Adelaide - Core Funding
2021/22 - 2024/25
Activity Work Plan

CF-COVID-VVP - 202207 - A202207 - COVID19 - Vaccination of Vulnerable Populations

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF-COVID-VVP

Activity Number *

202207

Activity Title *

A202207 - COVID19 - Vaccination of Vulnerable Populations

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

This Activity will assist Adelaide PHN to provide support and facilitate local solutions to vaccinate vulnerable populations who may have difficulty in accessing COVID-19 Vaccines in collaboration with COVID-19/Flu Vaccination providers including general practice, pharmacy, contracted providers, state health services and nurse practitioners (as appropriate).

Description of Activity *

The activity aims to vaccinate vulnerable population groups identified in the community

GP's vaccinating vulnerable people will use existing funding mechanisms (MBS items), or will receive financial support of an equivalent amount for the vaccination service.

Additional funding will only be provided to reimburse additional and necessary costs incurred in delivering targeted vaccination services for these population cohorts.

This activity provides funding for PHNs to:
- Provide financial support to general practices to deliver innovative COVID-19 vaccinations models in areas of need. This could include support with infrastructure (such as renting town halls and community hubs, mobile vans, pop-up tents) or financial support with expenses incurred to reach vulnerable populations (in excess to the current flag fall item);
- Reimburse health professionals the equivalent MBS COVID-19 Vaccine Suitability Assessment items for COVID-19 vaccination services provided to individuals who are not enrolled in Medicare.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Children, young people and their families have timely access to early intervention, prevention and support services	36
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access culturally safe and appropriate primary health care services in a timely way	36
People in the Adelaide PHN have awareness of and timely access to preventative and early intervention services	37
Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.	45
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in an ever-changing health landscape.	109

Activity Demographics

Target Population Cohort

* those who are experiencing homelessness, including those living on the streets, in emergency accommodation, boarding houses or between temporary shelters;
* those who do not have a Medicare card and are not eligible for Medicare;
* people with a disability or who are frail and cannot leave home (homebound individuals);
* culturally, ethnically, and linguistically diverse people, especially asylum seekers and refugees and those in older age groups who may find it difficult to use vaccination services;
* aged care and disability workers, with consideration to all auxiliary staff working on-site;
* Aboriginal and Torres Strait Islander populations;
* children aged 5-11 who have complex needs, who are not captured by another suitable vaccination channel and;
* any other vulnerable groups identified as requiring dedicated support to access vaccinations

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

The indigenous population has been identified as one of the high risk cohorts

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

• Expression Of Interest (EOI) disseminated to all appropriate Service Providers and Health care providers to help identify at risk population groups
• General practices are approached and encouraged to express interest in participating in the program if they are located in relevant 'hot spots' or have a higher number of patients who are non-Medicare eligible or identify via PENCS as having high numbers of vulnerable population as per above
• SA Health, Local Health Network staff (including SALHN, CALHN and NALHN)

Collaboration

Stakeholders involved in this program will design and implement the activity
Liaise with current CVC and In-Reach Vaccination providers to provide vaccination services to identified vulnerable groups
Pharmacies as appropriate
Partnership with Wellbeing SA as appropriate

Activity Milestone Details/Duration

Activity Start Date

01/01/2021

Activity End Date

31/12/2022

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

Yes

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

Yes

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

CF-COVID-LWC - 202208 - A202208 - COVID19 - Living With COVID

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF-COVID-LWC

Activity Number *

202208

Activity Title *

A202208 - COVID19 - Living With COVID

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The Activity aims to support and strengthen the health system to manage the anticipated increase in COVID-19 cases as Australia progresses from phases B and C to Phase D: Post Vaccination Phase, Manage COVID-19 consistent with public health management of other infectious diseases. With high levels of vaccination coverage, most of these cases will have mild symptoms and not require hospitalisation. The Activity will support effective and efficient community care management of COVID-19 patients outside of hospital and provide confidence and assurance to the community and health professionals in the region.

Description of Activity *

The South Australian government has announced the SA Health COVID-19 Health System Response Strategy outlining the safe easing of restrictions and how COVID-19 will be managed in this state. The Plan includes preparing our primary health and hospital system to cope with an increase of COVID-19 cases.

The Adelaide PHN is working with both Commonwealth and State departments of health to understand their plans, advocate for primary health care, and implement supports to ensure the highest quality of care for our community.
The Adelaide PHN is also working with Country SA PHN to ensure consistency across primary health care in South Australia.

Specific activities will include:

COVID-19 Positive Community Care Pathways
We will work in partnership with Local Health Networks (LHNs), GPs and other stakeholders (e.g. the Aboriginal community controlled health sector) to develop or update COVID-positive community care pathways for our region. The pathways will:
- provide clear treatment and escalation pathways through the local health system which supports both primary care and hospitals so that they are not overwhelmed or treating patients in clinically inappropriate settings;
- be consistent with the overall national scheme for COVID-positive community care pathways, with relevant State/Territory guidance, and with the RACGP guidelines for care of COVID positive patients;
- be responsive to the needs of at risk populations, including people in residential aged care facilities, older Australians, Aboriginal and Torres Strait Islander Australians, people with disability, culturally and linguistically diverse groups, and people in socioeconomically disadvantaged circumstances;
- support efficient testing arrangements including after hours access to assessment and care; and
- clearly delineate between formal hospital in the home arrangements (where the patient is admitted by a doctor to receive care delivered by a hospital) and –where the patient does not require admission –GP-led care in the community.

Support for Primary Care from the National Medical Stockpile
This activity supports the management of COVID-positive cases in the community through access, compliance arrangements, and distribution of Personal Protective Equipment (PPE) and pulse oximeters from the National Medical Stockpile (NMS) to individual primary care practices within our region which includes to general practices, General Practice Respiratory Clinics (GPRCs), Aboriginal Community Controlled Health Services (ACCHSs) until the 30th Sept 2022

Commissioned Home Visits
Adelaide PHN will engage clinical service providers (e.g. medical deputising services, nurse practitioners and practice nurses) to undertake home visits to provide care to Community (inclusive of homebound, RACF/Disability Services) patients (COVID positive/Respiratory indicated patients) where their GP does not have capacity, where a person does not have a managing GP, or during the after-hours period where the regular GP is not available. It is vital that this service integrates with a person's regular care team. Referrals will be made by the person's managing GP/healthcare professional, as per arrangements agreed with the PHN, and the service provider will connect the person back to their Primary Care provider.

Access to these home visits will to align with other aspects of the Primary Care Living with COVID Taskforce measures, including finalisation of joint PHN and LHN regional care pathways and commencement of Healthdirect assessment, triage and referral infrastructure

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Integration, coordination and partnerships between primary and acute care to improve continuity of care and health outcomes	36
People in the Adelaide PHN region receive holistic and person-centered care that is responsive to individual circumstances	37
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in an ever-changing health landscape.	109

Activity Demographics

Target Population Cohort

Primary care workforce and vulnerable and at-risk populations in the region, including people in residential aged care facilities, older Australians, Aboriginal and Torres Strait Islander Australians, people with disability, culturally and linguistically diverse groups, and people in socioeconomically disadvantaged circumstances.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Collaboration

Activity Milestone Details/Duration

Activity Start Date

01/01/2021

Activity End Date

31/12/2022

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Extended from 30/06/2022

Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments

CF - 1000 - CF1. Community and Provider Immunisation Engagement and Support

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

1000

Activity Title *

CF1. Community and Provider Immunisation Engagement and Support

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Community and Provider Immunisation Engagement and Support is commissioned to two organisations which both utilise specialist nurses to provide:
• immunisation program support and education to providers to increase childhood immunisation rates especially for Aboriginal and Torres Strait Islander children,
• support and information to the community, especially CALD communities and the impact of Hepatitis B,
• identify barriers to vaccine uptake and vaccine hesitancy within the local region

Description of Activity *

The commissioned Champion Nurse Immunisation Program (CNIP) will engage specialist nurses to provide:
• immunisation program support and education to providers
• support and information to the community
• identify barriers to vaccine uptake
• address vaccine hesitancy
• promote and advocate for immunisation at local community events
• address immunisation requirements for CALD and new emerging communities

The Immunisation Community Engagement Project has also engaged specialist nurses to provide the same activities, but concluded 30 June 2022.

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.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH 20. Prevention and early intervention strategies for childhood and youth health conditions	85
GPH 3. Identified areas of the Adelaide PHN (APHN) region have childhood immunisation rates below the national average	85
GPH 1. The CALD community are disproportionally affected by Hepatitis B	85
IH-GPH1. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non-Aboriginal and Torres Strait Islander children	92

Activity Demographics

Target Population Cohort

Immunisation providers, community members and under-immunised children

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

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.

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Holdfast Bay	40301
Charles Sturt	40401
Onkaparinga	40304
Prospect - Walkerville	40106
Port Adelaide - East	40203
Mitcham	40303
Marion	40302
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

• This activity was established in consultation with Immunisation service providers, including General Practice, Local Councils, Child and Family Health Service and Hospitals.
• 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.
• The South Australian Immunisation Provider Network (IPN) are consulted at their regular meetings.

Collaboration

• 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.
• 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:
- provide immunisation program support and education to providers support and information to the community
- identify barriers to vaccine uptake
- address vaccine hesitancy
- promote and advocate for immunisation at local community events
- address immunisation requirements for CALD and new emerging communities
• 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.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2023

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Decommissioning

Yes

Decommissioning details?

The Immunisation Community Engagement Project met project deliverables and was contracted until 30 June 2022.

Co-design or co-commissioning comments

na

N/A

CF - 2000 - CF2. Adelaide Refugees and New Arrivals Program (ARANAP)

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

2000

Activity Title *

CF2. Adelaide Refugees and New Arrivals Program (ARANAP)

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The aims of ARANAP model are:
1. Connect people who are from refugee, humanitarian entrant and newly arrived backgrounds to relevant health care services (including other APHN commissioned services) and provide care coordination to ensure immediate clinical needs are attended to and enable positive engagement with the health system.
2. Support people from refugee, humanitarian entrant and newly arrived backgrounds, through a health literacy approach, to understand their health condition and the health system and to better self-manage..
3. Support primary health care providers, including General Practice, to have increased capacity to deliver culturally safe and culturally appropriate services to people who are from refugee, humanitarian entrant and newly arrived background.

