



**Australian Government**

**Department of Health**



An Australian Government Initiative

## **Activity Work Plan 2019-2022:**

### **Core Funding**

### **GP Support Funding**

This Core Activity Work Plan template has the following parts:

1. The Core Activity Work Plan for the financial years 2019-20, 2020-2021 and 2021-2022.  
Please complete the table of planned activities funded under the following:
  - a) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
  - b) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.
2. The Indicative Budget for the financial years 2019-20, 2020-21 and 2021-22. Please attach an excel spreadsheet using the template provided to submit indicative budgets for:
  - c) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
  - d) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.

***Adelaide PHN***

***When submitting this 2019-2022 Activity Work Plan to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Activity Work Plan has been endorsed by the CEO.***

Approved by the Department of Health 12 October 2020

## Overview

This Core Activity Work Plan covers the period from 1 July 2019 to 30 June 2022. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of up to 36 months. Regardless of the proposed duration for each activity, the Department of Health will require PHNs to submit updates to the Activity Work Plan on an annual basis.

### Important documents to guide planning

The following documents will assist in the preparation of your Activity Work Plan:

- Activity Work Plan guidance material;
- PHN Needs Assessment Guide;
- PHN Program Performance and Quality Framework;
- Primary Health Networks Grant Programme Guidelines;
- Clause 3, Financial Provisions of the Standard Funding Agreement.

### Formatting requirements

- Submit plans in Microsoft Word format only.
- Submit budgets in Microsoft Excel format only.
- Do not change the orientation of any page in this document.
- Do not add any columns or rows to tables, or insert tables/charts within tables – use attachments if necessary.
- Delete all instructions prior to submission.

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# 1. (a) Planned PHN activities for 2019-20, 2020-21 and 2021-22

## – Core Flexible Funding Stream

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2022.

### CF1. Community and Provider Immunisation Engagement and Support

Proposed Activities – CF1. Community and Provider Immunisation Engagement and Support	
ACTIVITY TITLE	<b>CF1. Community and Provider Immunisation Engagement and Support</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>The activity title has changed and extend of service has expanded</i></p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Population Health</p> <p>If Other (please provide details): Immunisation</p>
Needs Assessment Priority	<p>IH-GPH1. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non-Aboriginal and Torres Strait Islander children</p> <p>GPH1. The CALD community are disproportionally affected by Hepatitis B</p> <p>GPH3. Identified areas of the Adelaide PHN (APHN) region have childhood immunisation rates below the national average</p> <p>GPH22. Prevention and early intervention strategies for childhood and youth health conditions</p>
Aim of Activity	<p>Community and Provider Immunisation Engagement and Support is one of five elements of the SA PHN Immunisation Hub program. This activity is commissioned to two organisations which both utilise specialist nurses to provide:</p> <ul style="list-style-type: none"> <li>immunisation program support and education to providers to increase childhood immunisation rates especially for Aboriginal and Torres Strait Islander children,</li> <li>support and information to the community, especially CALD communities and the impact of Hepatitis B,</li> <li>identify barriers to vaccine uptake and vaccine hesitancy within the local region</li> </ul>
Description of Activity	<p>The currently commissioned Champion Nurse Immunisation Program (CNIP) and Immunisation Community Engagement Project, will both engage specialist nurses to provide:</p>

	<ul style="list-style-type: none"> <li>• immunisation program support and education to providers</li> <li>• support and information to the community</li> <li>• identify barriers to vaccine uptake</li> <li>• address vaccine hesitancy</li> <li>• promote and advocate for immunisation at local community events</li> <li>• address immunisation requirements for CALD and new emerging communities</li> </ul> <p>With practice-based support available to providers and expert immunisation nurses accessible to communities, it is anticipated increased immunisation program awareness will lead to improved immunisation coverage. The program will be evaluated to determine its success and there is possibility for its expansion into rural regions.</p>
Target population cohort	Immunisation providers, community members and under-immunised children
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>Yes</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p> <p>The Champion Nurse Immunisation Project and Immunisation Community Engagement Project will engage local Indigenous schools to provide information about the importance of immunisations of Aboriginal and Torres Strait Islander children. They will offer support and training, where required and appropriate, to Aboriginal and Torres Strait Islander specific health services within primary health care.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APHN region but with a focus on areas with low coverage</p>
Consultation	<ul style="list-style-type: none"> <li>• This activity was established in consultation with Immunisation service providers, including General Practice, Local Councils, Child and Family Health Service and Hospitals.</li> <li>• Australian Immunisation Register (AIR) was consulted to identify low immunisation coverage regions across Metropolitan Adelaide. This then provided the priority localities for the Champion Nurse Immunisation Program and the Immunisation Community Engagement Project.</li> <li>• The South Australian Immunisation Provider Network (IPN) are consulted at their regular meetings.</li> </ul>
Collaboration	<ul style="list-style-type: none"> <li>• Australian Immunisation Register (AIR) - to effectively manage the childhood immunisation data through (AIR) data cleaning activities to accurately reflect the current immunisation status of children.</li> </ul>

	<ul style="list-style-type: none"> <li>The organisations commissioned to deliver the Champion Nurse Immunisation Program and the Immunisation Community Engagement Project will both collaborate with General Practice, Local Councils, Child and Family Health Service, Aboriginal schools, Migrant Health Service, Non-Government Organisations supporting identified population and community groups and Hospitals in order to:             <ul style="list-style-type: none"> <li>provide immunisation program support and education to providers support and information to the community</li> <li>identify barriers to vaccine uptake</li> <li>address vaccine hesitancy</li> <li>promote and advocate for immunisation at local community events</li> <li>address immunisation requirements for CALD and new emerging communities</li> </ul> </li> <li>The organisations commissioned to deliver the Champion Immunisation Nurse Program and the Immunisation Community Engagement Project will ensure all key elements of the program or project are undertaken in a timely manner and objectives met.</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates (<b>including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: July 2019</p> <p>Service delivery end date: June 2022</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach (please provide details)</p>

	<p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>

## CF2. Adelaide Refugees and New Arrivals Project (ARANAP)

**Proposed Activities – CF2. Adelaide Refugees and New Arrivals Program (ARANAP)**

ACTIVITY TITLE	<b>CF2. Adelaide Refugees and New Arrivals Program (ARANAP)</b>
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity.  Modified Activity
Program Key Priority Area	Choose from the following:  Population Health  If Other (please provide details): Culturally & Linguistically Diverse Communities
Needs Assessment Priority	<p>GPH2. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people.</p> <p>GPH14. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and specific health issues.</p> <p>GPH15. Lack of easily understood and accessible referral pathways across systems and settings.</p> <p>GPH17. Lack of community awareness about existing health care services for different population groups, consumers and providers.</p> <p>GPH19. Need to improve provision of education to consumers and professionals across the health sector to encourage the take up and application of preventative health measures.</p> <p>GPH20. Need to improve the aptitude/attitude and consistency of empathetic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>GPH23. Awareness and timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</p> <p>GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<p>The aims of ARANAP model are:</p> <ol style="list-style-type: none"> <li>1. Connect refugee and newly arrived people to relevant health care services (including other APHN commissioned services) and provide care coordination</li> </ol>



	<p>to have immediate clinical needs attended to and enable positive engagement with the health system.</p> <p>2. Support refugee and newly arrived people, through a health literacy approach, to understand their health condition and the health system and to better self-manage their health.</p> <p>3. Support primary health care providers, including General Practice, to have increased capacity to deliver culturally safe and culturally appropriate services to refugee and newly arrived people.</p>
Description of Activity	<p>Refugee and newly arrived people have ongoing challenges in accessing appropriate primary health care services in the APHN region. The ARANAP model addresses access to appropriate primary health care for refugee and new arrival communities through three streams.</p> <p>1. Supporting refugee and newly arrived people to access appropriate and timely health care services by:</p> <ul style="list-style-type: none"> <li>○ Connecting individuals with primary health care services,</li> <li>○ Refugee Health Nurses coordinating the care of program patients,</li> <li>○ Refugee Health Nurses working with both the patients and primary health care clinicians to ensure all health care concerns are attended to (including receiving a GP conducted comprehensive first health assessment in Australia, to support Refugee Health Service demand management, if necessary).</li> </ul> <p>2. Supporting refugee and new arrivals to understand their condition and the health system by:</p> <ul style="list-style-type: none"> <li>○ Bilingual-Bicultural workers using a Conversational Health Literacy Assessment Tool (CHAT) developed by Deakin University to measure health literacy and track progress in a patient's ability to self-manage and to understand their health,</li> <li>○ Patients receiving individualised support based on the results of the health literacy assessment and provided appropriate resources to make informed decision about their health care,</li> <li>○ Analysing patient's health literacy assessment results across the program to inform topic areas for further education and support to small groups of patients and the wider refugee and new arrival communities in culturally safe and appropriate ways, including multiple formats and multiple languages.</li> </ul> <p>3. Improving the capacity of mainstream primary health care services, including general practice to deliver culturally appropriate services to refugee and new arrival communities by:</p> <ul style="list-style-type: none"> <li>○ Using a best practice framework to generate a gap analysis and deliver targeted support to primary health care providers to improve the appropriateness of care to refugee and newly arrived people,</li> </ul>

	<ul style="list-style-type: none"> <li>Working with a focused number of practices to enable them to conduct first comprehensive health assessments for newly arrived people.</li> </ul> <p>ARANAP will also work towards improved system integration of primary health care services for refugees and newly arrived people including:</p> <ul style="list-style-type: none"> <li>Identifying and promoting best practice approaches and/or pathways for refugees and new arrivals across the spectrum of health care providers</li> <li>Facilitating, supporting and advocating for collaboration, coordination and integration.</li> </ul> <p>The APHN will ensure all components of the model are connected, integrated and promoted to community, service providers and the broader primary health care system.</p> <p>Additionally, to ensure a multi-pronged approach, refugee and new arrival Communities considerations will also be supported and embedded in other activities such as immunisation, HealthPathways, commissioned services, education and training. The APHN strives to be culturally safe and culturally appropriate in all activities undertaken.</p>
Target population cohort	Refugee and New Arrival Communities
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APHN region</p>
Consultation	<p>ARANAP was developed through an extensive consultation and codesign process involving an environmental scan, sector consultation, request for proposal, co-design workshop with sector-wide participation. These activities were conducted from 2017 through 2018.</p> <p>Adelaide PHN has worked with the providers of the program to conduct minor redesign and strengthen the health literacy component of the program. Continued consultation will be undertaken through sector networking and the program's Steering Group.</p>
Collaboration	<p>General Practices in target areas</p> <ul style="list-style-type: none"> <li>Increase program awareness</li> </ul>

	<ul style="list-style-type: none"> <li>• Increase knowledge and capacity to provide culturally appropriate services to refugee and new arrival communities</li> </ul> <p>Primary Health Care, including Pharmacy</p> <ul style="list-style-type: none"> <li>• To support clients and general practitioners in managing health conditions and medications</li> </ul> <p>State Health services and LHNs</p> <ul style="list-style-type: none"> <li>• Support referral pathways of identified population groups</li> <li>• Sector is kept informed and provided with information and resources regarding the program</li> <li>• Program is informed of trends, updated services and changes within state services</li> <li>• Identification of shared opportunities to minimise duplication and improve service delivery across the sector</li> </ul> <p>NGOs</p> <ul style="list-style-type: none"> <li>• To provide information, support and promotion of the program to other NGOs supporting refugee and new arrival populations</li> <li>• Identification of shared opportunities to minimise duplication and improve service delivery across the sector</li> </ul>
<p>Activity milestone details/ Duration</p>	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding the planning and procurement cycle)</b>:</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p> <p>Any other relevant milestones?</p>
<p>Commissioning method and approach to market</p>	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p>

	<p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach (please provide details)</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>

## CF3. Adelaide Integrated Respiratory Response Project

**Proposed Activities – CF3. Adelaide Integrated Respiratory Response (AIRR) Project**

ACTIVITY TITLE	<b>CF3. Adelaide Integrated Respiratory Response (AIRR) Project</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Title changed</i></p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Population Health</p> <p>If Other (please provide details): Chronic Condition Management</p>
Needs Assessment Priority	<p>IH-GPH2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.</p> <p>GPH4. Selected areas of the APHN region have high rates of smoking which correlates with areas of high prevalence of COPD.</p> <p>GPH11. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis).</p> <p>GPH23. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</p> <p>GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<ol style="list-style-type: none"> <li>1. Build the capacity of participating GPs and Pharmacies to deliver evidence based and best practice COPD and asthma care to the community;</li> <li>2. To facilitate and increase collaboration and integration between the participating General Practices, Pharmacies and other relevant organisations e.g. referral paths including the Contractor and Sub-Contractors;</li> <li>3. Develop resources to facilitate the successful replication of the project in additional settings.</li> <li>4. Build the capacity of participating patients to understand their individual health needs and be actively involved with their OPD/Asthma care plans.</li> </ol>

Description of Activity	<p>The Adelaide Integrated Respiratory Response (AIRR) Project will continue to support the development and/or delivery of solutions which aim to improve outcomes for people living with Chronic Obstructive Pulmonary Disease (COPD) and Asthma, build the capacity of service providers to deliver safe and effective care and demonstrate reductions in preventable hospitalisations for COPD and Asthma in the APHN region. The model focuses on interventions which support people living with COPD and/or Asthma across the continuum with a focus on vulnerable population groups including , Aboriginal and Torres Strait Islander people, Children and Youth, Palliative Care patients, people with multi-morbidities and people not able to access services due to frailty or disability.</p> <p>The results of this activity will continually aim to improve collaborative working across sectors (with particular focus on clinical handover and shared ways of working); Implementation of evidence best practice models that are practice and patient centred (such as Asthma/COPD action plans); increase the availability, efficiency and effectiveness of respiratory health care and increasing workforce capacity and capability.</p>
Target population cohort	People living with COPD and/or Asthma across the care continuum with a focus on vulnerable population groups (including, Aboriginal and Torres Strait Islander people, Children and Youth, Palliative Care patients, people with multi-morbidities and people not able to access services due to frailty or disability).
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Playford, Salisbury, Port Adelaide-East, Port Adelaide-West and Onkaparinga</p>
Consultation	<p>Previous funding through the Australian National Health Prevention Agency (ANPHA) enabled an 18-month partnership project (2013/15) with Asthma SA, Lung Foundation Australia, the Pharmaceutical Society of Australia (SA/NT Branch), Drug and Alcohol Services SA [DASSA], Cancer Council (Quitline), Northern Region GP Council and the Northern Adelaide Local Health Network [NALHN] to focus on an integrated approach to respiratory health in northern Adelaide, raising community awareness of the relationship between smoking rates and respiratory conditions.</p> <p>Learnings from evaluation of stakeholder feedback from both projects highlighted the benefit of organisations working collaboratively in targeted populations and areas of need and this approach has informed the development of the service model for the ARHP.</p>

