN**	**WHEN**
1. One month in advance 2. As soon as DIAC notifies Centacare 3. Within first week of arrival 4. ASAP - before appointment 5. n/a. 6. during transit. 7. before GP appointment	1. On arrival immediately 2, 3. In advance of appt. 4. First six weeks of arrival 5. Asap after client arrives	1-4 On appt. day 5. One week after initial appt. 6. ASAP after first appt	1-5 As appropriate and relevant 6. ASAP after first appointment	1, 2, & 3 When health case management is not needed. Within 3-6 months of registration. 4. Within 2 weeks of exit

[37] Confirmed arrival information does not include names but should include overall number of arrivals, family group, date of arrival, gender, date of birth, country of origin, language spoken.
[38] Health information (where available in a health manifest) is not to be forwarded to the Clinic until consent has been obtained from the client (post arrival)

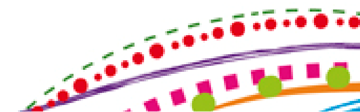


PROPOSED REFUGEE JOURNEY – LOGAN REFUGEE HEALTH SERVICES				
PRE-ARRIVAL PLANNING	**ARRIVAL**	**INITIAL ASSESSMENT & LINK TO GP**	**REFERRAL/COORDINATION OF HEALTH SERVICES**	**EXIT**
WHAT	**WHAT**	**WHAT**	**WHAT**	**WHAT**
1. DIAC notifies ACCESS Inc of subsequent month's arrivals 2. DIAC notifies ACCESS Inc of confirmed arrival information. 3. ACCESS Inc notifies Clinic of confirmed arrival details[39][40]. 4. ACCESS Inc to advise Clinics if Unaccompanied Minors included in newly arrived refugees 5. Clinic appointment is arranged – ACCESS Inc notified 6. Interpreter is booked by Clinic 7. ACCESS Inc locates a GP	1. Quick visual check, standard basic health questions asked. 2. If well go to accommodation. If unwell, go to hospital. 3. If there is a 24 hr health alert – to A&E 4. If a 48 hr health alert – to accommodation and taken to the hospital 5. If 72 hr health alert to accommodation and then taken to the hospital within 72hrs.[41] 6. Client consent obtained to share health information with Clinic. If consent obtained, client and health manifest information forwarded to Clinic. 7. Client consent obtained to forward discharge summary from ED to the Clinic. If consent obtained, Clinic advised of ED visit. 8. Clinic to contact ED to obtain copy discharge summary 9. ACCESS Inc notifies Clinic if language was incorrect in DIAC notification 10. Client registered on Clinic client database 11. Health Appointment made and ACCESS Inc notified. 12. Clinic to contact Mercy Family Services to advise of health assessment appointment for unaccompanied minors 13. Client notified of health appointment, transport arranged 14. ACCESS Inc educates client re health system 15. 100% referral to ACCESS Inc for mental health risk assessment. 16. For people arriving on 202 visas: a. ACCESS Inc to contact proposer and advise of the Clinic; b. ACCESS Inc to provide details to the Clinic; c. Clinic to make appointment and notify proposer, d If 3 'do not attends' – Clinic to notify ACCESS Inc; e. ACCESS Inc to follow up with proposer.	1. Client is transported to Clinic 2. Nurse commences health assessment 3. Immunisation given/ catch-up templates completed 4. Client registered on QRHS database 5. Link to GP	1. Management plan completed for client 2. Summary of health assessment given to the client 3. Appropriate referrals made by Clinic (mental health, school based nursing, oral health) Clinic sticker put on Oral Health form and consent signed). 4. Optometry referral by ACCESS Inc 5. ACCESS Inc Torture and Trauma Counsellor contacted if trauma or mental health issues identified to confirm if already accepted as a client. 6. QH Mental Health team contacted if clinical diagnosis needed. 7. Copy of appointments given to the client and to ACCESS Inc case worker 8. Transport arranged for referral appointments 9. Relevant public health issues raised with QH Public Health. 10. Client data to be entered into Clinic database 11. Client data to be entered into Queensland Refugee Health Service spreadsheet.	1. Client advised that nurse withdrawing & how to contact if required 2. GP advised nurse withdrawing & how to contact if required 3. ACCESS Inc advised of client exit 4. Client exit entered on QRHS database
WHO	**WHO**	**WHO**	**WHO**	**WHO**
1, 2 DIAC, ACCESS Inc 3, ACCESS Inc , Clinic 4, 7. ACCESS Inc 5, 6 Clinic,	1. ACCESS Inc (Hub/ QH Public Health to create questions). 2-7, 9, 13-15, 16 a, b, e ACCESS Inc 8. Clinic 10-12, 16 c, d Clinic	1. ACCESS Inc 2-5 Nurse	1-3, 5-7, 9Nurse 4, 8ACCESS Inc	1, 2 - Nurse 3, 4 – Nurse or Admin Officer
HOW	**HOW**	**HOW**	**HOW**	**HOW**
1. Routine email notification 2. Email notification 3. ACCESS Inc emails Clinic 4. Included in email to the	1. Standardised questions to be developed by Hub and QH Public Health 2, 3. ACCESS Inc transports clients to home or hospital 4. ACCESS Inc transports clients to home and takes client to the hospital the next day. 5. ACCESS Inc transports clients to home and then taken to the hospital	1. ACCESS Inc staff or other settlement workers 2. Standardised health assessment template 3. Standard immunisation catch-up schedule	1. Standard template used 2. Database summary printed and given to client. 3. Copy of the nursing assessment and the immunisation record is sent to the GP 4. Nurse completes referral information	1. Exit appointment 2. Prior to exit appointment being arranged b/w client and