Description of Activity *

People from refugee, humanitarian entrant and newly arrived backgrounds 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.
1. Supporting people from refugee, humanitarian entrant and newly arrived background to access appropriate and timely health care services by:
o Connecting individuals with primary health care services,

o Refugee Health Nurses coordinating the care of program participants,
o Refugee Health Nurses working with both the participants 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).
2. Supporting people from refugee, humanitarian entrant and newly arrived backgrounds to understand their condition and the health system by:
o Bicultural workers using the Steps to Better Health tool to measure health literacy and track progress in a participant's ability to self-manage and to understand their health,
o Participants receiving individualised support based on the results of the health literacy assessment and provided appropriate resources to make informed decision about their health care,
o Analysing participant's health literacy assessment results across the program to inform topic areas for further education and support to small groups of people and wider refugee and new arrival communities in culturally safe and appropriate ways, including multiple formats and multiple languages.

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:
o 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 people from refugee, humanitarian entrant and newly arrived backgrounds,
o Working with a focused number of practices to enable them to conduct first comprehensive health assessments.
ARANAP will also work towards improved system integration of primary health care services for refugees and newly arrived people including:
o Identifying and promoting best practice approaches and/or pathways for refugees and new arrivals across the spectrum of health care providers
o Facilitating, supporting and advocating for collaboration, coordination and integration.
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.
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.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH 15. Lack of community awareness about existing health care services for different population groups, consumers and providers.	85
GPH 2. Accessibility to and appropriateness of primary health care services, particularly for CALD and new & emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ & older people	85
GPH 18. 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.	85
GPH 21. Awareness and timely access to appropriate services (including after-hours services) for vulnerable populations particularly Aboriginal and Torres Strait Islander people,	85

children & youth.....	
GPH 17. 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.	85
GPH 22. A coordinated approach to improve navigation and pathways for patients to manage their conditions	85
GPH 13. Lack of easily understood and accessible referral pathways across systems and settings.	85
GPH 12. 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.	85

Activity Demographics

Target Population Cohort

Refugee, Humanitarian Entrant and New Arrival Communities

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Holdfast Bay	40301
Charles Sturt	40401
Onkaparinga	40304
Prospect - Walkerville	40106
Port Adelaide - East	40203
Mitcham	40303
Marion	40302
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

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.
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.

Collaboration

General Practices in target areas
• Increase program awareness
• Increase knowledge and capacity to provide culturally appropriate services to refugee and new arrival communities
Primary Health Care, including Pharmacy
• To support clients and general practitioners in managing health conditions and medications
State Health services and LHNs
• Support referral pathways of identified population groups
• Sector is kept informed and provided with information and resources regarding the program
• Program is informed of trends, updated services and changes within state services
• Identification of shared opportunities to minimise duplication and improve service delivery across the sector
NGOs
• To provide information, support and promotion of the program to other NGOs supporting refugee and new arrival populations
• Identification of shared opportunities to minimise duplication and improve service delivery across the sector

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

30/06/2023

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2023

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

Stakeholders and service providers were consulted and provided input in the initial design of intervention measures for the activity before tender.

CF - 3000 - CF3. Adelaide Integrated Respiratory Response (AIRR) Project

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

3000

Activity Title *

CF3. Adelaide Integrated Respiratory Response (AIRR) Project

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

1. Build the capacity of participating GPs and Pharmacies to deliver evidence based and best practice Chronic Obstructive Pulmonary Disease (COPD) and Asthma care to the community;
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;
3. Develop resources to facilitate the successful replication of the project in additional settings.
4. Build the capacity of participating patients to understand their individual health needs and be actively involved with their COPD/Asthma care plans.

Description of Activity *

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.

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.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH 21. Awareness and timely access to appropriate services (including after-hours services) for vulnerable populations particularly Aboriginal and Torres Strait Islander people, children & youth.....	85
GPH 4. Selected areas of the APHN region have high rates of smoking which correlates with areas of high prevalence of COPD.	85
GPH 22. A coordinated approach to improve navigation and pathways for patients to manage their conditions	85
GPH 9. 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 deficienc	85
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)	92

Activity Demographics

Target Population Cohort

People living with COPD and/or Asthma across the care continuum with a focus on vulnerable population groups (particularly, 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).

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Onkaparinga	40304
Port Adelaide - East	40203
Port Adelaide - West	40402
Playford	40202
Salisbury	40204

Activity Consultation and Collaboration

Consultation

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.
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.
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

• 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.
• 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.
• Pharmaceutical Society of Australia [SA/NT Branch] to support increased interventions and management at the pharmacy level to support patient medication compliance with Asthma and COPD.
• Local Health Networks across metropolitan Adelaide to assist in consistent, improved clinical pathways for appropriate patient management of respiratory conditions.
• All relevant stakeholders will be invited to provide representation on the project working group, where appropriate.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2022

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2022

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Decommissioning

Yes

Decommissioning details?

Activity deliverables achieved

Co-design or co-commissioning comments

na

CF - 4000 - CF4. Care Connections Program

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

4000

Activity Title *

CF4. Care Connections Program

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

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):
1. Improve healthy ageing and frailty management in identified patient cohorts through implementation of elements of patient-centred medical home models;
2. Connect and integrate local level primary health care systems and providers in targeted areas of the Adelaide PHN region;
3. Implement quality improvement initiatives to support the Quadruple Aim of primary health care; and
4. Improve the quality use of medicines (QUM) in line with the National Strategy for Quality Use of Medicines.

Description of Activity *

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:
• Integrated Care Hubs (ICH): 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:
o 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.
o Undertake to develop and implement mechanisms for supporting continuous quality improvement. This action will be supported by activities described in GPS1 and HSI3.
o 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)
o 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:
 improved utilisation and scope of practice team members, both health professionals and administrative staff
 utilisation of shared care platforms, patient portals and assistive technology
 coordinated options for medicines review and management
 nurse-led clinics, group self-management and shared medical appointments
 frailty and falls management
 health and lifestyle coaching for patients
 improved access to specialised care
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.
• Local Medical Neighbourhood: This activity seeks to strengthen and sustain relationships between and within ICHs and other key health providers. 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.
o ICHs will be asked to identify potential partners for local medical neighbourhood activities from their referral lists
o 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
o 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 & Activities and may include, for example:
 co-location of staff or shared resourcing of co-located health practitioners
 cross-professional group self-management and shared medical appointments
 comprehensive shared care planning, supporting the uptake of MBS case conferencing items

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH 16. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.	85
GPH 6. Selected APHN LGAs have higher rates of a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease, musculoskeletal) and multi-morbidities.	85
GPH 8. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.	85

GPH 9. 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 deficienc	85
GPH 10. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.	85
GPH 12. 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.	85

Activity Demographics

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.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Holdfast Bay	40301
Charles Sturt	40401
Onkaparinga	40304
Prospect - Walkerville	40106
Port Adelaide - East	40203
Mitcham	40303
Marion	40302
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

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.
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:
• Primary health care workforce
• 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.
• Pharmacies and allied health services in target areas to support general practices and patients in managing health condition(s).
• Aboriginal Community Controlled Health Organisation(s) (ACCHO) to support culturally appropriate services for Aboriginal and Torres Strait Islander people.
NGOs to provide additional support, educational and or health promotion services and activities.

Collaboration

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:
• The FORTRESS Study
• Local Health Networks
• Allied health
• Pharmacies

• Community Health and social support providers
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.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

31/08/2021

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

na

CF - 5000 - CF5. Living Well with Persistent Pain Program

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

5000

Activity Title *

CF5. Living Well with Persistent Pain Program

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The aim of the activity is to provide a multi-disciplinary, collaborative primary care-based persistent pain management network, which:
• supports individuals to better understand their condition;
• equips them with the necessary tools to improve their quality of life;
• improves individual's ability to navigate the health system; and
• minimises the burden of pain on the individuals and the wider community.

Description of Activity *

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. Individuals are referred to the program by their GP for a 12-month intervention. In the program, they can access:
• an education program focused on making changes to improve the patient's daily life;
• one-on-one discussions about the patient's pain and how it affects them;
• a tailored plan of allied health services.
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.
As people with persistent pain often require complex management plans, participants are supported with access to up to five allied health appointments as part of their care plan (in addition to any allied health appointments under an Enhanced Primary Care plan from their regular GP).
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.
Services will deliver the program, each aligned with the relevant Local Health Network boundary.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH 2. Accessibility to and appropriateness of primary health care services, particularly for CALD and new & emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ & older people	85
GPH 21. Awareness and timely access to appropriate services (including after-hours services) for vulnerable populations particularly Aboriginal and Torres Strait Islander people, children & youth.....	85
GPH 7. Services for people living with persistent pain are limited with long delays to access hospital-based services.	85
GPH 17. 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.	85
GPH 22. A coordinated approach to improve navigation and pathways for patients to manage their conditions	85

Activity Demographics

Target Population Cohort

People living with persistent pain

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Charles Sturt	40401
Prospect - Walkerville	40106
Port Adelaide - East	40203
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

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.
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.
Adelaide PHN continues to work with the commissioned service provider to identify opportunities and develop the program further. Tertiary services are also engaged ongoing basis.

Collaboration

Local Health Networks:
• Partnering as a delivery partner
• Referral of appropriate patients
• Pathways with the LHN chronic pain program
General Practices in target areas:
• Service delivery to support them to manage patients' persistent pain condition alongside any chronic condition(s)
• Referral of appropriate patients.
Allied health services, including pharmacies:

• Building capacity of these providers to support patients to manage their persistent pain.
Living Well with Persistent Pain programs:
• Identifying shared opportunities to minimise duplication.

Pain support groups:
• Identifying shared opportunities and pathways for support post-program.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2023

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2023

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

na

CF - 6000 - CF6. Indigenous Health Project Officer

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

6000

Activity Title *

CF6. Indigenous Health Project Officer

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aboriginal and Torres Strait Islander Health

Other Program Key Priority Area Description

Aim of Activity *

The project aims are:
• 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.
• 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
• 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.
• 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)
• Increase access to culturally safe services and appropriate chronic disease management programs for Aboriginal and Torres Strait Islander people

Description of Activity *

Previously called: CF6. Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program.

This project will deliver:
• 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.
• Cultural learning (accredited training) to the primary health care workforce which will include Adelaide PHN commissioned service providers.
• Capacity building hubs and workshops on the 6 Aboriginal Actions within the National Health and Safety Quality Standards for commissioned service providers.
• Support the delivery of best practice approaches to improve health outcomes and delivery of care to Aboriginal and Torres Strait Islander people.
• 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

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
People at risk of developing or living with chronic or complex conditions receive timely and appropriate interventions, care, support and management	36
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	45
Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.	45
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	109

Activity Demographics

Target Population Cohort

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.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

The commissioned agencies (for employer of the IHPO) 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.

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.