	A workshop was undertaken with members from the steering group involved in previous projects to determine key learning and issues encountered. The findings from this workshop assisted in refining the scope of the project.
Collaboration	<ul style="list-style-type: none"> <li>• Asthma SA will continue to raise community awareness and support primary health care practitioners (especially GPs and Pharmacists) with Asthma resources available to assist with management of the condition.</li> <li>• Lung Foundation Australia will continue support primary health care practitioners (especially GPs and Pharmacists) with COPD resources available to assist with management of the condition.</li> <li>• Pharmaceutical Society of Australia [SA/NT Branch] to support increased interventions and management at the pharmacy level to support smoking cessation and patient medication compliance.</li> <li>• Cancer Council [Quitline] to support the community and primary health care practitioners (especially GPs and Pharmacists) with the increasing referrals to Quitline and other smoking cessation resources and programs.</li> <li>• Local Health Networks across metropolitan Adelaide to assist in consistent, improved clinical pathways for appropriate patient management of respiratory conditions.</li> <li>• All relevant stakeholders will be invited to provide representation on the project working group, where appropriate.</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding the planning and procurement cycle)</b>:</p> <p>Service delivery start date: July 2019</p> <p>Service delivery end date: June 2022</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p>

	<p><input type="checkbox"/> Other approach (please provide details)</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>



## (To Cease / Complete) CF4. Care Connections Program

**Proposed Activities – CF4. Care Connections Program**

ACTIVITY TITLE	<b>CF4. Care Connections Program</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Population Health</p> <p>If Other (please provide details): Coordinated chronic condition management</p>
Needs Assessment Priority	<p>GPH6. Selected APHN LGAs have higher rates of a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease, musculoskeletal) and multi-morbidities.</p> <p>GPH8. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.</p> <p>GPH11. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis)</p> <p>GPH12. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.</p> <p>GPH14. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</p> <p>GPH18. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</p>
Aim of Activity	<p>Care Connections provides the opportunity for Adelaide PHN to coordinate and integrate healthy ageing and frailty management services for target patient cohorts to improve their health outcomes. Care Connections uses the Patient Centred Medical Home Model to support transformation of primary health care in the Adelaide PHN region. The aims are (to):</p> <ol style="list-style-type: none"> <li>1. Improve healthy ageing and frailty management in identified patient cohorts through implementation of elements of patient-centred medical home models;</li> <li>2. Connect and integrate local level primary health care systems and providers in targeted areas of the Adelaide PHN region;</li> <li>3. Implement quality improvement initiatives to support the Quadruple Aim of primary health care; and</li> <li>4. Improve the quality use of medicines (QUM) in line with the National Strategy for Quality Use of Medicines.</li> </ol>

Description of Activity	<p>Adelaide PHN will partner with researchers from the FORTRESS (Frailty in Older People: Rehabilitation Treatment Research Examining Separate Settings) Study and activities will support Care Connections with resources and information to assist primary care providers to understand and manage frailty and assist older people to live actively and independently at home. The main elements of Care Connections in 2019/22 will be:</p> <ul style="list-style-type: none"> <li>• <i>Integrated Care Hubs (ICH)</i>: Existing and future ICHs are targeted general practices who are undertaking, or will undertake, activities designed to explore elements of the Person-Centred Medical Home (PCMH) model. Activities seek to improve healthy ageing and frailty management, through leadership development, data-driven quality improvement, strengthening patient-clinician relationships, team-based care and participation in local medical neighbourhood initiatives. As practices move through the Care Connections program, they will: <ul style="list-style-type: none"> <li>○ Identify areas for improvement around frailty management within their practice and develop a plan for action. This action will be supported by activities described in GPS1 and HSI6.</li> <li>○ Undertake to develop and implement mechanisms for supporting continuous quality improvement. This action will be supported by activities described in GPS1 and HSI3.</li> <li>○ Identify patients who would benefit from a person-centred approach to the identification and management of frailty. This process allows practices to go beyond traditional condition-specific interventions and address patient needs across the entire care spectrum (including preventive, chronic and acute)</li> <li>○ Participate in (or co-design, where appropriate) PHN supported and/or commissioned evidence-based Improvement Activities which meet the specific needs of the identified patients and align with best-practice frailty management. These activities may include, for example: <ul style="list-style-type: none"> <li>▪ improved utilisation and scope of practice team members, both health professionals and administrative staff</li> <li>▪ utilisation of shared care platforms, patient portals and assistive technology</li> <li>▪ coordinated options for medicines review and management</li> <li>▪ nurse-led clinics, group self-management and shared medical appointments</li> <li>▪ frailty and falls management</li> <li>▪ health and lifestyle coaching for patients</li> <li>▪ improved access to specialised care</li> </ul> </li> </ul> <p>Each of these Improvement Activities within the ICH will be direct patient service delivery, enhancing the practices' ability to provide comprehensive care for the identified patients.</p> <li>• <i>Local Medical Neighbourhood</i>: This activity seeks to strengthen and sustain relationships between and within ICHs and other key health providers.</li> </li></ul>
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	<p>These relationships encourage collaboration and communication including the flow of information across and between clinicians and patients, to include specialists, hospitals, home health, long term care and other clinical providers.</p> <ul style="list-style-type: none"> <li>○ ICHs will be asked to identify potential partners for local medical neighbourhood activities from their referral lists</li> <li>○ Commissioned providers will upskill interested identified partners in the overarching PCMH-N (Neighbourhood) model and support them to build capacity for team-based care within their organisations. This action may be supported by activities described in HSI4 and HSI6</li> <li>○ Communities of practice, formed by the ICH with their local medical neighbourhood partners will review local population health issues, identify shared patients, and develop and deliver an integrated patient initiative supported by Adelaide PHN . They may also identify and undertake shared training opportunities to support their chosen patient initiative. These patient initiatives should build on the activities the ICH has undertaken as part of their Improvement Plan &amp; Activities and may include, for example: <ul style="list-style-type: none"> <li>▪ co-location of staff or shared resourcing of co-located health practitioners</li> <li>▪ cross-professional group self-management and shared medical appointments</li> <li>▪ comprehensive shared care planning, supporting the uptake of MBS case conferencing items</li> </ul> </li> </ul>
Target population cohort	Older adults (65+ years) living with or at risk of frailty who would benefit from improved coordination of care and flexible care options
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APHN region</p>
Consultation	Initial consultations were undertaken with APHN Clinical Councils for feedback to inform preliminary design. Further consultations were then conducted with general practices in the identified areas (see coverage for reference) to refine the activity model and ensure consistency with on-the-ground workforce concerns.

	<p>The following groups have been and will continue to be consulted to further inform activities undertaken as part of Care Connections program design and development:</p> <ul style="list-style-type: none"> <li>• Primary health care workforce</li> <li>• Specific Local Health Networks (LHNs) to coordinate referral pathways of identified population groups and or those with health condition(s) presenting at Emergency and/or Outpatient Departments and discharge summaries (after hospitalisation) in target areas.</li> <li>• Pharmacies and allied health services in target areas to support general practices and patients in managing health condition(s).</li> <li>• Aboriginal Community Controlled Health Organisation(s) (ACCHO) to support culturally appropriate services for Aboriginal and Torres Strait Islander people.</li> </ul> <p>NGOs to provide additional support, educational and or health promotion services and activities.</p>
Collaboration	<p>Collaboration on this activity continues and is integral to the ongoing nature of ICH's, medical neighbourhood and well-coordinated and integrated primary health care. Collaboration continues with:</p> <ul style="list-style-type: none"> <li>• The FORTRESS Study</li> <li>• Local Health Networks</li> <li>• Allied health</li> <li>• Pharmacies</li> <li>• Community Health and social support providers</li> </ul> <p>These engagements continue to build, strengthen and sustain targeted relationships in the local geographic regions, to support the development of the Local Medical Neighbourhood. This work may include clarifying referral pathways, identifying capacity and capability issues, and supporting linkages between these organisations and the Integrated Care Hubs.</p>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates (<b>including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2021</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: July 2019</p> <p>Service delivery end date: June 2021</p> <p>Any other relevant milestones?</p>

<p>Commissioning method and approach to market</p>	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input checked="" type="checkbox"/> Open tender</p> <p><input checked="" type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach (please provide details)</p> <p>Mixed commissioning approach will allow each element of Care Connections to be procured as is appropriate to the design of each element.</p> <p>2a. Is this activity being co-designed?</p> <p>No</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>
<p>Decommissioning</p>	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p> <p>Activity concludes at June 2021</p>

## CF5. Living Well with Persistent Pain Program

**Proposed Activities – CF5. Living Well with Persistent Pain Program**

ACTIVITY TITLE	<b>CF5. Living Well with Persistent Pain Program</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Existing Activity</p> <p><i>(Note to APHN staff: Previously referenced as CF5.1 and CF5.2 in 18/19 AWP)</i></p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Population Health</p> <p>If Other (please provide details): Chronic Condition Management</p>
Needs Assessment Priority	<p>GPH7. Services for people living with persistent pain are limited with long delays to access hospital-based services.</p> <p>GPH24. A coordinated approach to improve navigation and pathways for patients to better manage their conditions.</p>
Aim of Activity	<p>The aim of the activity is to provide a multi-disciplinary, collaborative primary care-based persistent pain management network, which:</p> <ul style="list-style-type: none"> <li>• supports individuals to better understand their condition;</li> <li>• equips them with the necessary tools to improve their quality of life;</li> <li>• improves individual's ability to navigate the health system; and</li> <li>• minimises the burden of pain on the individuals and the wider community.</li> </ul>
Description of Activity	<p>The Living Well with Persistent Pain (LWwPP) program is based on evidence showing multidisciplinary biopsychosocial interventions, such as pain management programs are successful in assisting people to manage ongoing or persistent pain. Based on the successful PainWise® Turning Pain into Gain Program, this activity is a comprehensive pain management program.</p> <p>Individuals are referred to the program by their GP for a 12-month intervention. In the program, they can access:</p> <ul style="list-style-type: none"> <li>• an education program focused on making changes to improve the patient's daily life;</li> <li>• one-on-one discussions about the patient's pain and how it affects them;</li> <li>• a tailored plan of allied health services.</li> </ul> <p>Participants undergo an initial assessment with the program Care Coordinator and have a personalised care plan developed. A GP with a Special Interest may also be available in the program to develop care plans for more complex cases such as those where the referring GP is seeking a second opinion, support in medication changes or deprescribing or other complications.</p> <p>As people with persistent pain often require complex management plans, participants are supported with access to up to five allied health appointments</p>

	<p>as part of their care plan (in addition to any allied health appointments under an Enhanced Primary Care plan from their regular GP).</p> <p>Alongside this, participants attend a series of six group education sessions delivered by the multi-disciplinary team to learn and develop self-management skills which support their work with the GP and the allied health team. The multi-disciplinary team, in the course of the education sessions also supports individuals to understand the roles and functions of clinicians that may be in their care team, assisting participants to develop an understanding of the components of the health system and how they work.</p> <p>Services will deliver the program, each aligned with the relevant Local Health Network boundary.</p>
Target population cohort	People living with persistent pain
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Northern and Central LHN SA3 areas (Note: Southern project withdrawn)</p>
Consultation	<p>Prior to the development of the program, consultations were undertaken with Royal Adelaide Hospital Pain Management Unit, Northern Adelaide Local Health Network, PainWise® Turning Pain into Gain Program operators and identified general practice and allied health.</p> <p>During the early stages of the program implementation, program leaders participated in the SA Health Transforming Health Chronic Pain Model of Care consultation process as part of both the Working Group and Steering Committee. This participation assisted to align the activity with the State model and ensure integration/prevent duplication across the sectors.</p> <p>Adelaide PHN continues to work with the commissioned service provider to identify opportunities and develop the program further. Tertiary services are also engaged ongoingly.</p>
Collaboration	<p>Local Health Networks:</p> <ul style="list-style-type: none"> <li>Partnering as a delivery partner</li> <li>Referral of appropriate patients</li> <li>Pathways with the LHN chronic pain program</li> </ul> <p>General Practices in target areas:</p> <ul style="list-style-type: none"> <li>Service delivery to support them to manage patients' persistent pain condition alongside any chronic condition(s)</li> </ul>

	<ul style="list-style-type: none"> <li>Referral of appropriate patients.</li> </ul> <p>Allied health services, including pharmacies:</p> <ul style="list-style-type: none"> <li>Building capacity of these providers to support patients to manage their persistent pain.</li> </ul> <p>Living Well with Persistent Pain programs:</p> <ul style="list-style-type: none"> <li>Identifying shared opportunities to minimise duplication.</li> </ul> <p>Pain support groups:</p> <ul style="list-style-type: none"> <li>Identifying shared opportunities and pathways for support post-program.</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding the planning and procurement cycle)</b>:</p> <p>Service delivery start date: July 2019</p> <p>Service delivery end date: June 2022</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input checked="" type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach (please provide details)</p> <p>2a. Is this activity being co-designed?</p> <p>No</p>