[39] Confirmed arrival information does not include names but should include overall number of arrivals, family group, date of arrival, gender, date of birth, country of origin, language spoken.
[40] Health information (where available in a health manifest) is not to be forwarded to the Clinic until consent has been obtained from the client (post arrival)
[41] A process for the Clinic to potentially respond to health alerts needs to be developed.

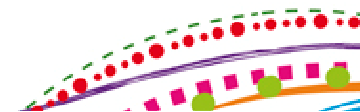


PROPOSED REFUGEE JOURNEY – LOGAN REFUGEE HEALTH SERVICES				
PRE-ARRIVAL PLANNING	**ARRIVAL**	**INITIAL ASSESSMENT & LINK TO GP**	**REFERRAL/COORDINATION OF HEALTH SERVICES**	**EXIT**
Clinic 5. Clinic appointment made and Clinic contacts ACCESS Inc worker 6. Nurse books interpreter via QH interpreter service 7. ACCESS Inc contacts GPs they have connections with	within 72 hrs. 6, 7. Signed consent for sharing health information. 8. Phone 9, 12, 16.b Email 10. Clinic database 11. Clinic database/ email 13. ACCESS Inc client visit/ processes 14, 16 e ACCESS Inc case management processes 15, 16a. ACCESS Inc protocols 16. c. Letter/ phone call 16. d. Email/phone call	4. QRHS database 5. Nurse contacts ACCESS Inc nominated GP, makes appointment and forwards summary. Nurse contacts ACCESS Inc with GP/appointment details. ACCESS Inc takes person to their first appointment.	forms where capacity allows. 5. ACCESS Inc advised, to organise referral. 6. Nurse contacts QH mental health or QTMHC if necessary 7. Nurse emails ACCESS Inc worker with appointments 8. ACCESS Inc arranges transport/ support to access referral appointment 9. Nurse contacts Public Health when necessary	nurse 3. Nurse emails ACCESS Inc 4. QRHS database
WHERE	**WHERE**	**WHERE**	**WHERE**	**WHERE**
1-5 – n/a 6. Clinic 7. ACCESS Inc	1. Airport 2, 4, 5 Client accommodation/ hospital 3 Hospital/ client accommodation 6. Client accommodation /hospital/ ACCESS Inc/ email 7. Email 8, 11, 16 c, d. Clinic 9, 10. ACCESS Inc / email 12. Clinic/email 13. ACCESS Inc / client contact 14. ACCESS Inc / client accommodation 15, 16 a, b, e ACCESS Inc	1. Client accommodation to Clinic 2-7.Clinic	1 - 7, 9. Clinic 8. ACCESS Inc	1-4. Clinic
WHEN	**WHEN**	**WHEN**	**WHEN**	**WHEN**
1. One month in advance 2. As soon as DIAC notifies ACCESS Inc (1-7 days before arrival) 3. Within one day of arrival 4. Within two days of arrival 5. When appointment made (within three days of arrival) 6. Prior to arrival	1. Immediately on arrival 2 – 6, 9, 10 Asap after client arrives 7. Asap after client visit to ED 8. Asap after notified, prior to appointment 9. Asap after client arrives 11. Within 3 days of being notified of client arrival 12. Within 3 days of being appt being made 13. Within 3 days of being notified of client appt 14, 15. According to ACCESS Inc contractual requirements 16. a. When receive notification from DIAC - prior to arrival. b. Prior to arrival. c. Within 5 working days of receiving notification from ACCESS Inc . d. On third non-attendance. e. Within two weeks of notification.	1. On appt. day 2. On appt. day (within 1-4 weeks or arrival) 3. On appt. day 4. One week after initial appt. 5. Asap after first appointment 6. a. When medical review is complete (within 3 months). b. If complex health care identified at initial medical review. 7. When nursing assessment is complete.	As appropriate and relevant	1, 2, & 3. After health assessment is completed. 4. Within 2 weeks of client exit