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Holdfast Bay	40301
Charles Sturt	40401
Onkaparinga	40304
Prospect - Walkerville	40106
Port Adelaide - East	40203
Mitcham	40303
Marion	40302
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

Consultations and codesign have occurred with the following stakeholders to help inform the development and ongoing review of this project:
• The Adelaide PHN Aboriginal Consumer Advisory Council
• South Australian Health and Medical Research Institute – Wardliparingga Aboriginal Research Unit
• Integrated Team Care Program workforce
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.

Collaboration

Collaboration on this activity is evolving and it is expected that the APHN will engage with:
• South Australian Health and Medical Research Institute – Wardliparingga Aboriginal Research Unit – established a working group to develop systematic approaches for commissioned service providers to implement the 6 Aboriginal Actions within the NHSQS.
• 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
• GP practices – Participants of the Cultural Learning Program and attend sessions with pre and post activities which include an evaluation component

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Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2024

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2024

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

na

CF - 7000 - CF7. Integrated Care with Northern Adelaide Local Health Network (ICwNALHN)

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

7000

Activity Title *

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

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

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.

Description of Activity *

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.
Professional Integration activities:
• Provide education and networking opportunities that brings GPs and hospital consultants together and improves knowledge,
• Work collaboratively with GPs to facilitate better GP understanding of Local Health Network pathways.

Service Integration activities:
• Collaborate with hospital consultants and GPs to understand and resolve systemic primary care-Local Health Network interface issues.

Administration Integration activities:

• Improve referral quality through use of HealthPathways, feedback to general practices, and updating of referral guidelines,
• Implement a quality improve approach to identify failure points and increase timely discharge summary completion.

Clinical Integration activities:
• Explore IT solutions to improve collaboration and information sharing between Local Health Network services and general practice.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH 18. 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.	85
GPH 19. Minimise instances of poor quality and unwarranted variations of care and follow up.	85
GPH 22. A coordinated approach to improve navigation and pathways for patients to manage their conditions	85
GPH 14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.	85
GPH-GPS2. Targeted support to increase awareness and utilisation of HealthPathways SA and specific pathways for patients.	86

Activity Demographics

Target Population Cohort

The target population will be adults and/or children with chronic conditions who have frequent contact with hospital services.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Port Adelaide - East	40203
Tea Tree Gully	40205
Playford	40202
Salisbury	40204

Activity Consultation and Collaboration

Consultation

This activity has been established in consultation with general practitioners in NALHN region and clinicians and administrative staff from NALHN.
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.

Collaboration

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.
Adelaide PHN:
• Integration Coordinators facilitate collaboration between the GP Units with other APHN activities, support GP Unit functions and provide Project Management oversight,
• Practice Facilitators extend the work of the GP Units into their visits to general practices.
Local Health Network:
• Local Health Network staff facilitate collaboration between GP Unit team members and staff from departments and units within Local Health Network services, and
• facilitate the identification, development and management of quality improvement activities.
General Practitioners:
• Participate in facilitated workshops to identify system issues and potential quality improvement activities.
• Participate in education and networking sessions to improve clinical skills and knowledge, relationships and understanding of pathways.
The GP Unit is comprised of:
• GP Liaison/Integration Officers (engaged through APHN)
• Nurse (employed by NALHN)
• Administrative support (employed by NALHN).

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2022

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2022

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

Yes

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

Yes

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

Consultation with Local Health Network (LHN) during design and implementation of activity

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CF - 8000 - CF8. Integrated Care with Southern Adelaide Local Health Network (ICwSALHN)

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

8000

Activity Title *

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

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

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.

Description of Activity *

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.
Professional Integration activities:
• Provide education and networking opportunities that brings GPs and hospital consultants together and improves knowledge,
• Work collaboratively with GPs to facilitate better GP understanding of Local Health Network pathways.

Service Integration activities:
• Collaborate with hospital consultants and GPs to understand and resolve systemic primary care-Local Health Network interface issues.

Administration Integration activities:

• Improve referral quality through use of HealthPathways, feedback to general practices, and updating of referral guidelines,
• Implement a quality improve approach to identify failure points and increase timely discharge summary completion.

Clinical Integration activities:
• Explore IT solutions to improve collaboration and information sharing between Local Health Network services and general practice.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH 18. 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.	85
GPH 19. Minimise instances of poor quality and unwarranted variations of care and follow up.	85
GPH 22. A coordinated approach to improve navigation and pathways for patients to manage their conditions	85
GPH 14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.	85
GPH-GPS2. Targeted support to increase awareness and utilisation of HealthPathways SA and specific pathways for patients.	86

Activity Demographics

Target Population Cohort

The target population will be adults and/or children with chronic conditions who have frequent contact with hospital services.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Holdfast Bay	40301
Onkaparinga	40304
Mitcham	40303
Marion	40302

Activity Consultation and Collaboration

Consultation

This activity has been established in consultation with general practitioners in SALHN region and clinicians and administrative staff from SALHN.
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.

Collaboration

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.
Adelaide PHN:
• Integration Coordinators facilitate collaboration between the GP Units with other APHN activities, support GP Unit functions and provide Project Management oversight,
• Practice Facilitators extend the work of the GP Units into their visits to general practices.
Local Health Network:
• Local Health Network staff facilitate collaboration between GP Unit team members and staff from departments and units within Local Health Network services, and
• facilitate the identification, development and management of quality improvement activities.
General Practitioners:
• Participate in facilitated workshops to identify system issues and potential quality improvement activities.
• Participate in education and networking sessions to improve clinical skills and knowledge, relationships and understanding of pathways.
The GP Unit is comprised of:
• GP Liaison/Integration Officers (engaged through APHN)
• Nurse (employed by SALHN)
• Administrative support (employed by SALHN).

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2022

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2022

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

Yes

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

No

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

Consultation with Local Health Network (LHN) during design and implementation of activity

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CF - 9000 - CF9. Integrated Care with Central Adelaide Local Health Network (ICwCALHN)

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

9000

Activity Title *

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

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

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.

Description of Activity *

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.
Professional Integration activities:
• Provide education and networking opportunities that brings GPs and hospital consultants together and improves knowledge,
• Work collaboratively with GPs to facilitate better GP understanding of Local Health Network pathways.

Service Integration activities:
• Collaborate with hospital consultants and GPs to understand and resolve systemic primary care-Local Health Network interface issues.

Administration Integration activities:

• Improve referral quality through use of HealthPathways, feedback to general practices, and updating of referral guidelines,
• Implement a quality improve approach to identify failure points and increase timely discharge summary completion.

Clinical Integration activities:
• Explore IT solutions to improve collaboration and information sharing between Local Health Network services and general practice.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH 18. 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.	85
GPH 19. Minimise instances of poor quality and unwarranted variations of care and follow up.	85
GPH 22. A coordinated approach to improve navigation and pathways for patients to manage their conditions	85
GPH 14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.	85
GPH-GPS2. Targeted support to increase awareness and utilisation of HealthPathways SA and specific pathways for patients.	86

Activity Demographics

Target Population Cohort

The target population will be adults with chronic conditions who have frequent contact with hospital services.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Charles Sturt	40401
Prospect - Walkerville	40106
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

This activity has been established in consultation with general practitioners in CALHN region and clinicians and administrative staff from CALHN.
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.

Collaboration

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.
Adelaide PHN:
• Integration Coordinators facilitate collaboration between the GP Units with other APHN activities, support GP Unit functions and provide Project Management oversight,
• Practice Facilitators extend the work of the GP Units into their visits to general practices.
Local Health Network:
• Local Health Network staff facilitate collaboration between GP Unit team members and staff from departments and units within Local Health Network services, and
• facilitate the identification, development and management of quality improvement activities.
General Practitioners:
• Participate in facilitated workshops to identify system issues and potential quality improvement activities.
• Participate in education and networking sessions to improve clinical skills and knowledge, relationships and understanding of pathways.
The GP Unit is comprised of:
• GP Liaison/Integration Officers (engaged through APHN)
• Nurse (employed by CALHN)
• Administrative support (employed by CALHN).

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2022

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2022

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

Yes

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

No

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

Consultation with Local Health Network (LHN) during design and implementation of activity

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CF - 15000 - CF15. SA Priority Care Centre

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

15000

Activity Title *

CF15. SA Priority Care Centre

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Previously referenced as AH8 (After Hours AWP).

The Priority Care Centres program aims to provide community-based healthcare and treatment for eligible patients who would otherwise be seeking a service from a SA Health Emergency Department during the After-Hours period.
The services address the needs identified above by:
• Providing services by General Practitioners, supported by SA Health hospital staff specially trained in acute assessment and care as well as offering support care and treatment such as:
o Diagnostic tools such as imaging and pathology
o Pharmacy services
o Community based health services for follow up care.
• Reducing the burden of triage 4 and 5 patients from the hospital sector to be serviced appropriately in primary care by adequately trained and resourced clinical teams.
• To improve integration across services and sectors.
• Reduce the number of potentially preventable hospitalisations.

Description of Activity *

Patients who present to a SA Health Emergency Department who are triaged as Category four or five (non-life threatening injuries and illnesses) or have called for a SA Ambulance Service (SAAS) are assessed for their eligibility and if deemed appropriate are then directed to a PCC. Patients can choose to attend a Centre with no out of pocket expenses or wait for their care to be delivered at an emergency department. Services are provided in line with care needs which may include imaging, pathology, pharmacy and other community-based services. Upon completion of service at the PCC, patients will either return home, be referred to appropriate community-based care, or in some cases be transferred back to hospital usually for admission. All services provided are communicated with the patient's regular health care provider by means of a summary report.
All patients are offered the opportunity to complete a survey to ascertain their satisfaction of the service received at the PCC. This will allow for quality improvement changes to the program over the duration of the contracted time period.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH-AH1. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations.	86

Activity Demographics

Target Population Cohort

The target cohort will be lower acuity adult patients such as those presenting with minor sprains and strains, suspected fractures, sporting injuries, minor cuts and wounds, general pain, early pregnancy complications, urinary tract infections and mental health issues.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Marion	40302
West Torrens	40403
Playford	40202
Salisbury	40204

Activity Consultation and Collaboration

Consultation

• General practices were approached and encouraged to express interest in participating in the program if they were located in relevant 'hot spot' (aligned with the above SA3 regions) and if they had the appropriate workforce and infrastructure to provide the service.
• SA Health, Local Health Network staff (including SALHN, CALHN and NALHN), South Australian Ambulance Service (SAAS).