	<p>2b. Is this activity this result of a previous co-design process?</p> <p>No</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>

## CF6. Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program

**Proposed Activities – CF6. Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program**

ACTIVITY TITLE	<b><i>CF6. Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program</i></b>
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity.  Existing Activity
Program Key Priority Area	Choose from the following:  Workforce  If Other (please provide details): Aboriginal Health
Needs Assessment Priority	IH-GPH2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.  IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.  GPH20. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.  GPH21. Minimise instances of poor quality and unwarranted variations of care and follow up.
Aim of Activity	The project aims are: <ul style="list-style-type: none"> <li>• Improve the level of Aboriginal and Torres Strait Islander cultural awareness and competency to contribute to increased culturally appropriate, safe services across the primary health care sector for improved patient experience.</li> <li>• Increase Adelaide PHN commissioned service providers and the primary health care services capacity in addressing identified local issues and supporting the health system better meet the needs of the Aboriginal and Torres Strait Islander people and communities</li> <li>• Increase mainstream primary health care provider knowledge and understanding of measures under the Indigenous Australian Health Program (IAHP) and improve access to primary health care for Aboriginal and Torres Strait Islander people.</li> <li>• Increase commissioned service provider and primary health care provider knowledge and understanding of the six Aboriginal Health Actions within the National Safety Quality Health Standards (NSQHS)</li> <li>• Increase access to culturally safe services and appropriate chronic disease management programs for Aboriginal and Torres Strait Islander people</li> </ul>

Description of Activity	<p>This project will deliver:</p> <ul style="list-style-type: none"> <li>• Cultural learning (accredited training) to improve the capacity of mainstream primary health care providers and workforce to deliver safe, accessible and culturally responsive services for Aboriginal and Torres Strait Islander people.</li> <li>• Cultural learning (accredited training) to the primary health care workforce which will include Adelaide PHN commissioned service providers.</li> <li>• Capacity building hubs and workshops on the 6 Aboriginal Actions within the National Health and Safety Quality Standards for commissioned service providers.</li> <li>• Support the delivery of best practice approaches to improve health outcomes and delivery of care to Aboriginal and Torres Strait Islander people.</li> <li>• Promote the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule (MBS) items, including Aboriginal and Torres Strait Islander Health Assessments and follow up items</li> </ul>
Target population cohort	<p>The target audience for the training will be Adelaide PHN commissioned service providers and the broader primary health care workforce. Focusing on mainstream service providers, such as general practitioners, practice managers and nursing staff, reception staff, allied health professionals, pharmacists and pharmacy assistants.</p>
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>Yes</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector</p> <p>The commissioned agency is an Aboriginal Organisation and will work in partnership with Adelaide PHN in collaboration with Aboriginal State peak bodies, consolidate and extend collaborative working relationships with Aboriginal Community Controlled Health Organisations, primary health and acute services, as well as primary and state based health and support agencies.</p> <p>Both organisations will continue their collaborative work with SAMHRI's Aboriginal Research Unit (Wardliparingga) on the implementation of programs and initiatives for culturally appropriate best practice management. And the implementation of the six Aboriginal Health Actions within the National Safety Quality Health Standards (NSQHS) and how the providers will align with the User Guide for Aboriginal and Torres Strait Islander Health.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Adelaide PHN region</p>

Consultation	<p>Consultations and codesign have occurred with the following stakeholders to help inform the development and ongoing review of this project:</p> <ul style="list-style-type: none"> <li>• The Adelaide PHN Aboriginal Consumer Advisory Council</li> <li>• South Australian Health and Medical Research Institute – Warldaparingga Aboriginal Unit</li> <li>• Integrated Team Care Program workforce</li> </ul> <p>Further consultation will be conducted with primary health care workforce and community members to explore how the Adelaide PHN can further support cultural learning and capacity building for the primary health care workforce.</p>
Collaboration	<p>Collaboration on this activity is evolving and it is expected that the APHN will engage with:</p> <ul style="list-style-type: none"> <li>• South Australian Health and Medical Research Institute – Warldaparingga Aboriginal Unit – established a working group to develop systematic approaches for commissioned service providers to implement the 6 Aboriginal Actions within the NHSQS.</li> <li>• Integrated Team Care Program – The Indigenous Health Project Officer co-facilitates some of the Cultural Learning sessions ensuring information is provided about incentives within the IAHP and program promotion. Then follow up visits to practices are supported</li> <li>• GP practices – Participants of the Cultural Learning Program and attend sessions with pre and post activities which include an evaluation component</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding the planning and procurement cycle)</b>:</p> <p>Service delivery start date: July 2019</p> <p>Service delivery end date: June 2022</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p>

	<p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach (please provide details)</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>

## CF7. Integrated Care with Northern Adelaide Local Health Network (ICwNALHN)

**Proposed Activities – CF7. Integrated Care with Northern Adelaide Local Health Network (ICwNALHN)**

ACTIVITY TITLE	<b>CF7. Integrated Care with Northern Adelaide Local Health Network (ICwNALHN)</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Activity number has changed. Previously referenced as CF9.</i></p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Population Health</p> <p>If Other (please provide details): Integrated Care</p>
Needs Assessment Priority	<p>GPH14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>GPH18. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>GPH19. Minimise instances of poor quality and unwarranted variations of care and follow up.</p> <p>GPH22. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<p>This activity aims to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and the Lyell McEwin and Modbury Hospitals in the Northern Adelaide Local Health Network (NALHN) region. This activity aims to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and NALHN (i.e. the Network).</p>
Description of Activity	<p>The activity will work in the following domains to improve patient outcomes through a -strengthened acute-primary care interface in the NALHN region. These activities have been aligned to APHN's Integrated Care Framework dimension of integration (as described in HSI4):</p> <p>Professional Integration activities:</p> <ul style="list-style-type: none"> <li>• Provide education and networking opportunities that brings GPs and hospital consultants together and improves knowledge,</li> <li>• Work collaboratively with GPs to facilitate better GP understanding of Local Health Network pathways.</li> </ul>

	<p>Service Integration activities:</p> <ul style="list-style-type: none"> <li>Collaborate with hospital consultants and GPs to understand and resolve systemic primary care-Local Health Network interface issues.</li> </ul> <p>Administration Integration activities:</p> <ul style="list-style-type: none"> <li>Improve referral quality through use of HealthPathways, feedback to general practices, and updating of referral guidelines,</li> <li>Implement a quality improve approach to identify failure points and increase timely discharge summary completion.</li> </ul> <p>Clinical Integration activities:</p> <ul style="list-style-type: none"> <li>Explore IT solutions to improve collaboration and information sharing between Local Health Network services and general practice.</li> </ul>
Target population cohort	The target population will be patients with chronic conditions who have frequent contact with hospital services
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Playford</p> <p>Salisbury</p> <p>Tea Tree Gully</p> <p>Port Adelaide – East</p>
Consultation	<p>This activity has been established in consultation with general practitioners in NALHN region and clinicians and administrative staff from NALHN.</p> <p>This activity is governed by a Steering Group, involving participants from APHN, NALHN to oversee the performance, monitoring and evaluation functions and use this information to review and adapt planned activity ahead of each financial year.</p>
Collaboration	<p>The Steering Group, involving key representatives from APHN, NALHN and the GP Unit to collaborate in the oversight and performance monitoring and evaluation functions. In addition, each partner contributes the following.</p> <p>Adelaide PHN:</p>

	<ul style="list-style-type: none"> <li>• Integration Coordinators facilitate collaboration between the GP Units with other APHN activities, support GP Unit functions and provide Project Management oversight,</li> <li>• Practice Facilitators extend the work of the GP Units into their visits to general practices.</li> </ul> <p>Local Health Network:</p> <ul style="list-style-type: none"> <li>• Local Health Network staff facilitate collaboration between GP Unit team members and staff from departments and units within Local Health Network services, and</li> <li>• facilitate the identification, development and management of quality improvement activities.</li> </ul> <p>General Practitioners:</p> <ul style="list-style-type: none"> <li>• Participate in facilitated workshops to identify system issues and potential quality improvement activities.</li> <li>• Participate in education and networking sessions to improve clinical skills and knowledge, relationships and understanding of pathways.</li> </ul> <p>The GP Unit is comprised of:</p> <ul style="list-style-type: none"> <li>• GP Liaison/Integration Officers (engaged through APHN)</li> <li>• Nurse (employed by NALHN)</li> <li>• Administrative support (employed by NALHN).</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates (<b>including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p>



	<p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input checked="" type="checkbox"/> Other approach (please provide details) Partnership</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>Yes</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>Consultation with Local Health Network (LHN) during design and implementation of activity</p> <p>Yes</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>

## CF8. Integrated Care with Southern Adelaide Local Health Network (ICwSALHN)

Proposed Activities – CF8. Integrated Care with Southern Adelaide Local Health Network (ICwSALHN)	
ACTIVITY TITLE	<b>CF8. Integrated Care with Southern Adelaide Local Health Network (ICwSALHN)</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Activity number has changed. Previously referenced as CF10.</i></p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Population Health</p> <p>If Other (please provide details): Integrated Care</p>
Needs Assessment Priority	<p>GPH14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>GPH18. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>GPH19. Minimise instances of poor quality and unwarranted variations of care and follow up.</p> <p>GPH22. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<p>This activity aims to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and the Flinders Medical Centre and Noarlunga Hospital in the Southern Adelaide Local Health Network (SALHN) region. This activity aims to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and SALHN (i.e. the Network).</p>
Description of Activity	<p>The activity will work in the following domains to improve patient outcomes through a -strengthened acute-primary care interface in the SALHN region. These activities have been aligned to APHN's Integrated Care Framework dimension of integration (as described in HSI4):</p> <p>Professional Integration activities:</p> <ul style="list-style-type: none"> <li>• Provide education and networking opportunities that brings GPs and hospital consultants together and improves knowledge,</li> <li>• Work collaboratively with GPs to facilitate better GP understanding of Local Health Network pathways.</li> </ul>

	<p>Service Integration activities:</p> <ul style="list-style-type: none"> <li>Collaborate with hospital consultants and GPs to understand and resolve systemic primary care-Local Health Network interface issues.</li> </ul> <p>Administration Integration activities:</p> <ul style="list-style-type: none"> <li>Improve referral quality through use of HealthPathways, feedback to general practices, and updating of referral guidelines,</li> <li>Implement a quality improve approach to identify failure points and increase timely discharge summary completion.</li> </ul> <p>Clinical Integration activities:</p> <ul style="list-style-type: none"> <li>Explore IT solutions to improve collaboration and information sharing between Local Health Network services and general practice.</li> </ul>
Target population cohort	The target population will be patients with chronic conditions who have frequent contact with hospital services
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Holdfast Bay</p> <p>Marion</p> <p>Mitcham</p> <p>Onkaparinga</p>
Consultation	<p>This activity has been established in consultation with general practitioners in SALHN region and clinicians and administrative staff from SALHN.</p> <p>This activity is governed by a Steering Group, involving participants from APHN, SALHN to oversee the performance, monitoring and evaluation functions and use this information to review and adapt planned activity ahead of each financial year.</p>

Collaboration	<p>The Steering Group, involving key representatives from APHN, SALHN and the GP Unit to collaborate in the oversight and performance monitoring and evaluation functions. In addition, each partner contributes the following.</p> <p>Adelaide PHN:</p> <ul style="list-style-type: none"> <li>• Integration Coordinators facilitate collaboration between the GP Units with other APHN activities, support GP Unit functions and provide Project Management oversight,</li> <li>• Practice Facilitators extend the work of the GP Units into their visits to general practices.</li> </ul> <p>Local Health Network:</p> <ul style="list-style-type: none"> <li>• Local Health Network staff facilitate collaboration between GP Unit team members and staff from departments and units within Local Health Network services, and</li> <li>• facilitate the identification, development and management of quality improvement activities.</li> </ul> <p>General Practitioners:</p> <ul style="list-style-type: none"> <li>• Participate in facilitated workshops to identify system issues and potential quality improvement activities.</li> <li>• Participate in education and networking sessions to improve clinical skills and knowledge, relationships and understanding of pathways.</li> </ul> <p>The GP Unit is comprised of:</p> <ul style="list-style-type: none"> <li>• GP Liaison/Integration Officers (engaged through APHN)</li> <li>• Nurse (employed by SALHN)</li> <li>• Administrative support (employed by SALHN).</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates (<b>including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p>

	<p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input checked="" type="checkbox"/> Other approach (please provide details) Partnership</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>Yes</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>Consultation with Local Health Network (LHN) during design and implementation of activity</p> <p>Yes</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>
Funding from other sources	<p>If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation).</p>

## CF9. Integrated Care with Central Adelaide Local Health Network (ICwCALHN)

**Proposed Activities – CF9. Integrated Care with Central Adelaide Local Health Network (ICwCALHN)**

ACTIVITY TITLE	<b>CF9. Integrated Care with Central Adelaide Local Health Network (ICwCALHN)</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Activity number has changed. Previously referenced as CF11.</i></p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Population Health</p> <p>If Other (please provide details): Integrated Care</p>
Needs Assessment Priority	<p>GPH14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>GPH18. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>GPH19. Minimise instances of poor quality and unwarranted variations of care and follow up.</p> <p>GPH22. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<p>This activity aims to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and the Royal Adelaide Hospital and Queen Elizabeth Hospital in the Central Adelaide Local Health Network (CALHN) region. This activity aims to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and CALHN (i.e. the Network).</p>
Description of Activity	<p>The activity will work in the following domains to improve patient outcomes through a -strengthened acute-primary care interface in the CALHN region. These activities have been aligned to APHN's Integrated Care Framework dimension of integration (as described in HSI4):</p> <p>Professional Integration activities:</p> <ul style="list-style-type: none"> <li>• Provide education and networking opportunities that brings GPs and hospital consultants together and improves knowledge,</li> <li>• Work collaboratively with GPs to facilitate better GP understanding of Local Health Network pathways.</li> </ul>

	<p>Service Integration activities:</p> <ul style="list-style-type: none"> <li>Collaborate with hospital consultants and GPs to understand and resolve systemic primary care-Local Health Network interface issues.</li> </ul> <p>Administration Integration activities:</p> <ul style="list-style-type: none"> <li>Improve referral quality through use of HealthPathways, feedback to general practices, and updating of referral guidelines,</li> <li>Implement a quality improve approach to identify failure points and increase timely discharge summary completion.</li> </ul> <p>Clinical Integration activities:</p> <ul style="list-style-type: none"> <li>Explore IT solutions to improve collaboration and information sharing between Local Health Network services and general practice.</li> </ul>
Target population cohort	The target population will be patients with chronic conditions who have frequent contact with hospital services
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Port Adelaide – West</p> <p>Charles Sturt</p> <p>West Torrens</p> <p>Unley</p> <p>Adelaide City</p> <p>Burnside</p> <p>Prospect-Walkerville</p> <p>Norwood – Payneham – St Peters</p> <p>Campbelltown</p>
Consultation	This activity has been established in consultation with general practitioners in CALHN region and clinicians and administrative staff from CALHN.

	<p>This activity is governed by a Steering Group, involving participants from APHN, CALHN to oversee the performance, monitoring and evaluation functions and use this information to review and adapt planned activity ahead of each financial year.</p>
Collaboration	<p>The Steering Group, involving key representatives from APHN, CALHN and the GP Unit to collaborate in the oversight and performance monitoring and evaluation functions. In addition, each partner contributes the following.</p> <p>Adelaide PHN:</p> <ul style="list-style-type: none"> <li>• Integration Coordinators facilitate collaboration between the GP Units with other APHN activities, support GP Unit functions and provide Project Management oversight,</li> <li>• Practice Facilitators extend the work of the GP Units into their visits to general practices.</li> </ul> <p>Local Health Network:</p> <ul style="list-style-type: none"> <li>• Local Health Network staff facilitate collaboration between GP Unit team members and staff from departments and units within Local Health Network services, and</li> <li>• facilitate the identification, development and management of quality improvement activities.</li> </ul> <p>General Practitioners:</p> <ul style="list-style-type: none"> <li>• Participate in facilitated workshops to identify system issues and potential quality improvement activities.</li> <li>• Participate in education and networking sessions to improve clinical skills and knowledge, relationships and understanding of pathways.</li> </ul> <p>The GP Unit is comprised of:</p> <ul style="list-style-type: none"> <li>• GP Liaison/Integration Officers (engaged through APHN)</li> <li>• Nurse (employed by CALHN)</li> <li>• Administrative support (employed by CALHN).</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates (<b>including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p> <p>Any other relevant milestones?</p>



<p>Commissioning method and approach to market</p>	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input checked="" type="checkbox"/> Other approach (please provide details) Partnership</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>Yes</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>Consultation with Local Health Network (LHN) during design and implementation of activity</p> <p>Yes</p>
<p>Decommissioning</p>	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>

## CF10. Aboriginal and Torres Strait Islander Community Peer Support for Cancer Screening

Proposed Activities – CF10. Aboriginal and Torres Strait Islander Community Peer Support for Cancer Screening	
ACTIVITY TITLE	CF10. Aboriginal and Torres Strait Islander Community Peer Support for Cancer Screening
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Activity number has changed. Previously referenced as CF12.</i></p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Aboriginal and Torres Strait Islander Health</p> <p>If Other (please provide details): Population Health</p>
Needs Assessment Priority	<p>IH-GPH3. Accessibility to and appropriateness of primary health care services, particularly for Aboriginal and Torres Strait Islander people.</p> <p>IH-GPH4. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people.</p>
Aim of Activity	This project aims to increase participation in breast, bowel and cervix screening for Aboriginal and Torres Strait Islander people living in metropolitan Adelaide, through the use of community peer educators and a lived experience service delivery approach.
Description of Activity	<p>Through community peer educator approaches the project which will:</p> <ul style="list-style-type: none"> <li>• Develop and implement activities to increase Aboriginal and Torres Strait Islander people's awareness and understanding of cancer prevention and improve cancer screening health literacy</li> <li>• Work collaboratively with cancer screening services to increase accessibility for Aboriginal and Torres Strait Islander people in culturally appropriate ways</li> <li>• Promote coordinated and consistent approaches to cancer screening pathways for Aboriginal and Torres Strait Islander people</li> </ul> <p>The project will enable the service provider to engage Aboriginal peer workers as "peer ambassadors" to deliver culturally appropriate messages and information (yarning circles) about cancer screening and advocate with primary health care services for improved, culturally appropriate approaches to promoting and providing cancer screening.</p> <p>The project will comprise activities which assist with the implementation of recommendations from both the <a href="#">National Aboriginal and Torres Strait Islander Cancer Framework</a> and the <a href="#">South Australian Aboriginal Cancer</a></p>

	<p><a href="#">Control Plan</a> regarding screening and early detection of cancer in Aboriginal and Torres Strait Islander people.</p> <p>The desired outcome of this project is to reduce the impact of cancer in Aboriginal communities, by empowering Aboriginal people to improve their cancer screening literacy and support their decisions and actions in relation to cancer screening.</p> <p>The intended outcomes of the Aboriginal Cancer Screening Project are:</p> <ul style="list-style-type: none"> <li>Aboriginal people have improved health literacy for cancer screening including changing attitudes toward participating in screening (e.g. intention to be screened and actual screening), increased knowledge of causes and risk / protective and wellbeing factors, the benefits and importance of screening and where and how to access services;</li> <li>Cancer screening service providers have increased confidence and ability to deliver culturally sensitive and appropriate services to Aboriginal People;</li> <li>A coordinated and consistent cancer screening message is provided to Aboriginal people.</li> </ul>
Target population cohort	Aboriginal and Torres Strait Islander population
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>Yes</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p> <p>Collaboration and support initiatives between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors. Key Stakeholders will be engaged to promote the Yarning Circles within their service region.</p> <p>Stakeholders include:</p> <ul style="list-style-type: none"> <li>SAHMRI – Aboriginal Chronic Disease Consortium, Cancer Leadership Group</li> <li>LHNs</li> <li>Nunkuwarrin Yunti</li> <li>Aboriginal Health Council of South Australia</li> </ul>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Adelaide, Playford, Salisbury, Port Adelaide-East, Port Adelaide-West, West Torrens and Onkaparinga.</p>

Consultation	<p>During the beginning stage of the activity, Adelaide PHN consulted with the Aboriginal HPG in the scoping and design stage of the activity. We will now ensure we include the Aboriginal Community Council (newly established) in feedback and ongoing improvement for these activities.</p> <p>Adelaide PHN provides ongoing updates on activity to the Adelaide PHN Consumer Advisory Council.</p> <p>The provider will continue to consult with local Elders on the program activity and provide feedback to the Aboriginal Advisory Group of the Aboriginal Chronic Disease Consortium (South Australian Medical Research Institute) and the Integrated Team Care Workforce (Sonder).</p>
Collaboration	<p>SA Health Cancer Screening program staff actively support and promote the Aboriginal Cancer Screening project, across local health networks (LHNs), providing appropriate pathway information to their Aboriginal and Torres Strait Islander patients.</p> <p>General Practitioners, with Aboriginal Torres Strait Islander patients provide project information/collateral. And refer their patients to the project coordinator.</p> <p>Closing the Gap staff are aware of the Aboriginal Cancer Screening project and are working collaboratively with Cancer Council SA to raise community and Aboriginal</p> <p>Cancer Council SA in partnership with Adelaide's Aboriginal Community Advisory Council designed the project, to ensure a culturally appropriate lens was applied. Cancer Council SA has responsibility for project deliverables, including evaluation.</p> <p>One of the key desired outcomes of this program will be to promote coordinated and consistent approaches to cancer screening pathways for Aboriginal people in the Adelaide PHN region. To support this, the Adelaide PHN will facilitate bi-monthly meetings with the project's service provider and other key stakeholders to build relationships, address barriers and enablers and seek collaborative solutions to a coordinated approach to cancer screening for Aboriginal people.</p> <p>There is also scope to encourage collaboration through the coordination and integration the cancer screening peer ambassador workforce with the Closing the Gap Integrated Team Care teams, once established – enhancing the Closing the Gap's programs ability to access culturally appropriate supports to address the cancer screening requirements of its clients, and increasing the reach of the peer ambassadors into the community.</p>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date: 1/07/2019</p>

	<p>Activity end date: 30/06/2021</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: Month. 2019</p> <p>Service delivery end date: Month. 2021</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach (please provide details)</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p> <p>Activity has achieved its objectives and concludes on June 2021</p>

(To move to PMHCS AWP) CF11. Mental Health Clinical Internship (MHCI) Program

Proposed Activities – CF11. Mental Health Clinical Internship (MHCI) Program	
ACTIVITY TITLE	CF11. Mental Health Clinical Internship (MHCI) Program
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Activity number has changed. Previously referenced as CF13.</i></p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Workforce</p> <p>If Other (please provide details): Mental Health</p>
Needs Assessment Priority	<p>GPH15. Lack of easily understood and accessible referral pathways across systems and settings.</p> <p>GPH16. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>GPH20. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>IH-PMH6. Greater prevalence of intentional self-harm and suicide in selected areas and specific population groups across the region including Aboriginal and Torres Strait Islander people.</p> <p>PMH2. Provision of psychological services comparatively low in areas of highest need.</p>
Aim of Activity	<p>The MHCI Program aims to support post graduate students from the disciplines of psychology, occupational therapy, social work and/or mental health nursing to develop the specific clinical skills required to effectively deliver mental health services within a stepped care model. The Program will contribute to the development of the mental health workforce through the provision of internships:</p> <ul style="list-style-type: none"> <li>that provide structured career pathways within built-in support, supervision and continuing professional development; and</li> <li>are consistent with recognised standards for mental health clinicians and associated competencies.</li> </ul>
Description of Activity	<p>This activity addresses workforce capacity and skills development in clinical therapeutic intervention in mental health to address workforce shortages, particularly in relation to experienced Mental Health Clinicians capable of working with hard to reach populations. The Core Flex needs assessment refers to the Mental Health aspects of Primary Care and chronic conditions</p>

	<p>throughout the report, as well as the needs related to specific population groups. This is an area of need and is also identified in our Mental Health &amp; Suicide Prevention Needs Assessment.</p> <p>The MHCI Program will continue to be offered as a targeted 2-year program in regions with high need and offered to post graduate students to develop their skills and expertise in clinical practice. Upon completion of the program the Intern will have fulfilled the requirements for application for registration as an accredited Clinical Mental Health Social Worker, or in the case of other disciplines, two years post graduate clinical experience.</p> <p>The program will consist of:</p> <ul style="list-style-type: none"> <li>• Professional Development</li> <li>• Community Development, Education and Engagement</li> <li>• Observing Direct Clinical Practice</li> <li>• Co-facilitation of Clinical Practice</li> <li>• Supervised Practice</li> <li>• Clinical Supervision.</li> </ul> <p>The MHCI Program offers the dual benefit of supporting increased levels of service provision for hard to reach populations in areas of high need in the Adelaide metropolitan region and contributing to the development of overall workforce capacity, responsiveness and availability.</p>
Target population cohort	Post-graduate students looking to develop their skills in clinical practice and can work towards credentialing suitable for delivering clinical mental health services.
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Playford, Salisbury, Onkaparinga</p>
Consultation	The MHCI program has been informed by workforce requirements in the Adelaide PHN region (particularly with hard-to-reach populations) and community/stakeholder consultation.
Collaboration	The two commissioned service providers delivering the MHCI program ensure interns are exposed to a range of programs within their organisations to ensure program knowledge is acquired and opportunities for collaboration are

	provided e.g. program requiring escalating or referring clients on to state based or other specialist services.
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2021</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: Month. 2019</p> <p>Service delivery end date: Month. 2021</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach (please provide details)</p> <p>2a. Is this activity being co-designed?</p> <p>No</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>



Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p> <p>Activity moved to PMHCS Funding Schedule</p>
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## (To Cease / Complete) CF12. Domestic and Family Violence Support for Aboriginal Families

**Proposed Activities – CF12. Domestic and Family Violence Support for Aboriginal Families**

ACTIVITY TITLE	<b>CF12. Domestic and Family Violence Support for Aboriginal Families</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Activity title and number has changed. Previously referenced as CF15.</i></p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Aboriginal and Torres Strait Islander Health</p> <p>If Other (please provide details): Population Health</p>
Needs Assessment Priority	<p>IH-GPH2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.</p> <p>IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.</p> <p>IH-GPH4. Awareness of timely access to appropriate services (including after-hours services) for Aboriginal and Torres Strait Islander people.</p> <p>IH-PMH6. Greater prevalence of intentional self-harm and suicide in selected areas and specific population groups across the region including Aboriginal and Torres Strait Islander people.</p> <p>IHAOD7. Increase access to and availability of culturally appropriate AOD treatment services particularly alcohol and illicit drugs for Aboriginal and Torres Strait Islander people.</p>
Aim of Activity	<p>This activity aims to reduce violence and its impacts in Aboriginal and Torres Strait Islander families, by:</p> <ul style="list-style-type: none"> <li>• increasing access to appropriate early intervention programs and primary health care services to better support Aboriginal families experiencing domestic and family violence (DFV);</li> <li>• strengthening relationships between primary care services and DFV specialist services to improve service integration and develop effective care pathways using a co-design process;</li> <li>• providing extended wrap around services to Aboriginal families experiencing family violence; and</li> <li>• providing access to informed and active participation of individuals and family in interventions.</li> </ul>

Description of Activity	<p>This activity has increased access to appropriate early intervention programs and primary health care services to better support Aboriginal families experiencing domestic and family violence (DFV).</p> <p>The project works with families and perpetrators targeting those with drug and alcohol dependence and mental health issues. Working both clinically and culturally supporting prevention and referring clients to other trusted specialised services as needed; and with the aim to improve clinical outcomes for clients – e.g. reduced distress, improved functioning, maximise health and wellbeing</p> <p>The project provides strengths-based health services and real time referrals as needed. Each role supports family members to access culturally appropriate services, and provides timely care to clients presenting with mental health conditions and AOD use.</p> <p>The activity also involves specific workforce support and capacity building to provide counselling support and increase access to services across the Adelaide metro region.</p> <p>This activity integrates with Activities AOD3. <i>Ensure access to Indigenous-specific and culturally appropriate drug and alcohol treatment services for Aboriginal and Torres Strait Islander people</i>, AOD7. <i>Coordination and integration of culturally appropriate drug and alcohol treatment services for Aboriginal and Torres Strait Islander people across the stepped care model</i>, AOD8. <i>Enhance culturally appropriate, targeted treatment services for illicit drug users identifying as Aboriginal and/or Torres Strait Islander, in collaboration with stakeholders and service providers</i> and AOD9. <i>Improving access for Aboriginal and / or Torres Strait Islander people requiring support and treatment by increasing coordination between various sectors and improving sector efficiency</i> as outlined in the Activity Work Plan 2019-2022: Drug and Alcohol Treatment Services Funding, and MH9. <i>Commission culturally appropriate, primary mental health care services, that are sensitive and safe services for Aboriginal and Torres Strait Islander peoples</i> - outlined in the Activity Work Plan 2019-2022: Primary Mental Health Care Funding.</p>
Target population cohort	Aboriginal and Torres Strait Islander population
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>Yes</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>

	<p>The provider is the leading Aboriginal organisation that aims to reduce violence and its impacts in Aboriginal and Torres Strait Islander families,</p> <p>Key Aboriginal Stakeholder organisations are engaged to support wrap around supports for families in need. These include:</p> <ul style="list-style-type: none"> <li>• Nunkuwarrin Yunti</li> <li>• Aboriginal Health Services, funded through SA health</li> <li>• Aboriginal Legal Rights Movement</li> <li>• Integrated Team Care Program</li> <li>• Aboriginal Sobriety Group</li> </ul>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>APHN region</p>
Consultation	<p>Aboriginal consultation workshops were facilitated by Adelaide PHN with Aboriginal and Torres Strait Islander communities across Adelaide to explore issues and opportunities related to provision of primary care services. One agreed strategy is for Adelaide PHN is to work with mainstream and Aboriginal organisations to provide culturally safe and accessible services.</p> <p>This project was identified as a need through the work of the commissioned Aboriginal organisation, to provide very specific targeted services in the area of primary mental health care and alcohol and other drugs for Aboriginal families experiencing family violence.</p> <p>The Adelaide PHN Aboriginal Community Advisory Council has been part of the discussions in the co-design of this project and provides ongoing advice to the Adelaide PHN on community engagement strategies to support the commissioned service provider.</p> <p>In addition to the Adelaide PHN Aboriginal Advisory Council, this project will consult with the Aboriginal and Torres Strait Islander community and other primary health organisations (such as Aboriginal Family Clinic and Nunkuwarrin Yunti) including the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group.</p> <p>This project will consult with the Aboriginal and Torres Strait Islander community and other primary health organisations</p> <p>Aboriginal consultation workshops were facilitated by Adelaide PHN with Aboriginal and Torres Strait Islander communities across Adelaide to explore issues and opportunities related to provision of primary care services. One agreed strategy is for Adelaide PHN is to</p>

	<p>work with mainstream and Aboriginal organisations to provide culturally safe and accessible services.</p> <p>This project was identified as a need through the work of the commissioned Aboriginal organisation, to provide very specific targeted services in the area of primary mental health care and alcohol and other drugs for Aboriginal families experiencing family violence.</p> <p>The Adelaide PHN Aboriginal Community Advisory Council has been part of the discussions in the co-design of this project and provides ongoing advice to the Adelaide PHN on community engagement strategies to support the commissioned service provider.</p>
Collaboration	<p>List and describe the role of each stakeholder that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services.</p> <ul style="list-style-type: none"> <li>• Adelaide PHN Commissioned Service providers - referral pathways established to and from appropriate agencies that provide PMHCs and AODs services.</li> <li>• Drug and Alcohol services – such as Aboriginal Sobriety Group -referral pathways and integration services established to and from appropriate treatment and support services</li> <li>• Aboriginal Community Controlled Health Organisations – implementing referral pathways to and from the service to ensure appropriate and timely access to GPs and primary health care services. Promotion of appropriate Aboriginal programs.</li> <li>• General Practices – Establish partnerships and referral pathways to ensure timely access to Aboriginal health checks mental health treatment plans and other screening programs.</li> <li>• Department of Child Protection – partnership and referral pathways established to provide notification guidance, working together on family issues especially children at risk.</li> <li>• Aboriginal Legal Rights Movement – referral pathways established to provide access for victims in need of legal advice and representation.</li> <li>• Partnerships with external social agencies to provide wrap around supports for families - Centrelink, SA housing and emergency relief organisations such as Anglicare, Uniting Communities.</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates (<b>including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2021</p>

	<p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: July 2019</p> <p>Service delivery end date: June 2021</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input checked="" type="checkbox"/> Other approach (please provide details)</p> <p>An unsolicited proposal was received from the key Aboriginal family violence service whose core business is to specifically work with and support Aboriginal families experiencing family violence. The organisation has demonstrated experience in delivering a culturally safe and trauma informed service, applying to Adelaide PHN for specific funding to address the need for sensitive wrap around, accessible and appropriate mental health and AOD services to support their programs and services.</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p>

	<p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p> <p>Service has achieved its contract deliverables.</p>

## CF13. Hospital Avoidance Project

Proposed Activities – CF13. Hospital Avoidance Project	
ACTIVITY TITLE	<b>CF13. Hospital Avoidance Project</b>
Existing, Modified, or New Activity	<p>New Activity</p> <p>If activity is existing or modified, provide the relevant reference/s from previous Activity Work Plan/s where possible.</p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Population Health</p> <p>If Other (please provide details):</p>
Needs Assessment Priority	<p>GPH9. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis).</p> <p>GPH12. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</p> <p>GPH16. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</p> <p>GPH21. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</p> <p>GPH22. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<p>The activity aims to improve the health, wellbeing, social inclusion and housing security of people at risk of, or experiencing, homelessness by delivering case management services for clients to address their ill-health and their housing security vulnerability. The program will support those that have identified chronic disease and /or acute care needs in an attempt to avoid readmission to hospital by offering primary health care as an onsite service, as well as referral opportunities to link with appropriate providers for ongoing management and review.</p>
Description of Activity	<p>Current Australian research reports that people experiencing homelessness have multiple complex health conditions yet are typically disengaged from primary health care services and place a significant burden on the acute health</p>



system (Davies & Wood, 2018). The emergency department (ED) is frequently used by homeless people for issues that could be better and more efficiently addressed in a primary health care setting or by social services (Jelinek et al 2008).

According to the Australian Bureau of Statistics (ABS) in 2016, CALHN region had the highest estimated number (1,642) of people experiencing homelessness when compared to SALHN (990) and NALHN (1,122) regions in the APHN. This activity aims to increase access to appropriate early intervention programs and primary health care services to better support people at risk, or experiencing, homelessness in CALHN region.

The project will:

- Serve as a gateway to a range of mainstream support including but not limited to: assistance with social connectedness, financial information, sector education and employment information and opportunities as well access to health care for those with chronic conditions; no wrong door approach
- Offer service delivery that is flexible and responsive to the client's needs including, timely intervention to minimise ongoing dependency and maximise client's independence
- Service provision based on transparent eligibility, intake and assessment processes
- Service provision that prioritises people in primary, secondary and tertiary care especially those with high complex needs
- Service provision that encourages and supports healthy lifestyles
- Participation in sector and service provider partnerships
- The provision of formal training and development to service staff and volunteers to enhance effective and ethical practice.

Clients are identified in Royal Adelaide Hospital (RAH) either in Emergency Department or ward by the Central Adelaide Local Health Network (CALHN) Integrated Coordinator Care (CICC) team who then facilitate the referral to Homeless Respite Facility. Once assessed as appropriate clients are transferred to facility for assessment and ongoing case management.

A Case Management approach will be used, undertaking a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's identified needs through communication and available resources to promote quality, cost effective outcomes. A plan is developed in collaboration with identified clients and reflects their choices and preferences for the support services being developed.

The Case Managers with the Homelessness Respite Facility will ensure appropriate information sharing between services and agencies. The Homelessness Respite Facility will serve as a guide to intake assessments, referrals, case planning, and reviewing service delivery.

	The Homelessness Respite Facility recognises the unique elements of Aboriginal client engagement and service provision and has good connections with a range of Aboriginal specific services.
Target population cohort	Adults who are at risk of readmission to hospital as a result of chronic/acute disease and are homeless and at risk of homelessness
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>Yes</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p> <p>Engagement between the CALHN, Baptist Care SA and Aboriginal specialist services, will be facilitated by the Operational Governance Group, to determine strategies on working together to implement formal and informal engagement approaches with key stakeholders, such as Aboriginal Community Health Organisations and local Aboriginal Community groups.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APHN region</p>
Consultation	<p>Central Adelaide Local Health Network identified a significant proportion of at-risk patients regularly attending acute care services. Targeted consultation with Baptist Care SA, the Hospital Research Foundation and the Wyatt Trust saw the pooling of resources to establish the pilot program.</p> <p>Ongoing consultation with other NGOs, including homelessness services, Aboriginal Community Groups, CALHN Integration Care Coordinator (CICC) and other local hospital avoidance services will aim to continue to address the intermediate health care needs of the local community accessing this service. Consultation with adult mental health and alcohol and other drugs service providers will expand the scope of options available to those accessing the facility due to experiencing housing crisis, homeless or escaping family violence.</p>
Collaboration	<p>List the stakeholders that will be directly involved in the design and/or implementation of the Activity, <b><u>including their specified roles</u></b>. Include stakeholders who will be contributing resources such as funding or in-kind support, as well as stakeholders who will be closely involved in processes such as co-commissioning or implementation of the activity.</p> <p>The service for people experiencing Homelessness will include a variety of partners including:</p> <ul style="list-style-type: none"> <li>Royal Adelaide Hospital – identifying patients (from ED or in-patient) that fit the eligibility criteria for the homeless Respite Facility and liaise</li> </ul>

	<p>with other CALHN team to support appropriate transfer of care to service.</p> <ul style="list-style-type: none"> <li>• Central Adelaide Local Health Network (CALHN) Integrated Coordinator Care (CICC) team – facilitate the referral pathways to and from services to ensure appropriate and timely access to housing and other primary health care services required by clients.</li> <li>• Nunkuwarrin Yunti General Practitioner attending Homeless Respite Facility on a weekly basis providing ongoing health care needs and assisting with referrals to other appropriate health care services.</li> <li>• Adult Mental Health Services – referral pathways and integration services established to and from appropriate treatment and support services.</li> <li>• Drug and Alcohol Services South Australia - referral pathways and integration services established to and from appropriate treatment and support services.</li> <li>• South Australian Ambulance Service – assistance with client transfer and transport.</li> <li>• Centrelink – supporting a range of ongoing range of services including financial support.</li> <li>• Allied health professionals - referral pathways and integration services established to and from appropriate treatment and support services, where required and appropriate.</li> <li>• Psychologists, psychiatrists and other mental health and alcohol and drug service providers - referral pathways and integration services established to and from appropriate treatment and support services, where required and appropriate.</li> <li>• Employment, education and training providers – aiding support to clients transitioning from facility to longer term arrangements and social supports.</li> <li>• Justice, legal services and advocacy providers where required.</li> </ul> <p>The project has an established partnership approach with other regional homelessness services such as “Street to Home”, the Eastern Adelaide Generic Homelessness Service and the Aspire Program provided by the Hutt Street Centre, and collaborative ventures such as the “Adelaide Zero Project”, in order to transition people into long term sustainable housing and community stability.</p>
	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date: 1/07/2020</p> <p>Activity end date: 30/06/2021</p>

Activity milestone details/ Duration	<p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding the planning and procurement cycle)</b>:</p> <p>Service delivery start date: April 2020</p> <p>Service delivery end date: June 2021</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input checked="" type="checkbox"/> Direct engagement. Central Adelaide Local Health Network (CALHN) and Baptist Care SA</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>No</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>Yes</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>Yes</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>

## CF14. Community Based Infusions

Proposed Activities – CF14. Community Based Infusions	
ACTIVITY TITLE	<b>CF14. Community Based Infusions</b>
Existing, Modified, or New Activity	<p>New Activity</p> <p>If activity is existing or modified, provide the relevant reference/s from previous Activity Work Plan/s where possible.</p>
Program Key Priority Area	<p>Choose from the following:</p> <p>Population Health</p> <p>If Other (please provide details):</p>
Needs Assessment Priority	<p>Please select relevant “GPH” prefix Needs Assessment priorities from <a href="#">here</a>.</p> <p>GPH7. Services for people living with persistent pain are limited with long delays to access hospital-based services.</p> <p>GP8. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.</p> <p>GPH9. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis).</p> <p>GPH10. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.</p> <p>GPH16. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</p> <p>GPH22. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<p>The rapid rise in conditions requiring treatment with injectable medications (infusions), such as infections, iron deficiencies, immune and inflammatory disorders, cancer and palliative care, has resulted in an increased demand for acute care hospitals to provide these services. This has created fiscal pressures on hospitals, competition for infusion chairs in outpatient clinics, and indirect patient costs associated with time spent attending hospital and waiting for infusions.</p> <p>The project will develop an innovative community-based infusion service that is coordinated through a network of community-based infusion sites using</p>

	<p>existing services and facilities, such as home nursing, community pharmacy and aged care wellness centres.</p> <p>This project seeks to co-design, pilot and evaluate a community-based service to ensure a cost effective, sustainable and scalable model, that will address the avoidable increasing demand on hospitals to deliver this type of care.</p> <p>Outcomes of the project are expected to be:</p> <ul style="list-style-type: none"> <li>• Reduction in hospital attendance for chronic conditions requiring infusion therapy</li> <li>• Increased utilisation and integration of primary care services</li> <li>• Improved communication and clinical governance between acute and primary care setting</li> <li>• Sustainable remuneration model for infusion services in Community-based care setting</li> <li>• New roles for pharmacists and pharmacies in primary care setting</li> <li>• Expanded access to services in the community for patients and carers</li> <li>• Improved specialist and patient confidence in services delivered in the community; and</li> <li>• Inform standardised processes that can be applied at the national level.</li> </ul>
Description of Activity	<p>Many of the current models used in Australia to avoid hospital-based injectable medication delivery, such as Hospital in the Home (HITH), have had limited impact on reducing hospital attendance that is both cost effective and scalable. This can be partly attributed to the lack of codesign of the healthcare models themselves and a lack of integration between hospitals and community care providers.</p> <p>As a community-based service that is an Australian first, the project approach involves:</p> <ul style="list-style-type: none"> <li>• Administration of infusions in a network of community-based infusion sites (including community pharmacy clinics and aged care community facilities),</li> <li>• Shared clinical governance between acute and primary care setting, and</li> <li>• Flexibility in location of treatment administration (patient preference).</li> </ul> <p>The project will build on existing data obtained from Australian and international interventions to manage infusions outside the acute care setting. This project will bring together a recognised, multidisciplinary team comprising specialist physicians, general practitioners (GP), aged care providers, home nursing, pharmacists and community pharmacies, and researchers.</p>
Target population cohort	<p>The target population includes patients currently being treated with infusion therapies that are deemed suitable for community-based infusions; including treatment of iron deficiencies, dehydration, immune and inflammatory disorders, infections and palliative care.</p>

	The intervention will initially prioritise those patients currently treated in ambulatory infusion clinics of the Lyell McEwin Hospital (LMH) and Modbury Hospital (MH), and those that reside in metropolitan suburbs in the locality of our infusion sites
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire PHN region</p>
Consultation	This model has to date undertaken considerable stakeholder engagement, indicating the willingness to support and codesign this novel approach. These include the Adelaide PHN, Northern Adelaide Local Health Network (NALHN), SA Health, hospital pharmacists and community pharmacies, private health insurers, private home nursing services, aged care providers, specialist physicians across multiple local health networks (infectious diseases, oncology, rheumatology), aged care providers, and ambulance services (SA Ambulance).
Collaboration	<p>Formal collaboration has resulted in the development of an MOU between ECH (South Australia's largest community aged care provider), Health Partners (private health insurers), Your Health Navigator (specialist home nursing), CPIE Pharmacy Services (specialist home infusion pharmacy) and Commission on Excellence and Innovation in Health (SA Health).</p> <p>CPIE – will provide pharmacy related products and services to support specific agreed objectives</p> <p>ECH – will provide access to suitable community based clients and/or clients staying at ECH College Grove and/or other ECH facilities</p> <p>Health Partners – will contribute to the funding of its members for community based care that would otherwise need to be provided in an acute hospital (i.e. hospital substitute treatment), where that care is provided and/or supported by any or all of the other parties.</p> <p>YHN – will provide specialised clinical services by appropriately skilled registered nurses to support community based hospital substitute care.</p> <p>SA Health/LHNs will co fund the services that would typically be provided in an inpatient setting and provide appropriate clinical governance</p>

	Adelaide PHN will co fund and contribute to the primary care aspect of the project establishment, including GP and community pharmacy engagement and involvement in clinical service development and pathways
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date: 1/07/2020</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding the planning and procurement cycle)</b>:</p> <p>Service delivery start date: July 2020</p> <p>Service delivery end date: June 2022</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input checked="" type="checkbox"/> Direct engagement.</p> <p><i>This was originally the result of an unsolicited proposal from CPIE in Feb 2018. The proposal is their intellectual property and they are uniquely positioned to be able to provide such services. We have worked with the applicant since that time to seek appropriate support and co funding from SA Health and LHNs being that infusions are primarily the business of state and local health networks. Now that such support has been determined and additional partners including community aged care services and private health insurers have been obtained APHN is supportive of ensuring there is adequate primary care input in the development of pathways and access to community-based infusion services.</i></p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p>



	<p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>Yes</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>Yes</p>
Decommissioning	<p>1a. Does this activity include any decommissioning of services?</p> <p>No</p> <p>1b. If yes, provide a description of the proposed decommissioning process and any potential implications.</p>

## HSI1. South Australia (SA) Immunisation Hub

**Proposed Activities – HSI1. South Australia (SA) Immunisation Hub**

ACTIVITY TITLE	<b><i>HSI1. South Australia (SA) Immunisation Hub</i></b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Existing Activity</p>
Needs Assessment Priority	<p>IH-GPH1. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non-Aboriginal and Torres Strait Islander children.</p> <p>GPH1. The CALD community are disproportionally affected by Hepatitis B</p> <p>GPH3. Identified areas of the Adelaide PHN (APHN) region have childhood immunisation rates below the national average</p> <p>GPH22. Prevention and early intervention strategies for childhood and youth health conditions</p>
Aim of Activity	<p>Provide a service across South Australia which will reduce the incidence of vaccine preventable disease in children, reduce the incidence and severity of influenza/pneumonia in adults and reduce hospitalisations from vaccine preventable disease. The Hub targets geographic regions of low vaccination compliance with a focus on Aboriginal and Torres Strait Islander communities, Culturally and Linguistically Diverse communities and low-income groups.</p>
Description of Activity	<p>The Adelaide and Country SA PHNs have jointly implemented the SA PHN Immunisation Hub, a multi-faceted approach to bridge gaps in immunisation service provision, support the skill base of immunisation providers, improve accessibility to after-hours immunisation services and promote the need for a well immunised community. The Hub engages with SA Health to monitor Aboriginal childhood immunisation rates and with immunisation providers to ensure communities are assisted to overcome barriers leading to under-immunisation.</p> <p>The objectives are:</p> <ol style="list-style-type: none"> <li>1. Bridge gaps in immunisation service provision and increase uptake of immunisation for targeted population groups</li> <li>2. Support the skill base of immunisation providers to provide safe, accessible and high-quality local immunisation initiatives through education, training and targeted practice support.</li> <li>3. Improve accessibility to after-hours services and home immunisation services for disadvantaged groups</li> <li>4. Raise awareness of the need for a well immunised community, augment the voice of immunisation supporters and increase community confidence in vaccines and the childhood, adolescent and adult immunisation programs</li> </ol>

	<p>There five domains or activity elements of the SA PHN Immunisation Hub are:</p> <ol style="list-style-type: none"> <li>1. Australian Immunisation Register (AIR) Data Cleansing (2016/17-current)</li> <li>2. Community and Provider Immunisation Engagement and Support (2017/18 - current) (see CF1)</li> <li>3. Service Delivery (Ongoing since 2015/16)</li> <li>4. Stakeholder Engagement (Ongoing since 2015/16)</li> <li>5. Provider Support (Ongoing since 2015/16)</li> </ol>
Associated Flexible Activity/ies:	<p>Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity.</p> <p><i>CF1. Community and Provider Immunisation Engagement and Support</i></p>
Target population cohort	<p>All children overdue for immunisation and all individuals (specifically those with medical risk factors) who risk significant illness from vaccine preventable disease</p>
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>Yes</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p> <p>The Champion Nurse immunisation Project and Immunisation Community Engagement Project continue to engage with Aboriginal community organisations to advocate for immunisation. They will continue to attend community events such as CTG Day and NAIDOC week activities.</p> <p>The Immunisation Hub will continue to engage with the SA Health Immunisation Section who actively monitors Aboriginal Childhood immunisation coverage. The Hub will implement/assist with targeted activities as identified by SA Health.</p> <p>The Immunisation Hub will continue to produce Aboriginal Childhood Schedule fridge magnets for parents as a reminder of when immunisations are due.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APHN and CSAPHN regions</p>
Consultation	<ul style="list-style-type: none"> <li>• Australian Immunisation Register (AIR) data for Aboriginal and Torres Strait Islander children under 7 years of age is actively monitored and cleaned by the SA Health Immunisation Section. The Hub will continue to engage regularly with SA Health to develop strategies to respond to identified data and/or provider issues.</li> </ul>

	<ul style="list-style-type: none"> <li>• The Hub will continue to engage and consult with key stakeholders including: the Local Government Association, SA Health, Country Health SA, State Department of Education and Child Development (DECD), (State) Migrant Health Service, (State) Child and Family Health Service (CaFHS), Aboriginal Health Council SA, Hepatitis SA, General Practitioners and Local Councils in targeted areas of both APHN and Country SA PHN regions to enable sharing of information, resources and innovative ideas across the State.</li> <li>• The activity continues to engage and consult with the 510 members of the South Australian Immunisation Provider Network (IPN) by providing secretarial support to enable facilitation of meetings with stakeholders and relevant partners.</li> </ul>
Collaboration	<ul style="list-style-type: none"> <li>• Australian Immunisation Register (AIR) - to effectively manage the childhood immunisation data through (AIR) data cleaning activities to accurately reflect the current immunisation status of children.</li> <li>• The organisation (HAIMS) commissioned to deliver the Champion Immunisation Nurse Immunisation Program will continue to ensure all key elements of the Champion Immunisation Nurse Program are undertaken in a timely manner and with objectives met.</li> <li>• The organisation (Eastern Health Authority) commissioned to deliver the Immunisation Community Engagement Project will continue to ensure all key elements of the Immunisation Community Engagement Project are undertaken in a timely manner with objectives met.</li> <li>• Immunisation service providers, including General Practice, Aboriginal Health Organisations, Local Councils, Child and Family Health Services and Hospitals – this activity will collaborate and support providers through providing clinical advice, face to face education and information through newsletter articles and the Immunisation Provider Network.</li> <li>• Country SA PHN (CSAPHN) – a partner in the SA PHN Immunisation Hub. CSAPHN will continue to support delivery of provider education, AIR data cleaning activities, community engagement activities to increase awareness of the immunisation program and networking with key stakeholders to ensure there remains a united focus on immunisation across the state.</li> <li>• SA Health Immunisation Section – the Hub will continue to regularly engage with the Immunisation Section to ensure consistent messaging, monitoring of Aboriginal children immunisation data and ensure providers receive appropriate support.</li> <li>• SA Health – this activity will continue to require hospital presentation and admission data for vaccine preventable diseases to be articulated to the APHN. Analysing this data will enable targeted activities with providers and communities. This activity will collaborate with specific Local Health Networks (LHNs) to investigate opportunities for the identification of children and adults in target groups in areas with low immunisation rates who present to Emergency Departments or on discharge summaries (after hospitalisation) as under-immunised.</li> <li>• Country Health SA – will continue to assist the Hub to recognise service delivery gaps and requests for support in rural SA. This group enlists representation from General Practice, Aboriginal Health, Department of Education and Child Development, Migrant Health, SA Health,</li> </ul>

	<p>Country Health SA and the Women's and Children's Hospital and focusses on ensuring a cross sector approach to increasing immunisation rates and decreasing vaccine preventable disease.</p> <ul style="list-style-type: none"> <li>• Migrant Health – along with the Hub, this collaboration will ensure CALD and emerging communities are aware of immunisation recommendations and services.</li> <li>• Local Government Association – collaboration continues with Local Councils delivering immunisation programs including the School Immunisation Program (SIP). Most SIP providers are members of the Immunisation Provider Network (IPN).</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input checked="" type="checkbox"/> Other approach (please provide details) Partnership</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p>

	No
	3b. Has this activity previously been co-commissioned or joint-commissioned?
	No

## HSI2. Get Screened and Get on with Living Campaign

Proposed Activities – HSI2. Get Screened and Get on with Living Campaign	
ACTIVITY TITLE	<i>HSI2. Get Screened and Get on with Living Campaign</i>
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity.  Existing Activity
Needs Assessment Priority	<p>IH-GPH3. Accessibility to and appropriateness of primary health care services, particularly for Aboriginal and Torres Strait Islander people.</p> <p>IH-GPH4. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people.</p> <p>GPH2. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, LGBTIQ and older people.</p> <p>GPH13. Early screening of selected cancers (cervix, bowel, breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy.</p>
Aim of Activity	<p>Short term:</p> <ul style="list-style-type: none"> <li>• Increase awareness of the benefits of breast, bowel and cervical screening to the target population groups in South Australia</li> <li>• Support primary health care services, including general practice, in their role to encourage the population to screen for cancer</li> <li>• Enable sharing of resources and collaborative cancer screening promotion where the local primary health care system shares the same objective of increasing participation in cancer screening</li> </ul> <p>Long Term:</p> <ul style="list-style-type: none"> <li>• A health service system that works together to increase participation in breast, bowel and cervical screening in South Australia, and therefore increase the proportion of cancer detected at an early stage Develop and implement a tailored extension of campaign with the health service sector representatives from the Culturally and Linguistically Diverse communities and or Lesbian and Transgender community.</li> </ul>
Description of Activity	<i>'Get Screened and Get on with Living'</i> was a new collaborative approach to promoting cancer screening in SA, piloted in 2018-19. This activity was designed and funded between <b>Adelaide PHN, Country SA PHN, Cancer Council</b>

	<p><b>SA and SA Health</b>, to promote the three national cancer screening programs – breast, bowel, cervix in a combined message.</p> <p>The campaign aims to convince SA men and women that they need to get screened because knowing they are cancer free gives them peace of mind to enjoy life. It also sends a further positive message in that if cancer is detected, the sooner it is identified the greater the chances of successful treatment.</p> <p>The campaign’s tag line is “Get Screened and Get on with Living” and the call to action is for South Australians to talk to their GP about cancer screening, along with searching cancer screening online. This is matched with boosted responses in google.</p> <p>The campaign’s “home” is a landing page on Cancer Council SA’s website which features all campaign material available for free download and links to further information on the cancer screening programs. Campaign material includes digital video, online programmatic advertising collateral, newspaper and radio advertising as well as general practice information kits.</p> <p>Between October 2018 and March 2019, funding was provided for a pilot by the project partners to test the feasibility of the campaign and measure the success of this new approach.</p> <p>Interim program evaluation has indicated that the campaign has been received positively by local health care professionals, who have appreciated the efficiency of a coordinated approach from the services involved in the partnership. The campaign has also been received well by the public, with video completion and click through engagement via online advertising all performing above industry benchmarks. Further data in relation to participation rates for each cancer screening program in SA has been requested and will be available to the PHNs later in the year.</p> <p>In the 2019-2020, it is proposed that the current campaign be extended. This includes distributing general practice information kits, digital video playing on catch up TV, online programmatic advertising, paid social media, radio and print newspaper. Project partners will be approached to continue coordinating and co-funding the campaign, and additionally, Cancer Council SA will be approached to continue their in-kind contribution of managing oversight of the media campaign and evaluation plan. SA Health will be approached to continue their support in evaluation of campaign strategies.</p> <p>Funding allocation for 2020-21 will be used to develop a targeted campaign for the Culturally and Linguistically Diverse community and or Lesbian and Transgender individuals.</p>
Associated Flexible Activity/ies:	<p>Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity.</p> <p>Nil</p>



Target population cohort	<ul style="list-style-type: none"> <li>• Women aged 50-74 – eligible for breast screening in the Adelaide PHN region</li> <li>• Women aged 25-74 eligible for cervical screening in the Adelaide PHN region</li> <li>• People aged 50-74 who are eligible for the National Bowel Cancer Screening program in the Adelaide PHN region</li> </ul>
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APHN region</p>
Consultation	<p>The collaborative approach of this project has meant that key cancer screening health services in SA have been involved in the design, implementation and evaluation of the feasibility of this campaign.</p> <p>Individual General Practice and General Practice Peak Body feedback was sought prior to the launch of the campaign, in relation to how we can support practices with a potential increase in cancer screening related enquiries and how we could collaborate with Peak Bodies to support the campaign awareness with primary care. A general practice information kit was developed in response to this to raise awareness of the campaign and enable general practice to participate in the campaign.</p> <p>Consultation with the public in relation to awareness and behavioural response to the pilot campaign is being undertaken in March 2019 through an in-kind contribution from SA Health, who has included questions specifically about the campaign in the 2019 Public Health Survey. This is an 'omnibus-type' service available to government and non-government organisations to obtain data on a range of population health and wellbeing issues within South Australia.</p>
Collaboration	<p>The project is supported through an integrated approach in the local cancer screening sector, co-funded and designed.</p> <p>Adelaide and Country SA PHNs coordinate the project, managing contractual components, promoting the campaign to general practices across SA and ensure timelines and KPIs are achieved.</p> <p>Cancer Council SA are co-funders for the project, in addition they bring design and cancer screening campaign knowledge to the partnership. Cancer Council SA have responsibility for project delivery and evaluation.</p> <p>SA Health State-wide Cancer Screening program attend and promote the campaign to LHNs and other stakeholder organisations.</p>

Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date:        1/07/2019</p> <p>Activity end date:        30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding the planning and procurement cycle)</b>:</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input checked="" type="checkbox"/> Not yet known (2020-21 targeted version of campaign)</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input checked="" type="checkbox"/> Other approach (please provide details) Partnership approach</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>Yes</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>Yes</p>

## HSI3. Digital Health Support

**Proposed Activities – HSI3. Digital Health Support**

ACTIVITY TITLE	<b>HSI3. Digital Health Support</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Previously referenced as HSI4</i></p>
Needs Assessment Priority	<p>GPH14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>GPH21. Minimise instances of poor quality and unwarranted variations of care and follow up.</p> <p>GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<p>The Digital Health project aims to engage with health care providers from all sectors across APHN region to promote and facilitate the use of the My Health Record and appropriate digital health technologies in an effort to increase the communication and collaboration between service providers, improve clinical hand over, help identify and support improvements in the quality of healthcare and patient follow up and increase timely access to consumer health information.</p>
Description of Activity	<p>The Digital Health activity will provide the following:</p> <p><b>Digital Health</b></p> <ul style="list-style-type: none"> <li>• Increase the use of digital technology in the health care setting such as secure messaging delivery, data extraction tools and ongoing support with clinical applications and templates.</li> <li>• Provide access and support for practices around the PenCS Clinical Audit tool to help facilitate improved practice data quality, improve the completeness and quality of patient records to support clinical decision making and manage patient follow up, and provide a means to recall patients in a timely manner in an effort to minimise unwarranted variations of care and to provide appropriate care to patients.</li> <li>• Provide training and support in the use of PenCS Clinical Audit tool to facilitate identification of patients with high risk of developing preventable chronic conditions and to improve management of patients with a chronic condition/s.</li> <li>• Increase the use of clinical audit tools in a health care setting to assist in analysis of patient cohorts to improve population health outcomes.</li> <li>• Provide assistance and access to data extraction tools and importance of correct clinically coded records.</li> <li>• Work with health care providers to increase their understanding and utilisations of secure messaging technologies to assist with timely and secure sharing of information between health care providers.</li> </ul>

	<ul style="list-style-type: none"> <li>Assist consumers and health care providers to have access to timely information and assist with coordination of health care services to ensure the best possible outcomes for the consumer.</li> </ul> <p><b>My Health Record</b></p> <ul style="list-style-type: none"> <li>Continue to assist healthcare organisations to register and connect to the My Health Record.</li> <li>Continue to support the adoption and usage of the My Health Record by General Practice, Allied Health, Pharmacy and Specialists to improve information sharing across healthcare providers.</li> <li>Continue to educate practice staff to understand the My Health Record and its benefits and to assist consumers on how to access their health care information through the My Health Record.</li> <li>Continue to support primary health care providers to actively view and upload clinical documents to patients with an active My Health Record</li> <li>Continue to encourage and support active viewing and cross viewing of documents within patients My Health Record.</li> <li>Continue to support primary health care providers not registered to participate in the My Health Record to register and actively participate</li> <li>Continue to assist in providing information and support on security practices, policies and procedures required by healthcare organisation to participate in the My Health Record system.</li> <li>Continue to provide support and information on the requirements of general practice to participate in the Practice Incentives Program (PIP) eHealth Incentive.</li> </ul>
Associated Flexible Activity/ies:	GPS1. General Practice Support
Target population cohort	All health care providers and health care provider organisations working across all sectors of health care.
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APHN region</p>
Consultation	<p>Stakeholder engagement and consultation are currently ongoing with the following peak bodies;</p> <ul style="list-style-type: none"> <li>The Australian Digital Health Agency</li> <li>SA Health to support the implementation of the My Health Record system across all SA Health sites.</li> <li>Outcome Services Survey - identify service and quality improvement gaps in PHN services and experience in interactions with other healthcare providers and local hospital services.</li> </ul>

	<ul style="list-style-type: none"> <li>• APHN GP Survey – enable APHN to better support General Practice with respect to improving quality of care, practice accreditation improvement and uptake, meaningful use of digital health systems to streamline the flow of relevant patient information, develop health information management systems to inform quality improvement in healthcare and the collection and use of clinical data.</li> <li>• Membership Feedback</li> <li>• Pen Computing Systems – implementation, roll out and ongoing support of the PenCS clinical audit tool to General Practices across the APHN region.</li> </ul>
Collaboration	<ul style="list-style-type: none"> <li>• Digital Health Agency - to provide ongoing consultation with PHN staff to ensure consistent messaging across the PHN's, access to resources, data sources and a point of call to assist PHN's with addressment of issues, feedback and advice as needed.</li> <li>• All Health Care Providers and peak organisations - to gather ongoing feedback, issues and what's working well and what's not, to inform where the PHN can support General Practice, Pharmacy, Specialists of all specialities, Allied Health Providers etc. located with the APHN region</li> <li>• Peak organisations - to advise the APHN on how to best engage this cohort of health professionals also to advise on the barriers that effect access to Digital Health uptake for both the providers and consumers.</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding the planning and procurement cycle)</b>:</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p>

	<input checked="" type="checkbox"/> Other approach (please provide details)
	Partnership and direct PHN engagement with primary and allied health care providers
	2a. Is this activity being co-designed?
	No
	2b. Is this activity this result of a previous co-design process?
	No
	3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?
	No
3b. Has this activity previously been co-commissioned or joint-commissioned?	
No	

## HSI4. Integrated Care Strategy

**Proposed Activities – HSI4. Integrated Care Strategy**

ACTIVITY TITLE	<b>HSI4. Integrated Care Strategy</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Previously referenced as HSI5. Project description modified.</i></p>
Needs Assessment Priority	<p>GPH9. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis).</p> <p>GPH13. Lack of easily understood and accessible referral pathways across systems and settings.</p> <p>GPH14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>GPH22. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<p>Building on existing engagement and collaboration the Integrated Care Strategy aims to develop and implement prioritised shared activities with each Local Health Network within the APHN footprint that relate to clinical pathways and improved handover with aim of reducing Potentially Preventable Hospitalisations.</p>
Description of Activity	<p>Underpinned by APHN's Integrated Care Framework (see website for more information), the Framework aims to facilitate a connected, quality health system where health providers work together to improve people's experiences of the health system and their health outcomes. As such continued planning with SA Health and the LHNs will aim to develop collaborative targeted activity(s) that aligns with shared priorities including but not limited to:</p> <ul style="list-style-type: none"> <li>• Projects that reduce Potentially preventable hospitalisations</li> <li>• HealthPathways (see After Hours AWP, AH8)</li> <li>• GP Integration/Liaison Units (see CF9, CF10, CF11)</li> <li>• Clinical Engagement including facilitating sessions that identify system issues and potential solution</li> <li>• Regional Mental Health and Suicide Prevention (see PMHC AWP, MH11)</li> <li>• Digital Health (see HSI3)</li> <li>• Priority Care Centres (see After Hours AWP, AH9)</li> </ul>

Associated Flexible Activity/ies:	<p>CF4. Care Connections Program,</p> <p>CF9. Integrated Care with Northern Adelaide Local Health Network (ICwNALHN),</p> <p>CF10. Integrated Care with Southern Adelaide Local Health Network (ICwSALHN),</p> <p>CF11. Integrated Care with Central Adelaide Local Health Network (ICwCALHN), and</p> <p>HSI3. Digital Health Support</p>
Target population cohort	Patients with chronic conditions who have frequent contact with hospital services
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APHN region</p>
Consultation	<p>Multiple consultations have been undertaken with further sessions planned and underway to ensure that relevant groups are involved in co-design of this concept. These consultations have involved general practitioners and hospital consultants from each Local Health Network region (separate session schedules) with the aim of sharing perspective, understanding mutual issues and identification of solutions for an enhanced health system in metropolitan Adelaide.</p> <p>This activity is informed by ongoing regular consultation through both the existing Adelaide PHN membership and partnership mechanisms and through those of SA Health and the Local Health Networks. Further consultation will be undertaken with identified groups as the co-design process identifies it is required.</p>
Collaboration	<p>The Integrated Care Strategy is progressed separately within each Local Health Network and involves key senior executive representatives from APHN, the relevant Local Health Network and the GP Unit (as per each Local Health Network discretion) to collaborate in the oversight and performance monitoring and evaluation functions. In addition, each partner contributes the following.</p> <p>Adelaide PHN:</p>



	<ul style="list-style-type: none"> <li>Integration Coordinators provide Project Management oversight to each of the shared priority activities.</li> </ul> <p>Local Health Network:</p> <ul style="list-style-type: none"> <li>Local Health Network staff facilitate collaboration with relevant departments and units within Local Health Network services as per each shared priority activity, and</li> <li>facilitate the identification of potential future activities.</li> </ul> <p>These activities are linked with the GP Unit in each Local Health Network which is comprised of:</p> <ul style="list-style-type: none"> <li>GP Liaison/Integration Officers (engaged through APHN)</li> <li>Nurse (employed by CALHN/NALHN/SALHN)</li> <li>Administrative support (employed by CALHN/NALHN/SALHN).</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates (<b>including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input checked="" type="checkbox"/> Other approach (please provide details) Partnership</p>

	2a. Is this activity being co-designed?
	Yes
	2b. Is this activity this result of a previous co-design process?
	Yes
	3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?
	Yes
	3b. Has this activity previously been co-commissioned or joint-commissioned?
	No

## HSI5. South Australia PHNs Conference

**Proposed Activities – HSI5. South Australia PHNs Conference**

ACTIVITY TITLE	<b>HSI5. South Australia PHNs Conference</b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Existing Activity</p> <p><i>Previously referenced as HSI6</i></p>
Needs Assessment Priority	<p>GPH2. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, LGBTIQ and older people.</p> <p>GPH14. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</p> <p>GPH19. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures.</p> <p>GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p> <p>GPS1. Increase awareness and uptake of digital health systems and benefits for patients</p> <p>PSM3. Increase awareness and promotion of psychosocial support services for people with severe mental health conditions and their carers.</p> <p>PMH7. Increase awareness of appropriate mental health services to health professionals and community and carers through the provision of information and resources.</p> <p>AOD3. Increase integration between AOD and Primary Mental Health (PMH) service providers to improve health outcomes.</p> <p>IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people</p>
Aim of Activity	<p>The key aim of the activity is to engage Primary Health Care Professionals (General Practitioners and Practice Teams, Allied Health Professionals, Pharmacy, Mental Health Professionals and SA Health staff etc.) to facilitate innovative conversations around different models of care, integrated teams and referral pathways.</p>
Description of Activity	<p>The APHN in conjunction with Country SAPHN will run the (third) South Australian Primary Health Care Conference for all Primary Health Care Professionals with a focus on multidisciplinary teams, chronic disease and</p>

	integrated care. Future conferences will endeavour to build on established relationships and connections, whilst further developing collaborative approaches to care using innovative approaches where possible. Conferences are scheduled bi-annually – the first one was in 2017, second in 2019, third in 2021.
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity.
Target population cohort	Primary Health Care Professionals (General Practitioners and Practice Teams, Allied Health Professionals, Pharmacy, Mental Health Professionals and SA Health staff etc.)
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>No</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p>
Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APhN and Country SA PHN regions</p>
Consultation	<p>Provide details of stakeholder engagement and consultation activities to support this activity.</p> <p>Extensive consultation with memberships groups, key stakeholders – across sectors and community, and other primary health care providers, as well as feedback from previous conferences will inform the direction and focus of future conferences.</p>
Collaboration	<p>This activity will collaborate with:</p> <ul style="list-style-type: none"> <li>• General Practitioners, Practice Teams, Allied Health Professionals and other Primary Health Care Professionals to provide targeted education and facilitation of collaboration, integration and partnerships adopting innovative approaches where possible.</li> <li>• Royal Australian College of General Practitioners (RACGP) to facilitate/approve accredited education for General Practitioners attending the conference</li> <li>• SA Health and other APhN partners to sponsor, exhibit or present at the conference demonstrating effective engagement.</li> <li>• APhN commissioned service providers will be encouraged to promote their programs and services to primary health care professionals by participating in the conference as keynote speakers, presenters or exhibitors.</li> </ul>

Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates (<b>including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2021</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: April 2021</p> <p>Service delivery end date: April 2021</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input checked="" type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach (please provide details)</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>Yes</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>Yes</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>Yes</p>

## HSI6. Supporting our diverse Workforce

Proposed Activities – HSI6 Supporting our diverse Workforce	
ACTIVITY TITLE	<b><i>HSI6. Supporting our diverse Workforce</i></b>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p> <p><i>Previously referenced as HSI7</i></p>
Needs Assessment Priority	<p>GPH12. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.</p> <p>GPH 17. Lack of community awareness about existing health care services for different population groups, consumers and providers.</p> <p>GPH 19. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures.</p> <p>GPH20. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>GPH21. Minimise instances of poor quality and unwarranted variations of care and follow up.</p> <p>GPH 24. A coordinated approach to improve navigation and pathways for patients to manage their conditions</p> <p>PMH7. Increase awareness of appropriate mental health to health professionals and community and carers through the provision of information and resources.</p> <p>AOD2. Build the capacity of health professionals through the provision of information, education and resources to support health professionals in the management of drug and alcohol dependence and related morbidities.</p> <p>PSM3. Increase the health workforce capacity to provide appropriate care to people with severe mental health conditions.</p> <p>IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.</p>
Aim of Activity	<p>The aim of this activity is to design and deliver a range of integrated workforce initiatives that meet the specific and identified needs of our workforce, in line with national and local health priorities, and addressing skill gaps, professional development and continuous quality improvement.</p>

Description of Activity	<p>The APHN will provide a range of professional development activities and quality improvement supports for primary health care providers to enhance their ability to work as part of a primary health care system to provide the right care in the right time and the right place.</p> <p>Professional development, networking and quality improvement actions and methods of disseminating best practice will focus on identified areas of need including empathic system and service level responses to health care consumers/patients, culturally diverse consumers, and quality use of medicines. A dedicated focus on increasing the health literacy knowledge of those working in Primary Health Care will be supported by providing staff and organisations with a) strategies and tools to improve client/patient understanding of written and spoken health information and b) identify opportunities to embed health literacy strategies into systems, operations and planning.</p> <p>Aspects of this activity will be integrated in the General Practice support activities.</p> <p>The intended outcomes are:</p> <ul style="list-style-type: none"> <li>Increased participation of primary health care providers in workforce professional development</li> <li>Adoption and effective use of best practice approaches to improve clinical outcomes and delivery of care</li> <li>High satisfaction by attendees in professional development service delivery with learning outcomes consistently met</li> </ul> <p>Sharing of best practice business skills and leadership development</p>
Associated Flexible Activity/ies:	<p>Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity.</p> <p>GPS1</p>
Target population cohort	All Primary Health Care practitioners/providers/professionals
Indigenous specific	<p>Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?</p> <p>Yes</p> <p>If yes, briefly describe how this activity will engage with the Indigenous sector.</p> <p>Elements of the continuing professional development schedule will incorporate sessions to support culturally appropriate services and care to Aboriginal and Torres Strait Islander clients/patients. Ensuring that primary health care providers are proficient in culturally safe practice will be embedded within this program.</p>

Coverage	<p>Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)</p> <p>Entire APHN region</p>
Consultation	<p>Engagement with various Medical, Pharmacy, Allied Health Professional Associations/Peak Bodies; Feedback via previous continuing professional development service delivery providers; APHN membership groups.</p> <p>Collect Learning Needs Assessment survey of primary health care providers.</p>
Collaboration	<p>To ensure high-quality, evidence based continuing professional development and capacity building methods are used in delivering this activity, the activity will collaborate with:</p> <ul style="list-style-type: none"> <li>Professional organisations representing general practice, GPs and other allied health – to ensure the mode of delivery and topic content is relevant to various disciplines</li> <li>Local Health Networks (LHNs) – to assist with the development of appropriate clinical pathways and referral management guidelines</li> <li>Drug and Therapeutic Information Service (DATIS) – to assist with the latest updates on medication management for chronic conditions</li> <li>General Practices – for feedback on most relevant topics for professional development</li> <li>Pharmacies and Allied Health providers for feedback on most relevant topics for professional development</li> <li>Organisations working with Culturally and linguistically diverse communities such as Migrant Health Service – to assist in the provision of resources and delivery of culturally appropriate sessions such as cultural safety, cultural competence</li> <li>Development of partnerships with health professional, allied health, pharmacy, dental, medical organisations and collaborative work including information sharing and networking.</li> <li>Collaboration and consultation with the Aboriginal Community via the metropolitan ACCHO, Aboriginal Health Councils of SA and appropriate community forums to assist in the development of continuing professional development to support culturally appropriate services for Aboriginal and Torres Strait Islander people.</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates (<b>including</b> the planning and procurement cycle):</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates (<b>excluding</b> the planning and procurement cycle):</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p>



	Any other relevant milestones?
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input checked="" type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input checked="" type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input type="checkbox"/> Other approach (please provide details)</p> <p>2a. Is this activity being co-designed?</p> <p>Yes</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>No</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p> <p>No</p> <p>3b. Has this activity previously been co-commissioned or joint-commissioned?</p> <p>No</p>

## – General Practice Support funding

### GPS1. Primary Health Care Provider Support

Proposed Activities – GPS1. Primary Health Care Provider Support	
ACTIVITY TITLE	<i>GPS1. Primary Health Care Provider Support</i>
Existing, Modified, or New Activity	<p>Indicate if this is an existing activity, modified activity, or a new activity.</p> <p>Modified Activity</p>
Needs Assessment Priority	<p>GPS1. Increase awareness and uptake of digital health systems and the benefits for patients.</p> <p>GPS2. Targeted support to increase awareness and utilisation of HealthPathways SA and specific pathways for patients.</p> <p>GPS3. Promote and targeted support to adopt best practice in utilisation of clinical software's to improve patient care and quality improvement activities.</p>
Aim of Activity	<p>Support primary health care providers to deliver quality, efficient and effective services (right care, right place, and right time time) by delivering high quality information, training and promote continuous quality improvement.</p> <p>Support primary health care providers to increase understanding and/or utilisation of digital health systems, including how digital platforms can support patient care.</p>
Description of Activity	<p>This activity has Six elements:</p> <ul style="list-style-type: none"> <li>• Accreditation support – Support General Practices to either promoting accreditation and/or maintain current accreditation status by providing relevant information and access to supporting resources. The activity will be delivered by utilising workshops, face to face support and any other mechanism in which supports the practice to fulfil accreditation requirements. Where appropriate support will be given to assist with Gap Analysis.</li> <li>• Improving Patient Care through effective utilisation of clinical software – utilising clinical software and digital platforms to improve patient care and communication. The activity will be delivered by encouraging health care providers to take up digital platforms such as data extraction tools, Health Pathways, Clinical Templates, Shared Care Planning platforms, secure messaging, My Health Record and clinical information systems to assist with streamlining, timely access to information and appropriate clinical pathways. Assisting providers to use digital technologies that enhance current workflows and identify area's for population health improvements. Advise on how implementing digital systems will improve access to</li> </ul>

	<p>information. Support and guide where appropriate decision making and provide relevant training, policy and procedures templates.</p> <ul style="list-style-type: none"> <li>• General Practice participation in Quality Improvement (QI) activities (including the QI PIP and Patient experience) – work with and support general practices to understand the importance of quality improvement and implement quality improvement activities that support the provision of high-quality care to patients and encourage innovation. Assist general practice to understand the importance of the patient experience and gaging patient satisfaction in services and in turn support QI activities that improve the patient experience. The activity will be delivered by utilising and providing access to relevant information and resources, provide face to face visits, support where appropriate tools that assist in gaging patient experience and satisfaction via feedback mechanism. Provide general practice with QI support by assisting the practice to understand the demographics of the patient population. Provide information and support on the QI PIP including but not limited to, providing information, data extraction tools and training to identify patients that meet the criteria of the 10 key Improvement measure areas of the QI PIP.</li> <li>• Innovative Solutions through effective use of health information management systems – support health care providers to provide better care for patients and help achieve health equity through the effective use of health information systems such as Shared Care Platforms, My Health Record, Secure messaging, HealthPathways SA and other systems that may be identified to support the relevant outcomes. Support clinical coding in recording of patient data to improve healthcare delivery to allow for analysis and interrogation of information which will assist in informing current and future activities to provide quality improvement in health and patient care. The activity will be delivered by assisting providers to understand the importance of clinical coding either by providing information or face to face support, the providers will also be assisted to understand and perform data cleaning within the clinical information system and provide training, recourse and materials that support this.</li> <li>• Partnership and Engagement with Primary Health Care Providers – Partner and engage with providers to improve the persons experience of primary health care by developing the capacity of providers, supporting quality improvement and integration of primary and acute care. The Activity will be delivered by providing primary health care providers with relevant information in relation to health reform and change, regular communication via APhN newsletter, Education, engagement and networking events including quality improvement, digital health, chronic disease management, immunisation, screening, and other relevant topics as identified through needs assessment and/or surveys of General Practice.</li> <li>• Increase referral pathways for patients by utilising appropriate digital health system – encourage and support health care providers to utilise digital platforms that support the sharing of information, pathways to</li> </ul>
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	support clinical decision making for patients and systems that support the sharing of information between clinical providers, acute sector and clinical handover. The activity will be delivered by encouraging health care providers to understand secure messaging and where appropriate provide support to understand, implement and use secure messaging. Encourage health care providers to actively utilise HealthPathways SA to support clinical decision making. Support healthcare providers participating in the My Health Record system to understand and develop relevant eReferral for patients. Provide information on digital initiatives, changes and improvements via APHN newsletters and direct correspondence with healthcare providers.
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity.  CF4, CF8, CF12, CF13, CF14, CF15, HS13, HS16
Target population cohort	All primary health care providers in APHN region
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?  Yes  The activity will support the sector by engaging and supporting health care providers to provide culturally appropriate care to Aboriginal people within the APHN region. Supporting health care providers with understanding the need to have culturally appropriate services, utilise clinical templates that have been developed specifically for Aboriginal people such as 715 health checks and support General Practice to identify Aboriginal patients within their practice that require follow up and encourage health checks to be regularly performed.
Coverage	Please indicate if this activity covers the entire PHN region <u>or</u> list specific SA3 in PHN region (see attached jpeg in email for reference)  Entire APHN region
Consultation	Engagement with various health care providers such as General Practice, Allied Health, Pharmacy; APHN membership groups. Collect feedback from survey of primary health care providers both from internal GP Census and external outcomes services survey.
Collaboration	To ensure high-quality, evidence based continuing professional development and capacity building methods are used in delivering this activity, the activity will collaborate with:  <ul style="list-style-type: none"> <li>• general practice, GPs and other allied health</li> </ul>

	<ul style="list-style-type: none"> <li>Local Health Networks (LHNs) where relevant and appropriate – to assist with the development of appropriate clinical pathways and referral management guidelines</li> <li>Pharmacies and Allied Health providers to support providers with relevant resources and information.</li> <li>Other relevant health professional, allied health, pharmacy, dental, medical organisations.</li> </ul>
Activity milestone details/ Duration	<p>Provide the anticipated activity start and completion dates <b>(including the planning and procurement cycle)</b>:</p> <p>Activity start date: 1/07/2019</p> <p>Activity end date: 30/06/2022</p> <p><b>If applicable</b>, provide anticipated service delivery start and completion dates <b>(excluding the planning and procurement cycle)</b>:</p> <p>Service delivery start date: Month. Year.</p> <p>Service delivery end date: Month. Year.</p> <p>Any other relevant milestones?</p>
Commissioning method and approach to market	<p>1. Please identify your intended procurement approach for commissioning services under this activity:</p> <p><input type="checkbox"/> Not yet known</p> <p><input type="checkbox"/> Continuing service provider / contract extension</p> <p><input type="checkbox"/> Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date.</p> <p><input type="checkbox"/> Open tender</p> <p><input type="checkbox"/> Expression of Interest (EOI)</p> <p><input checked="" type="checkbox"/> Other approach (please provide details)</p> <p>Partnership and direct PHN engagement with primary health care providers</p> <p>2a. Is this activity being co-designed?</p> <p>No</p> <p>2b. Is this activity this result of a previous co-design process?</p> <p>No</p> <p>3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?</p>

	No
	3b. Has this activity previously been co-commissioned or joint-commissioned?
	No