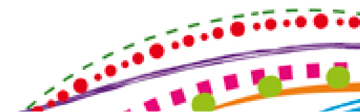
PROPOSED REFUGEE JOURNEY – TOOWOOMBA REFUGEE HEALTH SERVICE				
PRE-ARRIVAL PLANNING	**ARRIVAL**	**INITIAL ASSESSMENT & LINK TO GP**	**REFERRAL/COORDINATION OF HEALTH SERVICES**	**EXIT**
WHAT	WHAT	WHAT	WHAT	WHAT
1. DIAC notifies SPIRITUS/Kobi House of subsequent month's arrivals 2. SPIRITUS notifies nurse of confirmed arrival details[42] [43] 3. DIAC provides health undertaking to Kobi House. Red/yellow alert is received 4. Nurse appointment is arranged Interpreter is booked	1. If well go to accommodation. If unwell or have health alert, go to hospital. If unwell prior to the appt, to hospital. 2. Client consent obtained to share health information and to attend appointment. 3. Client notified of health appointment, transport arranged 4. SPIRITUS educates client re health 5. SPIRITUS notifies nurse if language was incorrect in DIAC notification 6. If red alert – take to hospital 7. If yellow alert – take to Kobi House (if possible)[44]	1. Client is transported to Kobi House 2. Client registered on Kobi House client database 3. Nurse commences health assessment 4. MO completes health assessment 5. Client registered on QRHS database	1. Management plan completed for client 2. Appropriate referrals made 3. Transport arranged for referral appointments 4. Interpreters booked for referral appointments 5. Client is followed up 6. Client data to be entered into Queensland Refugee Health Service database	1. Client advised where next medical appointment will be (either community GP or back at Kobi House) 2. SPIRITUS advised of client exit 3. Client exit entered on QRHS database
WHO	WHO	WHO	WHO	WHO
1, 3 DIAC 2. SPIRITUS 4, 5. Nurse	1, 2, 3, 4, 5, 6, 7 – all SPIRITUS	1. SPIRITUS 2. Nurse/admin staff 3, 5. Nurse 4. MO	1, 2. MO and nurse 3 - 5. Nurse contacts SPIRITUS 4. Nurse contacts referral agency to book interpreter	1, 2, 3, - nurse
HOW	HOW	HOW	HOW	HOW
1. Routine email notification 2. Email notification 3. Routine email 4. Nurse books client in 5. As per HSD procedures	1. SPIRITUS transports clients to hospital; discharge info to GP/nurse 2 Written consent 3& 4 Routine contact/info session 5. Email/phone call 6. and 7. SPIRITUS transports client	1. SPIRITUS staff or volunteers 2. Routine patient registration 3 & 4 Standardised heatlh assessment template 5. QRHS database	1, 2. Part of Item 714 3. Nurse contacts SPIRITUS to arrange transport. 4. Nurse contacts referral agency to book interpreter. Referral agency own arrangements 5. Nurse makes appointment with community GP or MO if complex health 6. QRHS database	1. Exit appointment 2. Phone call or email (discharge summary can be emailed) 3. QRHS database
WHERE	WHERE	WHERE	WHERE	WHERE
1,2,3, 6 – n/a 4, 5. Kobi House	1, 6. Toowoomba Hospital 2, 3, 4 Client accommodation/ SPIRITUS 5. n/a 7. Kobi House	1, 2, 3, 4, 5 – Kobi House	1, 2, 6 Kobi House 3. Spiritus. 4. as appropriate 5. community GP or Kobi House	1, 3 Kobi House 2. n/a
WHEN	WHEN	WHEN	WHEN	WHEN
1. One month in advance 2. As soon as confirmation is received 3, 5 As soon as possible 4. Within two weeks of arrival asap - before appointment	1. On arrival immediately. 2, 3. In advance of appointment 4. First six weeks of arrival 5. Asap after client arrives 6. Within 24 hours 7. Within 72 hours	1-3. On appt. day 4. One week after initial appt. 5. Asap after first appointment	As appropriate and relevant	1, 2, When health case management is not needed. Within 3-6 months of registration. 3. Within 2 weeks of client exit