Collaboration

• Adelaide PHN will continue to collaborate with SA Health, SAAS, LHN teams and general practice teams to ensure that the program continues to be monitored and modified where appropriate and required.
• APHN will continue to support the development, roll-out and evaluation of the patient satisfaction survey.
• APHN will support the general practice PCC teams with process and resource development or any upskilling regarding use of IT systems or programs
• SA Health continue to be the lead for the project and are responsible for coordinating the other stakeholders, developing committees to support any redesign to enable improvements.
• SAAS continue to advise and support their workforce and make amendments to current systems and processes to ensure smooth transition of patients to PCCs as well as reviewing the current eligibility criteria for PCC patients.
• Local Health Networks (LHN) are responsible for coordinating their ED teams to review the eligibility for PCC patients. Their ED specialist team provide the upskilling/refresher training for any general practitioners and other primary health care staff where required.
LHN provide the ED nurse/s located at each PCC that assist with triage and handover from ED/SAAS and also supports the discharge of patients requiring ongoing care with community-based services.

Activity Milestone Details/Duration

Activity Start Date

03/02/2020

Activity End Date

30/06/2022

Service Delivery Start Date

February 2020

Service Delivery End Date

June 2022

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

Yes

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

No

Decommissioning

No

Decommissioning details?

n/a

Co-design or co-commissioning comments

CF - 202205 - A202205 - Improving access for vulnerable populations

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

202205

Activity Title *

A202205 - Improving access for vulnerable populations

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

This activity aims to support the most vulnerable population groups in the Adelaide PHN region with the poorest health outcomes through the provision of accessible, coordinated, multidisciplinary and person-centred care and support for self-management of their health and health literacy to reduce the burden of long-term chronic conditions and improve people's quality of life by
- Facilitating the coordination and integration of quality population health programs in the primary health care settings in partnership with the community organisations, NGOs, and SA Health
- Supporting General practice and other primary care workers to contribute to improving population health outcomes by empowering and preparing patients to manage their health

Description of Activity *

The Adelaide PHN will work closely with the community and its stakeholders to develop population health management strategies to improve health outcomes. The Adelaide PHN is currently undertaking a major review to update the need assessment for the population health to identify the priority population groups and formulate targeted strategies for preventable hospitalisations for chronic conditions or associated risk factors.
This includes but not limited to consultation with the Adelaide PHN members in the Community Advisory Council, Aboriginal Community Advisory Council and the Clinical Council.
Effective population health management activities will be developed through commissioning activities where there are service

gaps- or partnering to address the health issue in the community for targeted population groups. At the services level, this will include but is not limited to enhancement of existing services or the creation of new services that directly address issues relating to service availability and accessibility within the Adelaide metropolitan region. At the system level, activities aimed at integrating or increasing partnerships between providers to streamline the patient's journey of care. At the community level interventions will be designed to build awareness and knowledge of members of a vulnerable community to support improved access and capability to navigate the system and mobilizing community resources to meet the need of consumers.
This activity will be informed by Adelaide PHN Need Assessment, Adelaide Integrated Care Framework and Health Promotion framework as well as the National strategic framework for chronic conditions and the Australian Health Performance Framework.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Children, young people and their families have timely access to early intervention, prevention and support services	36
People at risk of developing or living with chronic or complex conditions receive timely and appropriate interventions, care, support and management	36
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access culturally safe and appropriate primary health care services in a timely way	36
LGBTIQA+ communities can access safe, inclusive and appropriate primary health care services	37
People in the Adelaide PHN region understand how to access a variety of primary care services when and where they need them	37
People in the Adelaide PHN have awareness of and timely access to preventative and early intervention services	37
People in the Adelaide PHN region receive holistic and person-centered care that is responsive to individual circumstances	37
Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.	45

Activity Demographics

Target Population Cohort

Culturally & Linguistically Diverse Communities, Aboriginal and Torres Strait Islander health, Child and youth health

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The Adelaide PHN is in the process of updating the need assessment for the population health. Health needs and service gaps for the vulnerable population were short-listed. For prioritising the issues, the different channel and mode of engagement has been planned to consult the community and its stakeholders. This includes but not limited to Adelaide PHN Community and Clinical Advisory Councils and a community-wide survey.

Collaboration

To address the identified need, the Adelaide PHN plans to collaborate with multicultural organisations and NGOs and SA Health. Collaborations with Flinders University and other major universities in Adelaide may happen once the key activities are identified.

Activity Milestone Details/Duration

Activity Start Date

01/07/2023

Activity End Date

30/06/2024

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

CF - 202221 - A202221 - Integrated Care with Local Health Networks

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

202221

Activity Title *

A202221 - Integrated Care with Local Health Networks

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

System Integration

Aim of Activity *

This activity aims to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and the hospitals in the metropolitan Adelaide Local Health Networks (LHNs), namely Central Adelaide LHN (CALHN), Northern Adelaide LHN (NALHN) and Southern Adelaide LHN (SALHN).

Description of Activity *

The activity will work in the following domains to improve patient outcomes through a -strengthened acute-primary care interface in the CALHN, SALHN and NALHN regions. The GP Integration Unit within each LHN will support this activity.

These activities have been aligned to APHN's Integrated Care Framework dimension of integration:
Professional Integration activities:
• Provide education and networking opportunities that brings GPs and hospital consultants together and improves knowledge,
• Work collaboratively with GPs to facilitate better GP understanding of Local Health Network pathways.

Service Integration activities:
• Collaborate with hospital consultants and GPs to understand and resolve systemic primary care-Local Health Network interface issues.

Administration Integration activities:
• Improve referral quality through use of HealthPathways, feedback to general practices, and updating of referral guidelines,
• Implement a quality improve approach to identify failure points and increase timely discharge summary completion.

Clinical Integration activities:
• Explore IT solutions to improve collaboration and information sharing between Local Health Network services and general practice.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Integration, coordination and partnerships between primary and acute care to improve continuity of care and health outcomes	36
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	115
Support practitioners to improve communication and build relationships with other health care providers	109

Activity Demographics

Target Population Cohort

The target population will be adults and/or children with chronic conditions who have frequent contact with hospital services

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

This activity has been established in consultation with general practitioners in each of the three LHN regions and clinicians and administrative staff from the LHNs.

A Steering Group in each LHN oversees the performance, monitoring and evaluation functions and will use this information to review and adapt planned activity ahead of each financial year. Each Steering Group will involve participants from Adelaide PHN, the GP Integration Unit and the LHN.

Collaboration

In addition, each partner contributes the following.
Adelaide PHN:
• Integration Coordinators facilitate collaboration between the GP Integration Units with other Adelaide PHN activities, support GP Integration Unit functions and provide Project Management oversight,
• Practice Facilitators extend the work of the GP Integration Units into their visits to general practices.

Local Health Network:
• Local Health Network staff facilitate collaboration between GP Integration Unit team members and staff from departments and units within Local Health Network services, and
• facilitate the identification, development and management of quality improvement activities.

General Practitioners:
• Participate in facilitated workshops to identify system issues and potential quality improvement activities.
• Participate in education and networking sessions to improve clinical skills and knowledge, relationships and understanding of pathways.

Activity Milestone Details/Duration

Activity Start Date

01/07/2022

Activity End Date

30/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Each of the three steering groups will review and adapt planned activity ahead of each financial year

HSI - 202225 - A202225 - Health Pathways South Australia

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202225

Activity Title *

A202225 - Health Pathways South Australia

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

System Integration

Aim of Activity *

Previously referenced as CF16. Health Pathways (under CF Activity Prefix)

This activity aims to address the Needs Assessment priorities through the development and state-wide implementation of the HealthPathways online portal to support the consistent management of health conditions and improve the patient journey through our local health system.

Description of Activity *

HealthPathways is an online portal that provides General Practitioners (GPs) and other health professionals with access to evidence-based assessment, management and localised referral resources for specific health conditions. GPs and other health professionals across the health sectors collaborate on the development and implementation of locally agreed pathways to ensure patients receive the right care in the right place at the right time.
This activity is a collaborative partnership between Adelaide PHN and Country SA PHN (CSAPHN) alongside Wellbeing SA to implement HealthPathways across South Australia, and involves:
• Identification of clinical priorities for delivery of care in South Australia
• Development of clinical, information and referral pathways tailored to the local and national context
• Promotion of health professional use of HealthPathways in South Australia

Addressing the PHN objectives and priorities identified through the Needs Assessment, this activity looks to enhance consistent care and management of health conditions, increase awareness and utilisation of appropriate referral pathways and resources and improve the patient journey.

Priority clinical areas for 2021-2024 include
1. COVID-19
2. Palliative Care
3. Cancer Care
4. Cardiovascular Disease
5. Child & Youth Health
6. Endocrinology and Diabetes care
7. Ear, Nose and Throat health
8. Mental Health and Alcohol and other Drugs
9. Neurology
10. Older Persons' health
11. Ophthalmology
12. Orthopaedics
13. Vulnerable populations
including yet not limited to Culturally and Linguistically Diverse Health, Aboriginal and Torres Strait Islander Health, Intellectual disability health

This activity looks to be responsive to emerging national priorities, natural disasters and public health emergencies as appropriate to facilitate access to up-to-date and accurate guidance and advice.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Children, young people and their families have timely access to early intervention, prevention and support services	36
People at risk of developing or living with chronic or complex conditions receive timely and appropriate interventions, care, support and management	36
Integration, coordination and partnerships between primary and acute care to improve continuity of care and health outcomes	36
Primary health care workforce have knowledge, skills and capacity to safely support and meet the specific needs of LGBTIQA+ communities	36
Enhance service and clinical integration between mental health care providers, and with State services	75
Ensure visibility of Adelaide PHN commissioned services and eligibility criteria to GPs, state, community services and to underserviced groups to enhance access	76
People in the Adelaide PHN region understand how to access a variety of primary care services	37

when and where they need them	
Primary health care providers are supported to adopt and fully implement digital health technologies	115
Primary care providers are supported to use digital health tools that improve safety and quality of care	115
Support primary health care providers to adopt and implement patient-centred models of care	109
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care.	58
PHC providers can identify and support people with substance abuse issues and understand the scope of AOD treatment services and PHC services.	98

Activity Demographics

Target Population Cohort

This activity is targeted towards the wide variety of health professionals and health care providers across the APHN region including, but not limited to; GPs and practice nurses, specialists, pharmacists, allied health and aged care professionals.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The HealthPathways process includes targeted consultation with State Health, Local Health Networks, General Practice, allied health professionals, consumer groups and relevant peak organisations. Consultation occurs with existing Adelaide PHN

commissioned service providers and membership groups.
The HealthPathways SA Team and Steering Committee facilitates collaborative consultation mechanism with the activity partners and other stakeholders in the project.
Activities include but not limited to engagement and collaboration with Subject Matter Experts and clinical networks, facilitation of Clinical Work Groups and ongoing feedback loops via the website.

Collaboration

This is a collaborative partnership activity with Wellbeing SA and CSAPHN and reflects HealthPathways activities undertaken by local health jurisdictions and PHNs in other Australian States or Territories. Activities will continue to strengthen relationships and activities with local GP Liaison units.

Organisational Roles and Responsibilities:

Wellbeing SA (SA Health)
Key partner; responsible for contract management; provides specific FTE to support service navigation, collaboration and engagement of local health clinicians, clinical leads, GP liaison units and Subject Matter Experts

Adelaide PHN
Key partner; responsible for ensuring needs of primary care across the metropolitan area are identified; provides specific FTE for operational coordination, clinical GP editors, program management and administration.
Collaboration with Adelaide Metropolitan GP Liaison Units and engaging local general practitioners in consultation processes and online pathway feedback.

Country SA PHN
Key partner; responsible for ensuring the expectations and needs of primary care across the country area are identified; provides specific FTE to support the HPSA for operational coordination, clinical GP editors, IT support and program management.
Collaboration and engagement with regional and remote SA general practitioners in online consultation processes and pathway feedback.

Activity Milestone Details/Duration

Activity Start Date

01/07/2021

Activity End Date

30/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

Yes

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

Yes

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

CF-COVID-PCS - 3000 - COVID3. Primary Health Support

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF-COVID-PCS

Activity Number *

3000

Activity Title *

COVID3. Primary Health Support

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Aim of the activity is to support primary health care providers located in the Adelaide PHN region to understand and actively participate in Australia's COVID-19 Vaccine and Treatment Strategy (Strategy)

Description of Activity *

Provide guidance and expert advice to General Practice Respiratory Clinics (GPRCs), General Practices, Aboriginal Community Controlled Health Services (ACCHs), residential aged care facilitates (RACF), disability accommodation facilities and governments on local needs and issues.

Coordinate vaccine rollout within RACFs and disability accommodation facilities to ensure vulnerable populations have timely and appropriate access to COVID vaccinations and supportive COVID services. .

Support vaccine delivery sites in their establishment and operation, including where appropriate, performing functions of assurance and assessment of suitability and ongoing quality control support; and Support vaccine delivery to be integrated within local health pathways to assist with the coordination of local COVID-19 primary care responses, including identification and assistance for GPRCs and General Practices interested in participating, and ensuring consistent communications to local communities.

Provide relevant training and information sessions to Primary Health Care providers to assist and support with understanding the COVID landscape and keep up to date with relevant clinical information and applicable policy changes.

Support primary healthcare providers with access to PPE to support infection control process and management of infection control within Primary Health Care.

Continue to develop, review, enhance and promote the use of Health Pathways SA as a supportive tool to assist primary health care providers to find appropriate care pathways and information related to all areas of COVID including vaccinations, testing, for COVID positive patient management and post COVID syndrome.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in an ever-changing health landscape.	109

Activity Demographics

Target Population Cohort

Aged Care, Disability Support services, other community members located with the APHN region

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

N/A

Collaboration

N/A

Activity Milestone Details/Duration

Activity Start Date

01/01/2021

Activity End Date

31/12/2022

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Extended from 30/06/2022

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

HSI - 2000 - HSI2. Get Screened and Get on with Living Campaign

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

2000

Activity Title *

HSI2. Get Screened and Get on with Living Campaign

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Short term:
• Increase awareness of the benefits of breast, bowel and cervical screening to the target population groups in South Australia
• Support primary health care services, including general practice, in their role to encourage the population to screen for cancer
• 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

Long Term:
• 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.

Description of Activity *

'Get Screened and Get on with Living' was a new collaborative approach to promoting cancer screening in SA, piloted in 2018-19. This activity was designed and funded between Adelaide PHN, Country SA PHN, Cancer Council SA and SA Health, to promote the three national cancer screening programs – breast, bowel, cervix in a combined message.

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.

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.
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.

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.
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.

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.
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.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2019/20-2021/22 - Update November 2020

Priorities

Priority	Page reference
GPH 2. Accessibility to and appropriateness of primary health care services, particularly for CALD and new & emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ & older people	85
GPH 11. 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.	85
IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people	92
IH-GPH4. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people.	92

Activity Demographics

Target Population Cohort

- Women aged 50-74 eligible for breast screening in the Adelaide PHN region
- Women aged 25-74 eligible for cervical screening in the Adelaide PHN region
- People aged 50-74 eligible for the National Bowel Cancer Screening program in the Adelaide PHN region

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Holdfast Bay	40301
Charles Sturt	40401
Onkaparinga	40304
Prospect - Walkerville	40106
Port Adelaide - East	40203
Mitcham	40303
Marion	40302
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

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.

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.

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.

Collaboration

The project is supported through an integrated approach in the local cancer screening sector, co-funded and designed.
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.
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.
SA Health State-wide Cancer Screening program attend and promote the campaign to LHNs and other stakeholder organisations.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2022

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2022

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

Yes

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

Yes

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

Consultation with Cancer Council and Local Health Network

HSI - 3000 - HSI3. Digital Health Support

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

3000

Activity Title *

HSI3. Digital Health Support

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Digital Health

Other Program Key Priority Area Description

Aim of Activity *

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 a range of other 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.

Description of Activity *

The Digital Health activity will provide the following:

Digital Health
• Increase the use of digital technology in the health care setting such as telehealth, secure messaging delivery, data extraction tools and ongoing support with clinical applications and templates.
• 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.
• 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.
• Increase the use of clinical audit tools in a health care setting to assist in analysis of patient cohorts to improve population health outcomes.
• Provide assistance and access to data extraction tools and importance of correct clinically coded records.
• Work with health care providers to increase their understanding and utilisation of secure messaging technologies to assist with timely and secure sharing of information between health care providers.
• 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.

My Health Record Support
• Continue to assist healthcare organisations to register and connect to the My Health Record.
• 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.
The Digital Health activity will provide the following:

Digital Health
• Increase the use of digital technology in the health care setting such as telehealth, secure messaging delivery, data extraction tools and ongoing support with clinical applications and templates.
• 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.
• 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.
• Increase the use of clinical audit tools in a health care setting to assist in analysis of patient cohorts to improve population health outcomes.
• Provide assistance and access to data extraction tools and importance of correct clinically coded records.
• Work with health care providers to increase their understanding and utilisation of secure messaging technologies to assist with timely and secure sharing of information between health care providers.
• 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.

My Health Record Support
• Continue to assist healthcare organisations to register and connect to the My Health Record.
• 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.
• 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.
• Continue to support primary health care providers to actively view and upload clinical documents to patients with an active My Health Record
• Continue to encourage and support active viewing and cross viewing of documents within patients My Health Record.
• Continue to support primary health care providers not registered to participate in the My Health Record to register and actively participate
• 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.
• Continue to provide support and information on the requirements of general practice to participate in the Practice Incentives Program (PIP) eHealth Incentive.

Electronic Therapeutic Guideline (eTG)
• eTG provides accurate, independent and practical treatment advice and resource for a wide range of clinical conditions. It includes explicit instructions for therapy, assisting practitioners in making decisions to ensure their patients receive optimum treatment.
• Primary care providers will be granted access to digital evidence-based resources that enable them better manage and prescribe treatments or medications particularly for patients with unique or complex conditions without the risk of adverse drug reactions or events.
• Encourages and supports a coordinated, consistent, and evidence-based approach towards better prescription decision making

and management across primary care providers within our region.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Primary health care providers have access to resources and support to improve digital health literacy	115
Primary health care providers are supported to adopt and fully implement digital health technologies	115
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	115
Primary care providers are supported to use digital health tools that improve safety and quality of care	115
Support primary health care providers to adopt and implement patient-centred models of care	109

Activity Demographics

Target Population Cohort

All health care providers and health care provider organisations working across all sectors of health care.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Holdfast Bay	40301
Charles Sturt	40401
Onkaparinga	40304
Prospect - Walkerville	40106
Port Adelaide - East	40203
Mitcham	40303
Marion	40302
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

Stakeholder engagement and consultation are currently ongoing with the following peak bodies;
• The Australian Digital Health Agency
• SA Health to support the increased usage of the My Health Record system across all SA Health sites.
• Outcome Services Survey - identify service and quality improvement gaps in PHN services and experience in interactions with other healthcare providers and local hospital services.
• 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.
• Membership Feedback
• Pen Computing Systems – implementation, roll out and ongoing support of the PenCS clinical audit tool to General Practices across the APHN region.

Collaboration

• 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.
• 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
• 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.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2023

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2023

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

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na
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HSI - 4000 - HSI4. System Integration and Stakeholder Engagement

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

4000

Activity Title *

HSI4. System Integration and Stakeholder Engagement

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

System Integration

Aim of Activity *

This activity aims to build upon existing engagement and collaboration initiatives with each Local Health Network, SA Health and primary health care services within the Adelaide PHN region to improve the experience and health outcomes for people accessing both hospital and primary health care services.

Description of Activity *

We will continue to design, plan and develop initiatives alongside our stakeholders, enabling collaborative and targeted initiatives that support system and sector integration, connectivity and collaboration and in turn enable person centred service delivery models.

The Adelaide PHN Integrated Care Framework guides the development and implementation of agreed shared initiatives. 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.

Initiatives may be focused on, but not limited to:
- Applying a quality improvement lens to clinical pathways and improved handover between hospital and primary care clinicians (namely general practitioners) with the aim of reducing Potentially Preventable Hospitalisations;

- Clinical Engagement including facilitating sessions that identify system issues and potential solution;
- Digital Health;
- Activities supported by the GP Integration Units;
- Priority Care Centres;
- Regional Mental Health and Suicide Prevention; and
- Application of or engagement with HealthPathways.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Integration, coordination and partnerships between primary and acute care to improve continuity of care and health outcomes	36
Enhance service and clinical integration between mental health care providers, and with State services	75
Primary health care providers have access to resources and support to improve digital health literacy	115
Primary health care providers are supported to adopt and fully implement digital health technologies	115
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	115
Primary care providers are supported to use digital health tools that improve safety and quality of care	115
Support practitioners to improve communication and build relationships with other health care providers	109
Support primary health care providers to adopt and implement patient-centred models of care	109
Integration and partnership between AOD and Primary Health Care services improves continuity of care and experiences	98

Activity Demographics

Target Population Cohort

Patients with chronic conditions who have frequent contact with hospital services

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Holdfast Bay	40301
Charles Sturt	40401
Onkaparinga	40304
Prospect - Walkerville	40106
Port Adelaide - East	40203
Mitcham	40303
Marion	40302
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

Multiple consultations have been undertaken with further sessions planned and underway to ensure that relevant groups are involved. These consultations have involved general practitioners and hospital consultants from each Local Health Network region with the aim of sharing perspective, understanding mutual issues and identification of solutions for an efficient and effective health system in metropolitan Adelaide.
This activity is informed by ongoing regular consultation through the existing Adelaide PHN stakeholders and through those of SA Health and the Local Health Networks. Further consultation will be undertaken with identified groups.