[42] Confirmed arrival information does not include names but should include overall number of arrivals, family group, date of arrival, gender, date of birth, country of origin, language spoken.
[43] Health information (where available in a health manifest) is not to be forwarded to the Kobi House/ the Nurse until consent has been obtained from the client (post arrival)



PROPOSED REFUGEE JOURNEY – TOWNSVILLE REFUGEE HEALTH SERVICE				
PRE-ARRIVAL PLANNING	**ARRIVAL**	**INITIAL ASSESSMENT & LINK TO GP**	**REFERRAL/COORDINATION OF HEALTH SERVICES**	**EXIT**
WHAT	WHAT	WHAT	WHAT	WHAT
1. DIAC notifies TMSG/Nurse of subsequent month's arrivals 2. TMSG notifies nurse of confirmed arrival details[45][46] 3. GP appointment is arranged 4. Agreement b/w JCU & GP practice entered into 5. Interpreter is booked	1. If well go to accommodation. If unwell or a health alert, go to hospital. 2. Client consent obtained to share health information and to attend appointment. 3. Client notified of health appointment, transport arranged 4. TMSG educates client re health 5. TMSG notifies nurse if language was incorrect in DIAC notification	1. Client is transported to GP 2. Client registered on GP practice client database 3. Nurse commences health assessment 4. GP completes health assessment 5. Client registered on QRHS database	1. Management plan completed for client 2. Appropriate referrals made 3. Transport arranged by TMSG for referral appointments 4. Interpreters booked for referral appointments 5. Client is followed up 6. Client data entered in QRHS	1. Client advised that nurse withdrawing & how to contact if required 2. GP advised nurse withdrawing & how to contact if required 3. TMSG advised of client exit 4. Client exit entered on QRHS database
WHO	WHO	WHO	WHO	WHO
1. DIAC 2. TMSG 3, 5. Nurse 4. Nurse & Practice Manager/GP	1, 2, 3, 4, 5 – all TMSG	1.TMSG 2. Nurse/practice staff 3, 5.Nurse 4. GP	1, 2. GP and nurse 3 – 6 Nurse	1, 2, 3, 4 - nurse
HOW	HOW	HOW	HOW	HOW
1. Routine email notification 2. Email notification 3. Nurse approaches GP practices & appointment made 4. Standard agreement sent 5. Nurse books interpreter on behalf of GP – Dr Priority Line	2. TMSG transports clients to hospital; discharge info to GP/nurse 2, 3, 4 Routine contact/info session 5. Email/phone call	3. TMSG staff or volunteers 4. Routine practice registration 3 & 4 Standardised heatlh assessment template 5. QRHS database	1. 2. Part of Item 714 3. Nurse contacts TMSG 4. Nurse contacts referral agency to book interpreter. Referral agency has own arrangements 5. Nurse makes appointment for client with GP 6. QRHS database	1. Exit appointment 2. & 3. Prior to exit appointment being arranged b/w client and nurse 4. QRHS database
WHERE	WHERE	WHERE	WHERE	WHERE
1. and 2 – n/a 3. in GP practice 4. n/a 5. interpreter attends/telephones	1. Townsville Hospital 2, 3, 4 Client accommodation/ TMSG 5. n/a	1, 2, 3, 4 – GP practice 5. JCU/lap-top	1, 2, 3, 4, 5 GP practice 6. JCU/lap-top	1, 2, & 3 – GP Practice 4. JCU/lap-top
WHEN	WHEN	WHEN	WHEN	WHEN
1. One month in advance 2. As soon as DIAC notifies TMSG 3. Within first week of arrival 4. Asap - before appointment 5. n/a	1. On arrival immediately 2, 3. In advance of appt. 4. First six weeks of arrival 5. Asap after client arrives	1, 2, 3. On appt. day 4. One week after initial appt. 5. Asap after first appointment	1-5 As appropriate and relevant 6. Asap after first appointment	1, 2, & 3 When health case mgt not needed. Within 3-6 months of registration. 4. Within 2 weeks of client exit

[45] Confirmed arrival information does not include names but should include overall number of arrivals, family group, date of arrival, gender, date of birth, country of origin, language spoken.
[46] Health information (where available in a health manifest) is not to be forwarded to the Clinic until consent has been obtained from the client (post arrival)



Attachment 9: Role descriptions of hub staff – statewide functions

Statewide Coordinator

1. Coordinate, plan and monitor the Queensland Refugee Health Service
2. Coordinate the statewide planning and review of humanitarian arrivals and their health management with DIAC
3. Assist the Queensland Refugee Health Service to implement quality management practices
4. Provide leadership to progress and promote refugee health issues
5. Contribute to evidence based policy development: advocacy, representation, strategic partnerships and ongoing service development to improve accessibility and service delivery to humanitarian entrants
6. Monitor the deliverables and outcomes of refugee health services through implementation support, negotiations and troubleshooting
7. Coordinate the development of strategic resources including health information for humanitarian entrants that can be used state-wide
8. Facilitate consumer and community consultation to inform the development of the Queensland Refugee Health Service
9. Work with an ongoing statewide advisory committee to inform the development of the Queensland Refugee Health Service
10. Participate in strategic reviews of the Queensland Refugee Health Service to maintain and improve service delivery to humanitarian entrants
11. Facilitate and support research into refugee health needs and service delivery issues.

Medical Officer (half-time)

1. Manage and monitor refugee health care issues at a statewide level to facilitate high quality and standardised clinical services
2. Provide clinical expertise to support high quality health service delivery in the Queensland Refugee Health Service
3. Provide leadership to progress and promote refugee health issues
4. Provide mentoring, training, education and support to GPs in the Queensland Refugee Health Service and other relevant health providers
5. Lead the collaborative development, maintenance and review of standardised clinical protocols for refugee health
6. Monitor refugee health care issues and develop appropriate responses (clinical or non-clinical)
7. Provide expert advice to Queensland Health and other services in primary, secondary and tertiary health sectors on refugee health issues
8. Facilitate and participate in research into refugee health needs and service delivery issues to inform evidence based policy and service development
9. Participate in strategic reviews of the Queensland Refugee Health Service to maintain and improve service delivery to humanitarian entrants
10. Work with an ongoing clinical advisory committee to inform the clinical development of the Queensland Refugee Health Service
11. Work with an ongoing statewide advisory committee to inform the development of the Queensland Refugee Health Service.

Attachment 10: Non-PBS medications summary table: costing

Conditions common to recent refugees and recommended treatments

CONDITION	MEDICINES	ESTIMATE NUMBER AFFECTED	ESTIMATE OF UNIT COST	ESTIMATE TOTAL ANNUAL COST
Schistosomiasis	PRAZIQUANTEL	220 people per year who require one course of treatment	$52.54	$11,559
Vitamin D deficiencies	ERGOCALCIFEROL or CHOLECALCIFEROL	1360 people who require a 3 month treatment	Cholecalciferol $11.00 for 3 month supply	14,960
Malaria	ARTEMISIN plus LUMAFANTRINE	Should be treated in hospital, but nominal amount allocated		$2,000
Hookworm **Helminths**	MEBENDAZOLE ALBENDAZOLE	Very cheap – nominal amount allocated		$1,000
Anaemia	FERROUS SULFATE (iron supplements) Liquid tablets	185 children 200 women	$12 for 1 month supply – need on average of 3 months	$13,860
FUNGAL SCALP INFECTIONS (tinea capitis) IN CHILDREN	TERBINAFINE TERBINAFINE TABLETS	12 children		negligible
TOTAL COST				**$43,379**

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