Collaboration

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.
Adelaide PHN:
• Integration Coordinators provide Project Management oversight to each of the shared priority activities.
• Advisory Councils are regularly consulted with and actively contribute to our Annual Need Assessment process to support the Adelaide PHN to address barriers and foster local connectivity. And provide intelligence on local health conditions and trend, and assist in identifying opportunities to support access to a timely and responsive health system.
Local Health Network:
• Local Health Network staff facilitate collaboration with relevant departments and units within Local Health Network services as per each shared priority activity, and
• facilitate the identification of potential future activities.
These activities are linked with the GP Unit in each Local Health Network which is comprised of:
• GP Liaison/Integration Officers (engaged through APHN)
• Nurse (employed by CALHN/NALHN/SALHN)
• Administrative support (employed by CALHN/NALHN/SALHN).

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2025

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2025

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

This activity is being co-designed alongside the LHNs, SA Health and primary health care services, and Adelaide PHN Advisory Councils.

HSI - 6000 - HSI6. Supporting our diverse Workforce

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

6000

Activity Title *

HSI6. Supporting our diverse Workforce

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

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.

Description of Activity *

The Adelaide PHN 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.
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.
Aspects of this activity will be integrated in the General Practice support activities.

The intended outcomes are:
• Increased participation of primary health care providers in workforce professional development
• Adoption and effective use of best practice approaches to improve clinical outcomes and delivery of care
• High satisfaction by attendees in professional development service delivery with learning outcomes consistently met
• Sharing of best practice business skills and leadership development

Associated Activities:
GPS1; A202222

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Primary health care workforce have knowledge, skills and capacity to safely support and meet the specific needs of LGBTIQA+ communities	36
People in the Adelaide PHN region receive holistic and person-centered care that is responsive to individual circumstances	37
Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.	45
Support practitioners to improve communication and build relationships with other health care providers	109
Support primary health care providers to adopt and implement patient-centred models of care	109
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	109
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in an ever-changing health landscape.	109
Older people requiring community and residential aged care services are supported by a skilled, motivated, and empowered workforce	58

Activity Demographics

Target Population Cohort

All Primary Health Care practitioners/providers/professionals

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

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.

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Holdfast Bay	40301
Charles Sturt	40401
Onkaparinga	40304
Prospect - Walkerville	40106
Port Adelaide - East	40203
Mitcham	40303
Marion	40302
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

Engagement with various Medical, Pharmacy, Allied Health Professional Associations/Peak Bodies; Feedback via previous continuing professional development service delivery providers; APHN membership groups.
Collect Learning Needs Assessment survey of primary health care providers.

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:
• Professional organisations representing general practice, GPs and other allied health – to ensure the mode of delivery and topic

content is relevant to various disciplines
• Local Health Networks (LHNs) – to assist with the development of appropriate clinical pathways and referral management guidelines
• Drug and Therapeutic Information Service (DATIS) – to assist with the latest updates on medication management for chronic conditions
• General Practices – for feedback on most relevant topics for professional development
• Pharmacies and Allied Health providers for feedback on most relevant topics for professional development
• 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
• Development of partnerships with health professional, allied health, pharmacy, dental, medical organisations and collaborative work including information sharing and networking.
• 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.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2025

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2025

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

na

Co-design or co-commissioning comments

na

HSI - 202209 - A202209 - Expand PHNs Data Capacity

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202209

Activity Title *

A202209 - Expand PHNs Data Capacity

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Digital Health

Other Program Key Priority Area Description

Aim of Activity *

To improve the quality and timeliness of data provided to general practices to enhance effectiveness of stakeholder engagement, inform quality improvement activities, and enable GPs to make evidence-based decisions to improve patient outcomes.

Description of Activity *

A dedicated Data Analyst resource will work with internal and external stakeholders (such as Practice Facilitators, Digital Health Officers, Strategy Engagement team, Clinical Councils and general practice representatives) to develop analytics and reporting tools that deliver meaningful insights from general practice data.

These resources will support general practices across our region to:
- identify quality improvement activities in relation to the collection and use of clinical data
- to better identify priority patient cohorts and support them to respond to the needs of their communities,
- to measure the impact and outcomes of the services they are providing to their patients, and
- understand and meaningfully use digital health systems in order to streamline the flow of relevant patient information, including across the local health provider community

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Primary health care providers have access to resources and support to improve digital health literacy	115
Primary health care providers are supported to adopt and fully implement digital health technologies	115
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	115
Primary care providers are supported to use digital health tools that improve safety and quality of care	115

Activity Demographics

Target Population Cohort

General practice

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Input and feedback will be sought from general practitioners, Clinical Council and Adelaide Regional GP Council throughout the development and testing phases.

Collaboration

Adelaide PHN has collaborated with other PHNs in the development of/ presentation of data

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Activity Milestone Details/Duration

Activity Start Date

01/07/2022

Activity End Date

30/06/2023

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

HSI - 202210 - A202210 - Dementia Consumer Pathway Resource

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202210

Activity Title *

A202210 - Dementia Consumer Pathway Resource

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

Support older people and their carers and families to understand and make informed choices about health and aged care services that may be of benefit to them during their dementia journey via enhanced usage of consumer-focused resources and dementia support pathways.

Description of Activity *

The Adelaide PHN will map, develop, review, maintain and enhance localised consumer resources that support older people and their carers and families.
The PHN will work with and engage with Dementia Australia, to identify locally appropriate support pathways and encourage better utilisation of existing resources and tools. If required, the APHN will tailor dementia support resources which detail the post-diagnostic care and psychosocial supports available for people living with dementia, and their carersand families, within their local area, including local, state and federal government, private sector, and non-government community-based support
Consumer resources will be embedded into new and existing Dementia Pathways of care published on the HealthPathways South Australia (HPSA) online platform.
APHN will promote and increase the awareness, engagement with, and utilisation of dementia support pathways and the relevant consumer resources to local health care practitioners across the Metropolitan Adelaide region via existing HealthPathways mechanisms.

Other activities to enhance familiarity of the resources may include:
• upskilling GPs and other health professionals on their value and utilisation, including use and access of the associated pathways
• linkage to primary care providers via APHN practice facilitator and targeted Quality Improvement activities
• key communication strategies and collaboration with APHN commissioned service providers. key stakeholders and primary care sector.
Dementia Australia will support the initiative by
• Consulting with people living with dementia, their carers and family members in relation to the development of consumer resources
• Providing advice on available consumer resources that might be tailored for use by PHNs

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
People at risk of developing or living with chronic or complex conditions receive timely and appropriate interventions, care, support and management	36
People in the Adelaide PHN region understand how to access a variety of primary care services when and where they need them	37
People in the Adelaide PHN region receive holistic and person-centered care that is responsive to individual circumstances	37
Primary care providers are supported to use digital health tools that improve safety and quality of care	115
Support primary health care providers to adopt and implement patient-centred models of care	109
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care.	58

Activity Demographics

Target Population Cohort

• People living with dementia, their carers, family and friends
• General Practitioners and other health professionals

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The Adelaide PHN will consult with Dementia Australia and other stakeholders to identify gaps and opportunities related to consumer resources awareness and utilisation.
Additional engagement and communication will take place according to the guiding principles set out in the HPSA Program Plan.
The sharing of ideas, actions and outcomes is encouraged to maximise opportunities for greater engagement and impact.

Collaboration

Adelaide PHN and Country SA PHN have agreed to work together to facilitate development, review, and maintenance of localised consumer resources that meet the need whole of state, as well as their unique regional populations.
Whilst each PHN is responsible for dissemination of communication materials through their own processes and systems; strategies, mechanisms and key messaging will be shared to ensure a level of consistency. Joint messaging may be considered on an as needs basis and agreed upon by both PHNs and any other relevant stakeholders involved at the time.
APHN HealthPathways Operational team will participate in Australian HealthPathways Community collaborative meetings to facilitate sharing of ideas and information to support consistency of best practice across PHN regions.
APHN will cross-collaborate across portfolios and service, related commissioned services providers and programs to enhance awareness and usage of the pathways and resources. In particular, HPSA will integrate with primary mental health service activities, APHN central referral unit and older persons and palliative care projects to ensure pathways and resources are being promoted and utilised.

Activity Milestone Details/Duration

Activity Start Date

01/01/2021

Activity End Date

30/06/2024

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

Yes

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

APHN and CSAPHN have agreed to work together according to the broader HPSA program governance framework, which provides a defined process for the proper flow of information to HPSA Project Partners as part of the operational governance of the HPSA Program ensuring appropriate review of issues (encountered or emerging) and ensures required approvals and direction are obtained.

HSI - 202211 - A202211 - HealthPathways Aged Care

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202211

Activity Title *

A202211 - HealthPathways Aged Care

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

This activity aims to address aged care needs assessment priorities through the enhancement of state-wide implementation of aged care pathways within the HealthPathways SA (HPSA) online portal. The portal supports consistent management of dementia and aged care related health conditions and improves the patient journey through our local health system. This activity aims to create, review and boost aged care and dementia referral pathway offerings.

Description of Activity *

HPSA provides General Practitioners (GPs) and other health professionals with access to evidence-based assessment, management and localised referral resources for specific health conditions. GPs and other health professionals across the health sectors collaborate on the development and implementation of locally agreed pathways to ensure patients receive the right care in the right place at the right time. (See A202225 - Health Pathways)
This activity is a collaborative partnership between Adelaide PHN and Country SA PHN working alongside Wellbeing SA to implement HealthPathways across South Australia,
looks to enhance consistent and timely diagnosis, care and management of older persons health related health conditions, increase awareness and utilisation of appropriate services and resources and improve the journey of older persons and their family and carer's through our local health system.
Broadly activities involve:

• creating, reviewing and enhancing aged care and dementia clinical, information and referral pathway on the HPSA platform.
• Identification of clinical priorities, service gaps and needs with the region associated to aged care, dementia and older persons health and related areas.

HealthPathways for Aged Care
Aged care referral pathways will support health professionals to provide advice, referrals and connections for Older South Australians into local health, support and aged care services. Pathway implementation will be based on the need of the South Australian community.
APHN will work to increase the awareness, engagement, and utilisation of aged care pathways by local health care practitioners (including GPs, allied health and practice staff) and engage local clinical practitioners, consumers and aged care stakeholders and experts in their development.
In accordance with the PHN aged care policy guidance provided by the Department, HPSA will:
• Develop and review aged care clinical and referral pathways relevant to the health needs of the PHN region - or as directed by the Department - for use by clinicians during consultation with patients, to support assessment and referral to local services and supports
HealthPathways for Dementia
Dementia pathways will support clinicians, primary care and the allied health workforce to link people living with mild cognitive impairment or dementia, and their carers to diagnostic and post-diagnostic services and supports so they can receive early intervention and live well in the community for longer.
Activity will be undertaken with input from Dementia Australia to ensure the pathways are both nationally consistent at a high level and reflective of individual services and supports within the Adelaide Metropolitan region. APHN will
• Develop dementia specific pathways for use by clinicians and other primary care providers during consultation with patients, to support assessment and referral to local services and supports. Where an existing dementia HealthPathway is in place, HPSA will review, and enhance the pathway to ensure it is comprehensive and reflects contemporary best practice care.
• Develop, review, maintain and enhance localised consumer resources that support older people and their carers and families to understand and make informed choices about health and aged care services that may be of benefit to them (see CF – HIS Dementia Consumer Pathway Resource).
HealthPathways SA (HPSA) agrees to deliver the following pathways yet to be localised to the South Australian context:
• Carer Stress and Support
• Behaviour and Psychological Symptoms of Dementia
• Delirium
• Before Residential Aged Care (Entering a Residential Aged Care Facility)
• Weight and Nutrition in Older Persons
• Depression in Older Persons
• Restrictive Practices
HealthPathways SA agrees to review the following pathways that have already been localised to the South Australian context:
• Cognitive Impairment and Dementia
• Dementia Management & Support
• Non-Acute Older Person's Health Assessment
• Falls Prevention Screening
• Medication Management Review
• Aged Care Support
• Frail but Stable Older Persons
• Unexpected Deterioration in an Older Person

This activity looks to be responsive to emerging national and local priorities as appropriate to facilitate access to up-to-date and accurate guidance and advice.

Engagement and communication will be a key activity. Both will take place according to the guiding principles set out in the HealthPathways SA Program Plan and associated Operational Plans .
Adelaide PHN will undertake engagement activities within the local region. The sharing of ideas, actions and outcomes with Country SA PHN and broader Australian PHN networks will be encouraged to maximise opportunities for greater engagement and impact.
APHN and CSAPHN will consider joint engagement strategies where identified as appropriate.
Whilst each PHN is responsible for dissemination of communication materials through their own processes and systems; strategies, mechanisms and messaging will be shared to ensure a level of consistency. Joint messaging may be considered on an as

needs basis and agreed upon by both PHNs and any other relevant stakeholders involved at the time.

Associated activities of HealthPathways Aged Care are:
• A202225 - HealthPathways South Australia
• A202210 - Dementia Consumer Pathway Resource

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
People at risk of developing or living with chronic or complex conditions receive timely and appropriate interventions, care, support and management	36
Enhance service and clinical integration between mental health care providers, and with State services	75
Ensure visibility of Adelaide PHN commissioned services and eligibility criteria to GPs, state, community services and to underserviced groups to enhance access	76
People in the Adelaide PHN region understand how to access a variety of primary care services when and where they need them	37
People in the Adelaide PHN region receive holistic and person-centered care that is responsive to individual circumstances	37
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	115
Primary care providers are supported to use digital health tools that improve safety and quality of care	115
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care.	58

Activity Demographics

Target Population Cohort

This activity is targeted towards the wide variety of health professionals and health care providers across the APHN region including, but not limited to; GPs and practice nurses, specialists, pharmacists, allied health and aged care professionals.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation occurs with existing Adelaide PHN commissioned service providers and membership groups. The HealthPathways process also includes targeted consultation as well as broad local consultation strategies with but not limited to State Health, Local Health Networks, General Practice, local primary care clinicians, public and private specialists, allied health professionals, aged care providers, consumer, and advocacy groups along with relevant peak organisations.
The HealthPathways SA Team and Steering Committee facilitates collaborative consultation mechanism with the activity partners and other stakeholders in the project.

Collaboration

This is a collaborative partnership activity with SA Health and CSAPHN and reflects HealthPathways activities undertaken by local health jurisdictions and PHNs in other Australian States or Territories. Activities will continue to strengthen relationships and activities with GP Liaison units.

Organisational Roles and Responsibilities
Wellbeing SA - Key partner; provides specific FTE to support service navigation, collaboration and engagement of local health clinicians, clinical leads, GP liaison units and Subject Matter Experts
Adelaide PHN - Key partner; responsible for ensuring needs of primary care across the metropolitan area are identified; provides specific FTE for operational coordination, clinical GP editors and program management and administration.
Collaboration with Adelaide Metropolitan GP Liaison Units, Residential Aged Care Facilities and engaging local general practitioners in consultation processes and online pathway feedback.
Country SA PHN - Key partner; responsible for ensuring the expectations and needs of primary care across the country SA area are identified; provides specific FTE to support the HealthPathways SA Team for operational coordination, clinical GP editors and program management.
Collaboration and engagement with regional and remote SA general practitioners in online consultation processes and pathway feedback.

Other keys stakeholders
• HealthPathways Community (Australasian network of HealthPathways jurisdictions)
• Streamliners Pty Limited
• Dementia Australia
• SA Health
• General Practice community
• Pharmacy and Allied health communities
• Residential Aged Care Facilities
• Domiciliary care providers

• In home care providers
• Council of the Ageing SA
• Veterans' health services
• Vulnerable population community organisations inc but not limited to
o Aboriginal community controlled aged care providers and elder support services
o Culturally and linguistically diverse specific aged care providers and support services
o LGBTQIA+ older persons support services
o Older persons mental health services

Activity Milestone Details/Duration

Activity Start Date

01/01/2021

Activity End Date

30/06/2024

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

Yes

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Consideration may be given to commissioned activities related to key deliverables such as consumer resources, education and engagement.

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

HSI - 202213 - A202213 - Research Collaboration - Adelaide PHN & Flinders University (Caring Futures Institute)

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202213

Activity Title *

A202213 - Research Collaboration - Adelaide PHN & Flinders University (Caring Futures Institute)

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

To develop a collaborative of academic excellence to build research capacity and capability and increase research performance within the Caring Futures Institute and Adelaide PHN and support joint research endeavours that respond to the research needs and priorities of Flinders University (under which the Caring Futures Institute sits) and Adelaide PHN.

Description of Activity *

The focus will be on improving the health of ageing Australians, coordinating care to prevent poor outcomes and incorporating personal experiences into decision making. The activity will be informed by an evidence-based implementation of Australia's Primary Health Care 10 Year Plan 2022-2032 across the Adelaide metropolitan region.
In addition, the activity will facilitate evaluation guided by implementation approaches to evaluate both outcomes for older people and changes of practice.
By focussing on building research capacity and capability it will support the translation of research into practice and ultimately improved health outcomes for older people.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care.	58
Older people requiring community and residential aged care services are supported by a skilled, motivated, and empowered workforce	58
Older people living in the community and residential aged care are supported by timely, accessible, coordinated primary care services in and out of hours.	58
Older people have access and support from palliative care services which address their needs, wishes and health care preferences.	58

Activity Demographics

Target Population Cohort

Older people

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Collaboration

This activity is a collaboration with the Caring Futures Institute and will develop and expand the translational research agenda.

The Professor in Healthy Ageing, Support and Care will play a key role in setting the strategic goals of the collaborative in consultation with the University, Caring Futures Institute and Adelaide PHN, in order to develop and expand the research program and reputation of both organisations at an international level.

Activity Milestone Details/Duration

Activity Start Date

21/04/2022

Activity End Date

04/04/2024

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

Yes

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

The 2 organisations co-designed this activity.

HSI - 202219 - A202219 - Northern Health and Wellbeing Partnership

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202219

Activity Title *

A202219 - Northern Health and Wellbeing Partnership

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The Northern Adelaide Health and Wellbeing Partnership brings together a diverse group of partners who have identified alignment to a collective vision to create a flourishing and vibrant health and wellbeing community for Northern Adelaide (the North) that together can attract and increase research, education, health and wellbeing opportunities, as well as economic benefit through employment and future growth.

Description of Activity *

The role of Adelaide PHN in this partnership will be to provide timely advice, resources, identify opportunities for service integration and advocacy, to support the achievement of the health and social priorities of the partnership.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Children, young people and their families have timely access to early intervention, prevention and support services	36
People at risk of developing or living with chronic or complex conditions receive timely and appropriate interventions, care, support and management	36
Integration, coordination and partnerships between primary and acute care to improve continuity of care and health outcomes	36
People in the Adelaide PHN region understand how to access a variety of primary care services when and where they need them	37
People in the Adelaide PHN region receive holistic and person-centered care that is responsive to individual circumstances	37

Activity Demographics

Target Population Cohort

People living in the northern region of Adelaide

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Port Adelaide - East	40203
Port Adelaide - West	40402
Playford	40202
Salisbury	40204

Activity Consultation and Collaboration

Consultation

The Director of the partnership will consult with all appropriate stakeholders to:
1. Develop a Partnership Identity
2. Create a Partnership Charter
3. Produce an Intro/FAQs document to aid initial conversations
4. Develop an Advocacy Platform
5. Develop an approach to state and federal governments (linked to advocacy platform)

Collaboration

Adelaide PHN is one of 18 initial organisations in the partnership. The partnership will bring together the Local Health Network, other state and federal government agencies such as Wellbeing SA, non-government organisations including Adelaide PHN, private sector industries, the university and higher education sectors, and three local government councils. As the partnership evolves other agencies, businesses and sectors will join the initial 18 partners involved.

Activity Milestone Details/Duration

Activity Start Date

01/07/2022

Activity End Date

30/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Partnership Agreement Strategic enablers – key deliverables
An initial 6 month project plan outlining key priority areas, enablers and deliverables will be developed and progressed with input from all the Partners via small working groups, round tables and the partnership Executive Steering Committee, coordinated by the Director of the partnership.
Further project plans will be informed by and build on progress of the previous plans and activity.

HSI - 202220 - A202220 - Partnership in Medical Internship Program

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202220

Activity Title *

A202220 - Partnership in Medical Internship Program

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Aboriginal and Torres Strait Islander Health

Other Program Key Priority Area Description

Aim of Activity *

This activity aims to attract and increase the retention rates of medical officers in Aboriginal and/or Torres Strait Islander Health within the Northern Adelaide region through the co-designing of a Medical Internship program between Adelaide PHN (APHN), Northern Adelaide Local Health Network (NALHN), and Watto Purrunna Aboriginal Health Service.

Description of Activity *

Within the NALHN community, there are a high number of Aboriginal and/or Torres Strait Islander peoples, many of whom are from rural and remote Aboriginal communities with complex, chronic health conditions and are patients of the local health services. There is also currently a significant shortage of Doctors in primary health care in Adelaide's North.
The establishment of a Medical Internship Program between Watto Purrunna Aboriginal Primary Health Service and NALHN will provide a culturally comprehensive and safe environment to the medical interns to enhance their learnings of Aboriginal and/or Torres Strait Islander Health. The expectation is that program would not only attract medical officers to the region, but potentially increase retention rates of medical officers in Aboriginal and/or Torres Strait Islander Health.

Watto Purrunna's preliminary research shows that NALHN is likely to develop the first Medical Education Program in Australia to implement a placement of this nature. Early introduction of the vital skills that doctors require to provide culturally comprehensive and safe care is expected to greatly improve their ability to integrate these skills into clinical practice.

Adelaide PHN will assist in the operational coordination and evaluation of the effectiveness of the education program.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.	45
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	109

Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

This activity will be developed and established through consultation between APHN, NALHN and Watto Purrunna.

Collaboration

Watto Purrunna has four clinical sites across the Central and Northern Adelaide Local Health Network catchments, including

Kanggawodli, which serves as a residential facility for patients from rural and remote communities requiring stay and complex medical treatments.
APHN will co-invest 50% of the program cost to co-design a Medical Education Program that facilitates five (5) intern Medical Officers for ten (10) week placements in 2023 that embeds comprehensive education in Aboriginal and/or Torres Strait Islander Health.

Activity Milestone Details/Duration

Activity Start Date

01/08/2022

Activity End Date

30/06/2023

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

Yes

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Watto Purrunna Aboriginal Primary Health Service is seeking to be incorporated into the Medical Internship Program within NALHN in early 2023. This will be achieved through a co-funded Medical Education Program between APHN and Watto Purrunna.

HSI - 202222 - A202222 - Support to General Practices

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202222

Activity Title *

A202222 - Support to General Practices

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

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.
Support primary health care providers to increase understanding and/or utilisation of digital health systems, including how digital platforms can support patient care.

Description of Activity *

This activity has six elements:
• Accreditation support – Support General Practices to either become an accredited practice 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.

• 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 areas for population health improvements. Advise on how implementing digital systems will improve access to information. Support and guide where appropriate decision making and provide relevant training, policy and procedures templates.

• 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 gauging 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 gauging 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.

• 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, resources and materials that support this.

• 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.

• 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 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 e-Referral for patients. Provide information on digital initiatives, changes and improvements via APHN newsletters and direct correspondence with healthcare providers.

Previously undertaken under activity GPS1.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Primary health care providers have access to resources and support to improve digital health literacy	115
Primary health care providers are supported to adopt and fully implement digital health technologies	115
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	115
Primary care providers are supported to use digital health tools that improve safety and quality of care	115
Support practitioners to improve communication and build relationships with other health care providers	109
Support primary health care providers to adopt and implement patient-centred models of care	109
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	109
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in an ever-changing health landscape.	109

Activity Demographics

Target Population Cohort

General practitioners in APHN region

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

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:

- general practice, GPs and other allied health
- Local Health Networks (LHNs) where relevant and appropriate – to assist with the development of appropriate clinical pathways and referral management guidelines
- Pharmacies and Allied Health providers to support providers with relevant resources and information.
- Other relevant health professional, allied health, pharmacy, dental, medical organisations.

Activity Milestone Details/Duration

Activity Start Date

01/07/2021

Activity End Date

30/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

HSI - 202224 - A202224 - Aboriginal Health Needs Assessment

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202224

Activity Title *

A202224 - Aboriginal Health Needs Assessment

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Aboriginal and Torres Strait Islander Health

Other Program Key Priority Area Description

Aim of Activity *

To deliver an Aboriginal and Torres Strait Islander Health Needs Assessment 2022 that is academically constructed but Indigenous led and governed to ensure appropriate Indigenous Data Sovereignty and identifies protective factors from cultural determinants of Aboriginal and Torres Strait Islander Health to avoid further marginalisation and deficit discourse.

Description of Activity *

Data collection on population, risk factors, chronic conditions, lifestyle and family, aged care and palliative, digital health and workforce. Additional data considered important for assessing Aboriginal and Torres Strait Islander health needs will be included, if available including sustained grief and loss, health literacy and social and cultural determinants of health such as incarceration of Aboriginal women; home ownership (wealth creation); long-term unemployment and homelessness. Data collection of protective factors for health and wellbeing will provide valuable information for design of programs (eg, cultural, family, social etc factors).

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Aboriginal and Torres Strait Islander people can access timely, culturally safe and appropriate primary mental health care services	75
Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.	45
Awareness of timely access to appropriate services (including after-hours services) for Aboriginal and Torres Strait Islander people	45
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate AOD treatment services	45
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	109

Activity Demographics

Target Population Cohort

Aboriginal and Torres Strait Islander populations

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The Needs Assessment process will be inclusive of consultation with Aboriginal community and the PHN Aboriginal Community

Advisory Council. Surveys/interviews at the Adelaide PHN and commissioned organisations of both cultural responsiveness as a health organisation (governance) as well as a health service (quality of care and utilisation) will be undertaken.

Collaboration

An academic epidemiologist will be engaged to work with the research team, the PHN, and the PHN Aboriginal Community Advisory Council to produce the 2022 report. Where surveys and consultations are proposed to collect qualitative data, the epidemiologist will work with the PHN and Advisory Council to access survey/interview participants and collect and analyse the data. Analysis and interpretation will be done collectively.

Activity Milestone Details/Duration

Activity Start Date

23/05/2022

Activity End Date

30/09/2022

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments

CF - 202226 - A202226 - Paediatric Partnership Program

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

202226

Activity Title *

A202226 - Paediatric Partnership Program

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The Program contributes to the provision of quality, timely and responsive paediatric services, and care coordination supports for children and young people aged 0-18 years across metropolitan Adelaide.
The aims of the Project are:
1. Reduce the number of avoidable presentations in public hospital emergency departments, particularly in the after-hours period;
2. Reduce the number of unnecessary referrals to public hospital outpatient clinics;
3. Improve access to quality, timely and responsive care for children and young people aged 0 -18 years; and
4. Improve patient and family/carer health care experiences.

Description of Activity *

This activity is a collaborative partnership model across metropolitan Adelaide. The activity aims to reduce the avoidable presentations in public hospital Emergency Departments (ED) particularly in the afterhours period and unnecessary referrals to the Hospital Paediatric Outpatients clinics, and Paediatric Outpatient Waiting Lists. This is achieved by working closely with Local Health Networks, and a group of private Paediatricians. APHN commissions two Care Coordination roles across the projects to assist with the management of Paediatrics wait lists.

Previously called AH5 Northern and Southern Paediatric Partnership Program.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
Children, young people and their families have timely access to early intervention, prevention and support services	36
Integration, coordination and partnerships between primary and acute care to improve continuity of care and health outcomes	36

Activity Demographics

Target Population Cohort

Children and young people (aged 1-18 years of age) with chronic conditions who are frequent attendees at the hospital and their general practitioners.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Campbelltown (SA)	40104
Unley	40107
Holdfast Bay	40301
Charles Sturt	40401
Onkaparinga	40304
Prospect - Walkerville	40106
Port Adelaide - East	40203
Mitcham	40303
Marion	40302
Norwood - Payneham - St Peters	40105
Port Adelaide - West	40402
West Torrens	40403
Tea Tree Gully	40205
Playford	40202
Salisbury	40204
Adelaide City	40101
Burnside	40103

Activity Consultation and Collaboration

Consultation

• This activity was established in consultation with general practitioners and clinicians and administrative staff from NALHN and WCHN
• This activity is governed by Steering Groups, involving participants from partnered organisations to oversee the performance monitoring and evaluation functions of the unit.

Collaboration

This activity is jointly implemented in collaboration with Local Health Networks, and private paediatrics provider.
• Adelaide PHN: Provides funding for the project and coordination of the partners, facilitates communication, provides secretariat for Steering Group meetings.
• Private Paediatrics Provider: Delivers clinical services and care coordination of referred patients.
• Local Health Network(s)/Non-For-Profit partners: Refers appropriate children into the service.

Activity Milestone Details/Duration

Activity Start Date

01/07/2023

Activity End Date

30/06/2025

Service Delivery Start Date

July 2023

Service Delivery End Date

June 2025

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

n/a

Co-design or co-commissioning comments

n/a

COVID-GPLRC - 1000 - COVID1. Respiratory Clinics

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

COVID-GPLRC

Activity Number *

1000

Activity Title *

COVID1. Respiratory Clinics

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The aim of the activity is to ensure that community members located in the Adelaide PHN region have access to appropriately qualified healthcare professionals and services that understand COVID19 management and have the infrastructure and appropriate training in place to assess, test and/or support COVID positive patients.

Description of Activity *

Adelaide PHN will support the Commonwealth funded GP Respiratory clinics (GPRCs) to provide appropriate services/assessment and clinical management of patients either with suspected COVID and/or are COVID positive

Support will be provided to the GPRCs in relation to PPE, resources, infrastructure and other supportive mechanisms that are needed to ensure an appropriate service

Primary Care providers will be provided relevant information to support patients to access a GPRC.

Continued promotion of GPRCs through Social Media channels to raise awareness of the service by community members.

Provide ongoing support for community members to access appropriate services including home visits for COVID vaccinations,

supporting access and booking of appointments, providing relevant information and any other information and/or support required to ensure community members are well supported to access COVID relevant services

GPRCs will also provide COVID vaccinations through their Commonwealth Vaccination Clinics, the PHN will continue to support the ongoing roll out of the vaccination program by providing healthcare professionals with appropriate information, supportive clinical materials and training and supportive resource for patients to ensure they are appropriately informed.

Implement dedicated vaccination clinics to support identified health workforce that require vaccination specifically related to Government implemented mandates for vaccinations. Additionally implement dedicated clinics that support vulnerable populations (ATSI, CALD, Non-Medicare, homelessness etc.) to ensure that those in the community who are most vulnerable have access to COVID vaccinations and appropriate services.

Health Pathways SA will to be utilised to support Primary HealthCare providers to assist understanding of pathways available that support COVID care for community.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2022/23-2024/25

Priorities

Priority	Page reference
People in the Adelaide PHN region understand how to access a variety of primary care services when and where they need them	37
People in the Adelaide PHN have awareness of and timely access to preventative and early intervention services	37
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in an ever-changing health landscape.	109

Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Collaboration

Activity Milestone Details/Duration

Activity Start Date

01/01/2021

Activity End Date

30/09/2022

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments