



Australian Government
Department of Health



Activity Work Plan 2018-2019:

Core Funding

General Practice Support Funding

After Hours Funding

Adelaide PHN

Please follow the below steps (and the instruction sheet) for completing your Activity Work Plan (AWP) template for 2018-19:

1. **Core Operational and Flexible Funding** 2018-2019 has three parts:
 - a) Provide a link to the strategic vision published on your website.
 - b) Complete the table of planned activities funded by the *Core Flexible Funding Stream* under the Schedule – Primary Health Networks Core Funding (including description of any Health Systems Improvement (HSI) activity to support delivery of commissioned activity).
 - c) Complete the table of planned activities funded by the *Core Operational Funding Stream: HSI*¹ under the Schedule – Primary Health Networks Core Funding and planned activities under the Schedule – **General Practice Support Funding**².
2. Attach indicative Budget for Core Operational and Flexible Funding Streams for 2018-2019 using the template provided.
3. Attach the indicative Budget for General Practice Support for 2018-19 using the template provided.

¹ HSI Funding is provided to enable PHNs to undertake a broad range of activities to assist the integration and coordination of health services in their regions, including through population health planning, system integration, stakeholder engagement and support to general practice. HSI activities will also support the PHN in commissioning of health services in its region.

² Planned activities under the Schedule - General Practice Support Funding have been combined with the HSI activities to lessen the reporting burden on PHNs.

4. **After Hours Primary Health Care Funding** 2018-2019 has two parts:
 - a) Provide strategic vision for how your PHN aims to achieve the After Hours key objectives.
 - b) Complete the table of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Health Care Funding.
5. Attach the indicative Budget for After Hours Primary Health Care for 2018-2019 using the template provided.

This Activity Work Plan has been endorsed by the CEO.

Revised version submitted on 27 September 2018.

Overview

The key objectives of Primary Health Networks (PHN) are:

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care in the right place at the right time.

This Activity Work Plan covers the period from 1 July 2018 to 30 June 2019.

1. (a) Strategic Vision for Adelaide PHN (APHN)

Adelaide PHN (APHN) strategic vision and objectives are summarised below and the detailed framework and plan can be found on our website [here](#).

APHN Vision (our aspirations for the future)

Connecting you to health

APHN Purpose (our reason for existence)

Facilitating a collaborative and responsive health care system for metropolitan Adelaide.

The key objectives of (Primary Health Networks) are to:

1. Increase the efficiency of Health Services for patients, particularly those at risk of poor health outcomes, and
2. Improve the coordination of care to ensure patients receive the right care, in the right place, at the right time.

Our strategic objectives are:

Strategy 1

Support primary health care providers to deliver quality services, build capacity, resilience and sustainability in service provision that best responds to identified needs. (*Commonwealth determined PHN objective – right care, right place, right time*)

Strategy 2

Develop, advance and support system wide approaches and activities to achieve improvement in the patient experience of primary health, with a particular focus on complex and chronic conditions. (*Commonwealth determined PHN objective*)

Strategy 3

Have a sound understanding of the health needs of our communities, utilising appropriately sourced data and research, providing effective analysis and review.

Strategy 4

Innovating and creating potential solutions that meet community need, with a particular focus on the 'vulnerable' and 'disadvantaged.'

Strategy 5

Commission services to communities that are high quality, efficient and effective, delivered with attention to the need for equity.

Strategy 6

Be an efficient and effective organisation with appropriate systems designed to ensure effective corporate and clinical governance, community and clinical engagement while managing cost, human resources and capital finance.

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2. (a) Planned PHN activities – Core Flexible Funding Stream 2018-19

The table contains reference to the Adelaide PHN membership identified themes which together with the national and our local priorities inform the strategic vision.

CF 1.1 Champion Nurse Immunisation Program

Proposed Activities – CF 1.1 Champion Nurse Immunisation Program	
Activity Title / Reference (e.g. CF 1)	CF 1.1 Champion Nurse Immunisation Program (CNIP)
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Select one of the following: Other (please provide details) If Other (please provide details): Immunisation, Aboriginal and Torres Strait Islander Health, Culturally & linguistically diverse communities, Children & Youth
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	1. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non-Aboriginal and Torres Strait Islander children 3. The CALD community are disproportionally affected by Hepatitis B 5. Identified areas of the Adelaide PHN (APHN) region have childhood immunisation rates below the national average 24. Prevention and early intervention strategies for childhood and youth health conditions
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • Provide equitable and easy access to primary health services for Aboriginal and Torres Strait Islander communities • Provide timely, early and equitable access to appropriate services
Aim of Activity	The Champion Nurse Immunisation Program (CNIP) is one of five elements of the SA PHN Immunisation Hub program. The CNIP commissions specialist nurses to provide immunisation program support and education to providers, and support and information to the community. They utilise their specialised skills and experience to identify barriers to vaccine uptake, address vaccine hesitancy within their local region and promote and advocate for immunisation within the community and at local community events. Additionally, this activity includes key collaboration and

	integration with SA Health in promoting and incentivising the uptake of Meningococcal B vaccines in the 12 months to 4-year age group.
Description of Activity	<p>The currently commissioned Champion Nurse Immunisation Program (CNIP), will engage specialist nurses to provide:</p> <ul style="list-style-type: none"> • 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 <p>With practice-based support available to providers and expert immunisation nurses accessible to communities, it is anticipated increased immunisation program awareness will lead to improved immunisation coverage. The program will be evaluated to determine its success and there is possibility for its expansion into rural regions.</p>
Target population cohort	Immunisation providers, community members and under-immunised children
Consultation - HSI Component	<ul style="list-style-type: none"> • 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 cross Metropolitan Adelaide. This then provided the priority localities for the Champion Nurse Immunisation Program. • The South Australian Immunisation Provider Network (IPN) are consulted at their regular meetings.
Collaboration - HSI Component	<ul style="list-style-type: none"> • 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.

	<ul style="list-style-type: none"> The organisation commissioned to deliver the Champion Immunisation Nurse project – this co-designed activity will ensure all key elements of the Champion Immunisation Nurse project are undertaken in a timely manner and objectives met.
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	Currently until June 2019
Coverage	Entire APHN region
Commissioning method (if known)	Open approach to market; Expression of Interest; Commissioned in whole.
Decommissioning	NA

CF 2.1 Adelaide Refugees and New Arrivals Project (ARANAP)

Proposed Activities – CF 2.1 Adelaide Refugees and New Arrivals Project (ARANAP)	
Activity Title / Reference (e.g. CF 1)	CF2.1 Adelaide Refugees and New Arrivals Project (previously known as NP2.1 <i>Culturally and Linguistically Diverse (CALD) and New Emerging Communities Health Project</i>)
Existing, Modified, or New Activity	Modified Activity (previously known as NP2.1)
Program Key Priority Area	Select one of the following: Other (please provide details) If Other (please provide details): Culturally & linguistically diverse communities
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>3. The CALD community are disproportionately affected by Hepatitis B</p> <p>4. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people.</p> <p>16. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</p> <p>17. Lack of easily understood and accessible referral pathways across systems and settings.</p> <p>19. Lack of community awareness about existing health care services for different population groups, consumers and providers.</p> <p>21. Need to improve provision of education to consumers and professionals across the health sector to encourage the take up and application of preventative health measures.</p> <p>22. Need to improve the aptitude/attitude and consistency of empathetic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>27. Awareness and timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</p> <p>28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>

<p><i>APHN Membership Identified Themes</i> (Please refer to our Strategic Plan available on our website)</p>	<ul style="list-style-type: none"> • <i>Provide timely, early and equitable access to appropriate services</i> • <i>Improve health literacy and education for consumers and primary health care providers</i>
<p>Aim of Activity</p>	<ol style="list-style-type: none"> 1. Primary health care providers, including General Practice, have the support, training and capacity to deliver culturally safe and culturally appropriate services to Refugees and New Arrivals. 2. Connect individuals and communities to relevant health care services (including other APHN commissioned services) to enable positive engagement with the health system.
<p>Description of Activity</p>	<p>Refugee and New Arrival Communities have ongoing challenges in accessing appropriate primary health care services in the APHN region.</p> <p>The health project will address access to appropriate primary health care for Refugee and New Arrival Communities by:</p> <p>Supporting refugee and new arrivals to access appropriate and timely health care services</p> <ul style="list-style-type: none"> ○ Individuals and relevant communities are supported and enabled to make informed decisions about their health and health care ○ Supports for individuals to access care in a way that is culturally appropriate. ○ Community information and education is provided in culturally safe and appropriate ways, including multiple format and multiple languages <p>Improving the capacity of mainstream primary health care services, including general practice to deliver culturally appropriate services to refugee and new arrival communities</p> <ul style="list-style-type: none"> ○ Identification and establishment of refugee Ready primary health care services ○ Dedicated support and training for Refugee Ready primary health care services ○ Facilitated access to tools, resources, and opportunities for other primary health care services to increase capacity and work towards being Refugee Ready ○ Supported opportunities for service providers and other stakeholders to share learnings and develop formalised partnership and referral pathways

	<p>Improving system integration of primary health care services for refugees and new arrivals</p> <ul style="list-style-type: none"> ○ Identifying and implementing best practice approaches and/or pathways for refugees and new arrivals across the spectrum of health care providers ○ Facilitate, support and advocate for collaboration, coordination and integration, including information sharing and management <p>The project will support the delivery of a range of services and activities to be commissioned across the PHC system to meet the community needs, as identified through the APHN baseline needs assessment. A model of care which clearly articulates the scope of work being undertaken by the PHN is under development and will support the commissioning approach for the project.</p> <p>The APHN's role will be to ensure all components of the model are connected, integrated and promoted to community, service providers and the broader primary health care system.</p> <p>Additionally, to ensure a multi-pronged approach, refugee and new arrival Communities considerations will also be supported and embedded in other activities such as immunisation, education and training. The APHN strives to be culturally safe and culturally appropriate in all activities undertaken.</p>
Target population cohort	Refugee and New Arrival Communities
Consultation - HSI Component	<p>The following activities outlines the stakeholder engagement strategy undertaken to date by the Adelaide PHN in the development of the refugee and new arrival program.</p> <p>Environmental Scan</p> <p>An environmental scan has been conducted to help inform the design of the program. The environmental scan considered a range of data sources including the Adelaide PHN Baseline Needs Assessment, models and service being delivered across Australia (including other PHNs), previously commissioned services, and current research on best practice models.</p> <p>Sector Consultation</p> <p>To ensure input and advice from the sector, the Adelaide PHN held individual meetings with key stakeholders in the multicultural sector.</p>

The Adelaide PHN also facilitated a workshop with key stakeholders which focused on outcomes and objectives the proposed program model should achieve and address.

Request for Proposal

Based on the findings from the environmental scan and consultation, the Adelaide PHN developed a service model and undertook a formal Request For Proposal (RFP) process to find suitable providers.

The RFP was open to the public from 21 April 2017 and closed 18 May 2017. While the Adelaide PHN received many applications, the Adelaide PHN were unable to confidently move to contract with any provider. The assessment process found that no single provider or collection of providers would address the fragmentation or poor communication as identified in the sector consultation.

In response, the Adelaide PHN finalised that RFP process and made the decision to hold a workshop to further discuss integration and collaboration across streams and activities, thus co-designing a model before moving to contractual arrangements.

ARANAP Co-Design Workshop

The ARANAP Co-Design Workshop provided an opportunity for participants to have shared input, understanding and ownership of a collaborative model of care which allows cross organisational sharing of skills, knowledge and resources, that is efficient, cost effective and sustainable.

The intention of the workshop was not only to support the development of a second phase of commissioning, but also to understand the broader, strategic work which could be accomplished collaboratively.

Engagement and consultation has occurred with key stakeholders working with CALD and emerging communities including:

- Adelaide City General Practice
- Australia Migrant Resource Centre
- Australian Refugee Association
- Community Access and Services South Australia (CASSA)
- Federation off Ethnic Communities Council Australia (FECCA)
- Life Without Barriers

	<ul style="list-style-type: none"> • Migrant Health Services • Multicultural Communities Council • Northern Health Network • Prospect Day/Night Clinic • Relationships Australia • SHINE SA • Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) • Welcome to Australia <p>Through APHN engagement with these organisations identified that refugees and new arrival communities have greater challenges in accessing appropriate primary health care services. The information gathered identified that the following areas require addressing:</p> <p>health literacy for refugees and new arrivals to make informed decisions about their health and health care</p> <ul style="list-style-type: none"> ○ Advocacy and cross-cultural support to access and navigate the health system ○ Accessible information and education for individuals and community groups to make informed decisions about their health and health care <p>capacity building for primary health workers supporting the health of refugees and new arrivals</p> <ul style="list-style-type: none"> ○ Quality education, resources and tools for the workforce to increase cultural competency and refugee competency across the Adelaide primary health care system <p>system integration of primary health care services for refugees and new arrivals Collaboration, integration between and within services, sectors and agencies to enable quality health care for refugees and new arrivals</p>
Collaboration - HSI Component	<ul style="list-style-type: none"> • Collaborate with general practices in target areas to increase their knowledge and capacity to provide culturally appropriate services to refugee and new arrival communities. • Collaborate with Local Health Networks (LHNs) to coordinate and support referral pathways of identified population groups and or those with health condition(s) presenting at Emergency Departments and discharge summaries (after hospitalisation) in target areas.

	<ul style="list-style-type: none"> • Collaborate with pharmacies and allied health services in target areas to support general practices and patients in managing health condition(s). • Collaborate with relevant NGOs to provide additional support, educational and or promotional services. • Establish a network of appropriate agencies, organisations and community groups to support and guide the delivery of this activity • Collaborate with SA Health to ensure the sector is provided with information and resources to assist their work with refugees and new arrivals - as recommended by the Settlement Services Advisory Council for PHNs • Undertake effective needs analysis with refugee communities to ensure targeted support for new arrivals – as recommended by the Settlement Services Advisory Council for PHNs <p>Establish a Reference Group, consisting of key stakeholders including SA health and peak bodies, to oversee integration across sectors and to monitor and evaluate the implementation of a collaborative approach.</p>
HSI Component – Other	N/A
Indigenous Specific	No
Duration	The APHN issued an Approach To Market (ATM) September 2017 seeking organisation(s) to provide the ARANAP service model for 12 months from March 2018 to February 2019.
Coverage	Entire APHN region with specific focus on areas of high refugee and new arrival settlement in the north, south and central West of our region
Commissioning method (if known)	<p>Phase 1: Open approach to market; request for proposal</p> <p>Phase 2: Targeted approach to market; service specifications</p> <p>Australian Refugee Association (ARA) and Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) has been contracted for a 12-month period to deliver on key objectives/outcomes of the project.</p>
Decommissioning	N/A

CF 3.1 Adelaide Respiratory Health Project

Proposed Activities – CF 3.1 Adelaide Respiratory Health Project	
Activity Title / Reference (e.g. CF 1)	CF3.1 Adelaide Respiratory Health Project
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details): Aboriginal Health, Aged Care, Digital Health, Children & Youth, Disability, Palliative Care
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.</p> <p>6. Selected areas of the APHN region have high rates of smoking which correlates with areas of high prevalence of COPD.</p> <p>13. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis).</p> <p>27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</p> <p>28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • Provide equitable and easy access to primary health services for Aboriginal and Torres Strait Islander communities • Provide timely, early and equitable access to appropriate services • Improve care coordination, integration and navigation of the primary health care sector
Aim of Activity	1. Build the capacity of participating GPs and Pharmacies to deliver evidence based and best practice COPD and asthma care to the community;

	<p>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;</p> <p>3. Develop resources to facilitate the successful replication of the project in additional settings.</p>
Description of Activity	<p>The Adelaide Respiratory Health Project (ARHP) will 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 will focus on interventions which support people living with COPD and/or Asthma across the 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.</p> <p>The results of this activity will aim to improve collaborative working across sectors (with particular focus on clinical handover and shared ways of working); Implementation of evidence best practice models that are practice and patient centred (such as Asthma/COPD action plans); increase the availability, efficiency and effectiveness of respiratory health care and increasing workforce capacity and capability.</p>
Target population cohort	<p>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).</p>
Consultation - HSI Component	<p>In 2013 The Northern Adelaide Medicare Local was successful in securing grant funding through the Australian National Health Prevention Agency (ANPHA) to undertake an 18-month project (2013/15) working in partnership 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]. The Northern Respiratory Project (NRP) focused on an integrated approach to respiratory health in northern Adelaide and aimed to raise community awareness of the relationship between smoking rates and respiratory conditions.</p>

	<p>Adelaide Primary Health Network (APHN) continued to fund the project as a transition activity during 2015/16. The project was re-named the Adelaide Respiratory Project (ARP) and expanded to include all of metropolitan Adelaide - the focus and partnership arrangements remained the same.</p> <p>Learnings from evaluation of stakeholder feedback from both the NRP and ARP highlighted the benefit of organisations working collaboratively in targeted populations and areas of need and this approach has informed the development of the service model for the ARHP.</p> <p>A workshop was undertaken with members from the steering group involved in previous projects to determine key learning and issues encountered. The findings from this workshop assisted in refining the scope of the project.</p>
Collaboration - HSI Component	<p>Consistent with the co design concept the actual detailed role of each party will be determined by the ATM and the resultant co design process with each of the stakeholders.</p> <ul style="list-style-type: none"> • Ongoing collaboration with Asthma SA will continue to raise community awareness and support primary health care practitioners (especially GPs) with Asthma resources available to assist with management of the condition. • Ongoing collaboration with Lung Foundation Australia will continue support primary health care practitioners (especially GPs) with COPD resources available to assist with management of the condition. • Ongoing collaboration with Pharmaceutical Society of Australia [SA/NT Branch] to support increased interventions and management at the pharmacy level to support smoking cessation and patient medication compliance. • Ongoing collaboration with Cancer Council [Quitline] to support the community and primary health care practitioners (especially GPs) with the increasing referrals to Quitline and other smoking cessation resources and programs. • Continue to collaborate with Local Health Networks across metropolitan Adelaide to assist in consistent, improved clinical pathways for appropriate patient management of respiratory conditions. <p>All relevant stakeholders will be invited to provide representation on the project working group, where appropriate.</p>
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people

Duration	The APHN issued an Approach To Market (ATM) April 2017 seeking an organisation(s) to provide the ARHP service model for 18 months from November 2017 to May 2019.
Coverage	Preference will be given to services that support residents of the Local Government Areas of Playford, Salisbury and Onkaparinga.
Commissioning method (if known)	Open approach to market; request for proposal Asthma Australia has been contracted for an 18-month period to deliver on the key objectives/outcomes of the project in conjunction with Lung Foundation Australia.
Decommissioning	N/A

CF 4.1 Care Connections Program

Proposed Activities – CF 4.1 Care Connections	
Activity Title / Reference (e.g. CF 1)	CF 4.1 Care Connections
Existing, Modified, or New Activity	Modified Activity
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details): Integrated Care, Chronic Condition Management, Health Workforce
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.</p> <p>4. Accessibility to and appropriateness of primary health care services, particularly for CALD and new emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people.</p> <p>7. Selected areas of the APHN region have high rates of obesity and overweight and correlate with areas of low physical activity and poor nutrition.</p> <p>8. Selected APHN LGAs have higher rates of a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease, musculoskeletal) and multi-morbidities.</p> <p>10. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.</p> <p>13. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis)</p> <p>16. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</p> <p>17. Lack of easily understood and accessible referral pathways across systems and settings.</p> <p>20. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</p>

	<p>27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</p> <p>28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
<p><i>APHN Membership Identified Themes</i> (Please refer to our Strategic Plan available on our website)</p>	<ul style="list-style-type: none"> • <i>Provide timely, early and equitable access to appropriate services</i> • <i>Improve care coordination, integration and navigation of the primary health care sector</i> • <i>Address mental health, alcohol and other drug and physical health issues</i>
<p>Aim of Activity</p>	<ol style="list-style-type: none"> 1. Connect 2. and integrate local primary health care systems in the APHN region, and 3. improve chronic condition management in identified population groups through implementation of elements of a person-centred medical home model.
<p>Description of Activity</p>	<p>Care Connections is a flagship Adelaide PHN initiative in response to the Primary Health Care Advisory Group Final Report. The initiative has been designed to improve chronic condition management in primary care through supporting better coordination of care and integration across the health system.</p> <p>The main elements of Care Connections in 2018/19:</p> <ul style="list-style-type: none"> • <i>Integrated Care Hubs (ICH):</i> These are targeted general practices undertaking activities designed to explore elements of the Person Centred Medical Home Model. Activities seek to improve chronic condition management, including participation in local medical neighbourhoods, leadership development, and quality improvement. Activities align with their demographic data and patient needs and populations. <p>In 2018-19, practices currently enrolled in Care Connections will be supported to further develop strategies and implement new models of care that complement targeting of chronic disease management for the chosen patient cohort. For example, the inclusion of Pharmacists within the practice, assisting the care team to review medications and enhance medication management, Nurse Led Clinics, patient coaching etc. Each of these commissioned activities with the ICH will be direct patient service delivery, enhancing the model of care and overall coordination and integration of care for the ICH selected cohort.</p>

	<ul style="list-style-type: none"> • <i>Facilitation Support:</i> Support grants to the ICH practices to assist with implementation of improvement activities and to integrate them with the local medical neighbourhood. This is an HSI commissioned out activity which aims to provide system and quality improvement through targeted training, education, resources and support services that will directly support the care team to deliver better coordinated and integrated care to the patient cohort. • <i>Local Medical Neighbourhood:</i> Support activities 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. <p>Targeted commissioned Grants will be made available to ICH's. These grants aim to increase the collaboration and integration of other primary care providers into the ICH team – focusing on the ICH patient cohort and aiming to reduce hospital presentations and/or admissions. For example, this may be the inclusion of a Respiratory Nurse in an ICH care team, across a cluster of practices, providing education to patients with COPD and/or Asthma – currently not MBS billable. ICH's may apply for these grants and the criteria will ensure that the utilisation of the grant is specifically to fill current gaps and needs in the care teams that are NOT available through the LHNs or private MBS billable care plan arrangements. Communities of Practice will be linked to ensure most effective, quality and efficient utilisation of primary care providers as demonstrated through patient cohort needs.</p> <ul style="list-style-type: none"> •
Target population cohort	Vulnerable populations with demonstrated high prevalence of chronic conditions and poorer health outcomes.
Consultation - HSI Component	<p>Initial consultations were undertaken with APHN Clinical Councils for feedback to inform preliminary design. Further consultations were then conducted with general practices in the identified areas (see coverage for reference) to refine the activity model and ensure consistency with on-the-ground workforce concerns.</p> <p>The following groups are consulted to further inform activities undertaken as part of Care Connections program design and development:</p>

	<ul style="list-style-type: none"> • 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 - HSI Component	<p>Collaboration on this activity continues and is integral to the ongoing nature of ICH's, medical neighbourhood and well-coordinated and integrated primary health care. Collaboration continues with:</p> <ul style="list-style-type: none"> • Local Health Networks • Allied health • Pharmacies • Community Health and social support providers <p>These engagements continue to build, strengthen and sustain targeted relationships in the local geographic regions, to support the development of the Local Medical Neighbourhood. This work may include clarifying referral pathways, identifying capacity and capability issues, and supporting linkages between these organisations and the Integrated Care Hubs.</p> <p>The Care Connections project is complementary to the Health Care Home roll out and will enhance chronic disease care coordination with the targeting and provision of specific resources in areas of identified high need.</p>
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people (note: one ICH is an Aboriginal medical service).
Duration	Currently until June 2019
Coverage	Public Health Information Development Unit (PHIDU) Population Health Areas (PHAs) (based on ABS Statistical Area Level 2): Davoren Park, Elizabeth East, Elizabeth/ Smithfield - Elizabeth North,

	Parafield/ Parafield Gardens/ Paralowie, Salisbury/ Salisbury North, Dry Creek - South/ Port Adelaide/ The Parks, Largs Bay - Semaphore/ North Haven, Christie Downs/ Hackham West - Huntfield Heights, Christies Beach/ Lonsdale, Morphett Vale - East/ Morphett Vale – West.
Commissioning method (if known)	The commissioning approach will be identified and considered during the co-design phase with relevant stakeholders.
Decommissioning	N/A

CF 5.1 Northern Living Well with Persistent Pain Program

Proposed Activities – CF 5.1 Northern Living Well with Persistent Pain Program	
Activity Title / Reference (e.g. CF 1)	CF 5.1 Northern Living Well with Persistent Pain Program (previously known as NP5.1 Living Well with Persistent Pain Program)
Existing, Modified, or New Activity	Modified Activity (previously known as NP5.1)
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details):
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	9. Services for people living with persistent pain are limited with long delays to access hospital-based services. 28. A coordinated approach to improve navigation and pathways for patients to better manage their conditions.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • <i>Provide timely, early and equitable access to appropriate services</i> • <i>Improve health literacy and education for consumers and primary health care providers</i>
Aim of Activity	<p>The aim of the activity is to provide a multi-disciplinary, collaborative primary care-based northern Adelaide persistent pain management network, which:</p> <ul style="list-style-type: none"> • supports individuals to better understand their condition; • equips them with the necessary tools to improve their quality of life; and • minimises the burden of pain on the individuals and the wider community.
Description of Activity	<p>The Living Well with Persistent Pain program is based on evidence showing multidisciplinary biopsychosocial interventions, such as pain management programs are successful in assisting people to manage ongoing or persistent pain. Based on the successful PainWise® Turning Pain into Gain Program, this activity is a comprehensive pain management program.</p> <p>Individuals are referred to the program by their GP for a 12-month intervention. In the program, they can access:</p> <ul style="list-style-type: none"> • a Care Coordinator

	<ul style="list-style-type: none"> • a GP with a special interest in persistent pain management • a multidisciplinary allied health team at the one site. <p>Participants undergo an initial assessment and are referred to the GP for development of a personalised care plan, which includes access to subsidised allied health services through the MBS. As people with persistent pain often require complex management plans, participants are also supported with access to an extra five subsidised allied health appointments as part of their care plan.</p> <p>Alongside this, participants attend group education sessions to learn and develop self-management skills which support their work with the GP and the allied health team. These sessions are delivered by the multi-disciplinary team each month.</p>
Target population cohort	People living with persistent pain
Consultation - HSI Component	<p>Prior to the development of the program, consultations were undertaken with:</p> <ul style="list-style-type: none"> • Royal Adelaide Hospital Pain Management Unit (PMU) in the Central Adelaide Local Health Network to establish the level of need in the community, through examining the waiting lists for access to the PMU, establishing links between the pain specialists and the Program GP. • Northern Adelaide Local Health Network to support the location of a pain management program in northern Adelaide • PainWise® Turning Pain into Gain Program operators to understand the program procedures, impacts and outcomes. • Identified general practice and allied health to develop the local program implementation guidelines. <p>During the early stages of the program implementation, program leaders participated in the SA Health Transforming Health Chronic Pain Model of Care consultation process as part of both the Working Group and Steering Committee. This participation assisted to align the activity with the State model and ensure integration across the sectors.</p>
Collaboration - HSI Component	<p>Northern Adelaide Local Health Network:</p> <ul style="list-style-type: none"> • Partnering as a delivery partner • Referral of appropriate patients • Pathways with the new NALHN chronic pain program

	<p>Central Adelaide Local Health Network (specifically Pain Management Unit, Queen Elizabeth Hospital):</p> <ul style="list-style-type: none"> • Support development of the activity • Referral of appropriate patients <p>General Practices in target areas:</p> <ul style="list-style-type: none"> • Service delivery to support them to manage patients' persistent pain condition alongside any chronic condition(s). • Referral of appropriate patients <p>Allied health services, including pharmacies:</p> <ul style="list-style-type: none"> • Building capacity of these providers to support patients to manage their persistent pain <p>Living Well with Persistent Pain – Northern program</p> <ul style="list-style-type: none"> • Identifying shared opportunities to minimise duplication <p>Pain support groups</p> <ul style="list-style-type: none"> • Identifying shared opportunities and pathways for support post-program
HSI Component – Other	N/A
Indigenous Specific	Not specific but includes Aboriginal and Torres Strait Islander people
Duration	<ul style="list-style-type: none"> • Planning and development were undertaken in 2014-15 • Service delivery commenced in 2015 • Program redesign undertaken in 2016 • Evaluation data is being collected through 2016-17 and 2017-18 • Program extended for 2018-19 • Ongoing subject to project evaluation outcomes and funding availability
Coverage	Local Government Areas of Playford, Salisbury, Tea Tree Gully
Commissioning method (if known)	Direct engagement; Commissioned in whole

Decommissioning	N/A
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CF 5.2 Central Western Living Well with Persistent Pain Program

Proposed Activities – CF 5.2 Central Western Living Well with Persistent Pain Program	
Activity Title / Reference (e.g. CF 1)	CF 5.2 Central Western Living Well with Persistent Pain Program (previously known as NP5.2 Paediatric Chronic Pain Model of Care)
Existing, Modified, or New Activity	Modified Activity (previously known as NP5.2)
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details):
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	9. Services for people living with persistent pain are limited with long delays to access hospital-based services. 28. A coordinated approach to improve navigation and pathways for patients to better manage their conditions.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • <i>Provide timely, early and equitable access to appropriate services</i> • <i>Improve health literacy and education for consumers and primary health care providers</i>
Aim of Activity	<p>The aim of the activity is to provide a multi-disciplinary, collaborative primary care-based northern Adelaide persistent pain management network, which:</p> <ul style="list-style-type: none"> • supports individuals to better understand their condition; • equips them with the necessary tools to improve their quality of life; and • minimises the burden of pain on the individuals and the wider community.
Description of Activity	<p>The Living Well with Persistent Pain (LWwPP) program is based on evidence showing multidisciplinary biopsychosocial interventions, such as pain management programs are successful in assisting people to manage ongoing or persistent pain. Based on the successful PainWise® Turning Pain into Gain Program, this activity is a comprehensive pain management program.</p> <p>Individuals are referred to the program by their GP for a 12-month intervention. In the program, they can access:</p> <ul style="list-style-type: none"> • a Care Coordinator

	<ul style="list-style-type: none"> • a GP with a special interest in persistent pain management • a multidisciplinary allied health team at the one site. <p>Participants undergo an initial assessment and are referred to the GP for development of a personalised care plan, which includes access to subsidised allied health services through the MBS. As people with persistent pain often require complex management plans, participants are also supported with access to an extra five subsidised allied health appointments as part of their care plan.</p> <p>Alongside this, participants attend group education sessions to learn and develop self-management skills which support their work with the GP and the allied health team. These sessions are delivered by the multi-disciplinary team each month.</p> <p>Additionally, the Centre-West LWwPP program will support the Central Adelaide Local Health Network Pain Management Unit by attending their information sessions to support patients on the waiting list with access to the LWwPP activities. The Care Coordinator will also investigate small group interventions, such as walking groups, mindfulness and others, to support these patients and the participants of the LWwPP program.</p>
Target population cohort	People living with persistent pain
Consultation - HSI Component	<p>Prior to the development of the original LWwPP, consultations were undertaken with:</p> <ul style="list-style-type: none"> • Royal Adelaide Hospital Pain Management Unit (PMU) in the Central Adelaide Local Health Network (CALHN) to establish the level of need in the community, through examining the waiting lists for access to the PMU, establishing links between the pain specialists and the Program GP. • Northern Adelaide Local Health Network to support the location of a pain management program in northern Adelaide • PainWise® Turning Pain into Gain Program operators to understand the program procedures, impacts and outcomes. • Identified general practice and allied health to develop the local program implementation guidelines. <p>During the early stages of the program implementation, program leaders participated in the SA Health Transforming Health Chronic Pain Model of Care consultation process as part of both the</p>

	<p>Working Group and Steering Committee. This participation assisted to align the activity with the State model and ensure integration across the sectors</p> <p>Specific consultation undertaken as part of the development of the Centre-West expansion included ongoing discussions with the Pain Management Unit in CALHN as they move sites to the Queen Elizabeth Hospital. These discussions are informing the further alignment of the PMU and the LWwPP program.</p>
Collaboration - HSI Component	<p>Central Adelaide Local Health Network (specifically Pain Management Unit, Queen Elizabeth Hospital):</p> <ul style="list-style-type: none"> • Support development of the activity • Referral of appropriate patients • Identifying pathways for patients waiting for tertiary services <p>General Practices in target areas:</p> <ul style="list-style-type: none"> • Service delivery to support them to manage patients' persistent pain condition alongside any chronic condition(s). • Referral of appropriate patients <p>Allied health services, including pharmacies:</p> <ul style="list-style-type: none"> • Building capacity of these providers to support patients to manage their persistent pain <p>Living Well with Persistent Pain – Northern program</p> <ul style="list-style-type: none"> • Identifying shared opportunities to minimise duplication <p>Pain support groups</p> <ul style="list-style-type: none"> • Identifying shared opportunities and pathways for support post-program
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	<ul style="list-style-type: none"> • Activity commenced FY2017/2018 • Program to continue through FY2018/2019

	<ul style="list-style-type: none"> Evaluation of the activity will be undertaken during the activity period <p>Ongoing subject to project evaluation outcomes and funding availability</p>
Coverage	Central and Western Adelaide, aligning with the CALHN boundaries
Commissioning method (if known)	Direct engagement. Commissioned in whole
Decommissioning	N/A

CF 6.1 Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program

Proposed Activities – CF 6.1 Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program	
Activity Title / Reference (e.g. CF 1)	CF 6.1 Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program
Existing, Modified, or New Activity	Existing Activity (previously a component of NP 9.1 Workforce, education, networking, capacity building and quality improvement)
Program Key Priority Area	Select one of the following: Workforce If Other (please provide details): Aboriginal Health
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people. 4. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people. 22. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. 23. Minimise instances of poor quality and unwarranted variations of care and follow up.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • Provide equitable and easy access to primary health services for Aboriginal and Torres Strait Islander communities • Provide timely, early and equitable access to appropriate services
Aim of Activity	<p>The project aims are:</p> <ul style="list-style-type: none"> • Improve the level of Aboriginal and Torres Strait Islander cultural awareness and competency to contribute to increased culturally appropriate, safe and respectful services across the primary health care sector. • Increase commissioned service providers and the primary health care services capacity in addressing local issues and supporting the health system better meet the needs of the Aboriginal and Torres Strait Islander community.

	<ul style="list-style-type: none"> • 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 APHN professional and personal development that will provide a foundation to support practical application that equips the team with the context required to develop culturally appropriate engagement, innovation and commissioning strategies, policies, workforce and service delivery principles. • Support and promote Community and Organisational engagement with National Close the Gap Day
Description of Activity	<p>This project will deliver:</p> <ul style="list-style-type: none"> • Cultural competency training to improve the capacity of mainstream primary health care providers and workforce to deliver safe, accessible and culturally responsive services to Aboriginal and Torres Strait Islander people. • Fund an additional Health Project Officer Position within the Integrated Team Care (ITC) commissioned service provider. • Provide cultural competency training to the primary health care workforce which will include Adelaide PHN commissioned service providers. • Increase participation of primary health care providers in education that is specific to Aboriginal and Torres Strait Islander health. • Support the delivery of best practice approaches to improve health outcomes and delivery of care to Aboriginal and Torres Strait Islander people. • Assist in Improving the experience of Aboriginal people in accessing culturally safe primary health care. 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. • Provide formal and informal information sessions for mainstream primary health care providers, including GPs, practice staff, allied health, specialists and pharmacies on the IAHP and associated incentives

	<ul style="list-style-type: none"> • 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; • Support mainstream primary health care providers to encourage Aboriginal and Torres Strait Islander people to self-identify • Provide access to cultural competency training for Adelaide PHN staff specific to Aboriginal and Torres Strait Islander Health. • Provide resources to support the Close the Gap Day
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.
Consultation - HSI Component	<p>Consultations have occurred with the following stakeholders to help inform the development of this project:</p> <ul style="list-style-type: none"> • Integrated Team Care Program workforce • Aboriginal Health Priority Group Members • Kurna Elder <p>Further consultation may be conducted with primary health care workforce and community members to explore how the Adelaide PHN can further support cultural learning and capacity building for the primary health care workforce.</p>
Collaboration - HSI Component	<p>Collaboration on this activity is evolving and it is expected that the APHN engage with:</p> <ul style="list-style-type: none"> • Aboriginal Community Controlled Health Organisations • Aboriginal Services within LHNs • Primary Health Care Providers • Integrated Team Care Program • South Australian Health and Medical Research Institute – Warldaparingga Aboriginal Unit • Rural Doctors Workforce Agency
HSI Component – Other	N/A

Indigenous Specific	Yes
Duration	June 2018 – June 2019
Coverage	The training sessions will be delivered across the Northern, Western and Southern regions of metropolitan Adelaide.
Commissioning method (if known)	The project is commissioned through an open approach to market.
Decommissioning	N/A

CF 7.1 Mental Health Clinical Internship (MHCI) Program

Proposed Activities – CF 7.1 Mental Health Clinical Internship (MHCI) Program	
Activity Title / Reference (e.g. CF 1)	CF 7.1 Mental Health Clinical Internship (MHCI) Program
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Select one of the following: Workforce If Other (please provide details): Mental Health
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	17. Lack of easily understood and accessible referral pathways across systems and settings. 18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 22. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> Improve care coordination, integration and navigation of the primary health care sector
Aim of Activity	<p>The MHCI Program aims to support post graduate students from the disciplines of psychology, occupational therapy, social work and/or mental health nursing develop the specific clinical skills required to effectively deliver mental health services within a stepped care model. The Program will contribute to the development of the mental health workforce through the provision of internships:</p> <ul style="list-style-type: none"> that provide structured career pathways within built-in support, supervision and continuing professional development; and are consistent with recognised standards for mental health clinicians and associated competencies.
Description of Activity	Due to workforce shortages, particularly for experienced Mental Health Clinicians capable of working with hard to reach populations (particularly Aboriginal people and emerging communities), the APHN will be working collaboratively to support this through the project with commissioned service provider(s). This activity addresses workforce capacity and skills development, in clinical therapeutic

	<p>intervention in mental health. The Core Flex needs assessment refers to the Mental Health aspects of Primary Care and chronic conditions throughout the report, as well as the needs related to specific population groups. This is an area of need and is also identified in our Mental Health & Suicide Prevention Need Assessment specifically Priority 2 - <i>Provision of psychological services comparatively low in areas of high need</i> and Priority 6 - <i>Greater prevalence of intentional self-harm and suicide in selected areas and specific populations groups across the region including Aboriginal and Torres Strait Islander People</i>.</p> <p>The MHCI Program will continue to be offered as a targeted 2-year program in regions with high need and offered to post graduate students to develop their skills and expertise in clinical practice. Upon completion of the program the Intern will have fulfilled the requirements for application for registration as an accredited Clinical Mental Health Social Worker, or in the case of other disciplines, two years post graduate clinical experience.</p> <p>The program will consist of:</p> <ul style="list-style-type: none"> • Professional Development • Community Development, Education and Engagement • Observing Direct Clinical Practice • Co-facilitation of Clinical Practice • Supervised Practice • Clinical Supervision.
Target population cohort	Post-graduate students looking to develop their skills in clinical practice and can work towards credentialing suitable for delivering clinical mental health services.
Consultation - HSI Component	The MHCI program has been informed by workforce requirements in the APHN region (particularly with hard-to-reach populations) and community/stakeholder consultation.
Collaboration - HSI Component	The APHN has funded the MHCI as a transition program via Northern Health Network, with 2 interns who completed their internship in July 2016. They have been retained by the organisation as Mental Health Clinicians which demonstrates the worth of this project in attracting, building, retaining and sustaining suitably qualified clinical staff. Two further MHCI positions were funded in the Northern region and 2 MHCI positions in the Southern region. The program model has been shared across

	other identified regions and providers to build provider capacity to offer these positions within their provider workforce. The APHN, NHN and SA Health Mental Health community teams are keen to provide an opportunity for the MHCI positions to spend some time working with and alongside State Community Mental Health teams to further the integration and collaboration of both State and primary care service delivery. Further NHN is acting as mentor to the other large PMHCS provider Links to Wellbeing to establish and sustain the MHCI program in the Southern and Centre East region.
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include skills development in the provision of clinical mental health services to Aboriginal and Torres Strait Islander people.
Duration	July 2018 to June 2019 (rolling 2-year commissioned positions)
Coverage	APHN region and targeted to areas of need
Commissioning method (if known)	Successful applicants from the Primary Mental Health Care Services (Stepped-care) request for proposal was selected directly.
Decommissioning	N/A

CF 8.1 Aboriginal Health and Youth Care Coordination Project

Proposed Activities – CF 8.1 Aboriginal Health and Youth Care Coordination Project	
Activity Title / Reference (e.g. CF 1)	CF 8.1 Aboriginal Health and Youth Care Coordination Project (previously known as NP13.1 General Practice Outreach Project – Aboriginal Health)
Existing, Modified, or New Activity	Modified Activity (previously known as NP13.1)
Program Key Priority Area	Select one of the following: Aboriginal and Torres Strait Islander Health If Other (please provide details): Workforce, Children and Youth
Needs Assessment Priority Area (e.g. 1, 2, 3)	2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non-Aboriginal and Torres Strait Islander people. 25. Accessibility to primary health services for Aboriginal and Torres Strait Islander people. 27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
Aim of Activity	The aim of the Project includes: <ul style="list-style-type: none"> • providing access to a consistent and culturally sensitive, medically appropriate GP service to Aboriginal and Torres Strait Islander people in Southern Adelaide Local Health Network (SALHN) region; • providing specialised GP services for other groups, specifically teenagers and adolescents in the SALHN region; and • improving patient outcomes by ensuring consistency and clinical compliance surrounding the management acute and chronic conditions of vulnerable communities in SALHN region.
Description of Activity	This project expands on the successful completion of the pilot project in 2017/18. Due to workforce shortage specifically delivering primary health care services for Aboriginal and Torres Strait Islander people in SALHN region, the pilot project provided seed funding in the establishment of a general practice including workforce education and training.

	<p>In this phase of the project, it aims to address the significant shortage of general practice services for Aboriginal and Torres Strait Islander people in the south by supporting care the delivery comprehensive primary health care services in the southern region of Adelaide.</p> <p>In addition to this, the pilot project also identified a gap in specialised GP services for other groups, including people living with mental health conditions, teenagers and adolescents. Whilst a number of organisations exist in the Noarlunga precinct to support teenagers and adolescents (e.g. Headspace), the added support from a specialised GP service will assist with the timely identification and referral of patients that may benefit from timely access and support from GP's with experience and training in mental health.</p> <p>Currently, there are no specific programs in South Australia to encourage an integrated 'GP in schools' model. This is an important step to not only engage with the teenage and adolescent community but also to provide preventative health programs and education sessions. This project aims to address this gap in the south by implementing specific programs (e.g. Aboriginal Health and Adolescent Health Programs) to meet the needs of the vulnerable communities identified in the target areas.</p> <p>The project outcomes are:</p> <ul style="list-style-type: none"> • Local health care providers provide culturally appropriate services to Aboriginal and Torres Strait Islander people • Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care • Aboriginal and Torres Strait Islander people are able to access primary health care services as required • Young people are educated and informed about relevant health issues, including sexual health, mental health, chronic disease prevention and disability and have an enhanced understanding on accessing appropriate health services • Partnerships and pathways are formalised with other local health care providers to ensure there is an integrated approach to the provision of care in the region.
Target population cohort	Aboriginal and Torres Strait Islander people and teenagers and adolescents

Consultation - HSI Component	Building on previous consultation undertaken for the pilot project with patients, LHN and health professionals involved in the (pilot) project, this project will continue to consult with the Aboriginal and Torres Strait Islander community, youth, schools and other primary health organisations (such as Aboriginal Family Clinic and Nunkuwarrin Yunti) in SALHN region.
Collaboration - HSI Component	<ul style="list-style-type: none"> Aboriginal Family Clinics (Southern Adelaide Local Health Network) – Client sharing an integration of services. GPEX – Providing placement and training for GP registrars St. John's Ambulance – Providing GP and nursing support for community events, including Schoolies festival and the City to Bay Immanuel College – Official school GP's, providing a weekly GP clinic onsite at the school Sacred Heart College – Providing education sessions for students in year 7-12 University of Adelaide – Medical Student placements Seacliff Surf Lifesaving Club– Sponsor the club and provide education sessions to teenage members aged 13-18
HSI Component – Other	N/A
Indigenous Specific	Yes
Duration	June 2018 – June 2019
Coverage	SALHN region
Commissioning method (if known)	Direct engagement; Commissioned in whole
Decommissioning	N/A

CF 9.1 Palliative Care Access to Medicines

Proposed Activities – CF 9.1 Palliative Care Access to Medicines	
Activity Title / Reference (e.g. CF 1)	CF 9.1 Palliative Care Access to Medicines
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Select one of the following: Workforce If Other (please provide details): Palliative Care
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>11. Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations.</p> <p>14. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.</p> <p>20. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</p> <p>22. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>23. Minimise instances of poor quality and unwarranted variations of care and follow-up.</p> <p>27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly Aboriginal and Torres Strait Islander people, children and youth, people with a disability, older people, palliative care patients and their carers.</p>
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • Provide timely, early and equitable access to appropriate services • Improve health literacy and education for consumers and primary health care providers • Improve care coordination, integration and navigation of the primary health care sector
Aim of Activity	<p>This activity aims to:</p> <ul style="list-style-type: none"> • increase prescriber and community pharmacy knowledge and collaboration across metropolitan Adelaide, with a focus on a previously developed Core Medicines List (CML) to improve medication access and palliative care.

Description of Activity	<p>South Australian research has shown that access to subcutaneous palliative care medicines from community pharmacies can be difficult, with pharmacists unable to anticipate which medicines to stock. This prompted the development of a Core Medicines List (CML) to improve community access to terminal phase medicines.</p> <p>The PCAM project has been designed to improve timely access to end-of-life medicines for people with life-limiting illnesses. Based around a list of medicines recommended by SA Health Specialist Palliative Care Services – the Core Medicines List (CML) – and anticipatory prescribing strategies, the PCAM project will:</p> <ul style="list-style-type: none"> • Raise awareness of the CML and anticipatory prescribing strategies; and • Mitigate barriers associated with the access to and supply of CML and other essential end-of-life medications. • The commissioned service provider will identify 20 community pharmacies and 20 general practitioners per quarter for the duration of the project and work with them to: • Improve GP prescribing practices for palliative and end-of-life care and management, based on the CML and anticipatory prescribing strategies, through evidence-based educational approaches • Support community pharmacies to increase the routine stocking and replenishing the medicines on the CML; and utilising a consistent approach regarding problem-solving around issues of access to and supply of CML • Identify where shared patients may exist and improve communication practices between the involved general practitioners and pharmacies <p>The commissioned service provider will also build on, support and implement strategies and targeted resources to raise awareness of the CML for end-of-life care in the community and anticipatory prescribing in end-of-life care in the community through a variety of activities, including linking with key stakeholders through a Project Steering Group. The PCAM PSG will provide guidance on project implementation; promote the CML and PCAM project widely to relevant networks; contribute knowledge and understanding of community-based end-of-life care; and foster alignment with other palliative care initiatives.</p>
Target population cohort	People with life-limiting conditions nearing the end of life

Consultation - HSI Component	<p>Consultation on this activity has been undertaken through working party meetings attended by the following organisations:</p> <ul style="list-style-type: none"> • Country SA Primary Health Network • GP Partners • Palliative Care SA • Pharmaceutical Society of Australia (SA Branch) • Pharmacy Guild of Australia (SA Branch) • Silverchain (RDNS) • SA Ambulance Services <p>Specialist Palliative Care Services Pharmacists (SALHN, CALHN, NALHN)</p>
Collaboration - HSI Component	<p>The successful service provider will collaborate with the APHN and the following organisations through a Project Steering Group to ensure system integration. They consist of but not limited to:</p> <ul style="list-style-type: none"> • SA Health (Specialist Palliative Care Services) • GP Partners – locate GPs who participate in the Palliative Care Shared Care Program; linking with these GPs and existing resources; understanding GP issues • Palliative Care SA – Resources and links around advocacy • Pharmacy Guild of Australia (SA Branch) – engagement with pharmacies; understanding pharmacy issues • Aged and Community Services SA & NT and Leading Age Services Australia
HSI Component – Other	N/A
Indigenous Specific	Not specific but may include Aboriginal and Torres Strait Islander people
Duration	<ul style="list-style-type: none"> • Planning undertaken in 2016-17 • Procurement process late 2017 • Project to commence 2018-19 • Evaluation data to be collected through 2018-19 <p>Ongoing subject to project evaluation outcomes and funding availability</p>
Coverage	Entire APHN region

Commissioning method (if known)	Request For Proposal (RFP) - The successful applicants to receive funding to implement this initiative is Pharmaceutical Society of Australia (SA Branch).
Decommissioning	N/A

CF 10.1 Northern Adelaide General Practice Liaison Unit

Proposed Activities – CF 10.1 Northern Adelaide General Practice Liaison Unit	
Activity Title / Reference (e.g. CF 1)	CF 10.1 Northern Adelaide General Practice Liaison Unit (NAGPLU)
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Select one of the following: Workforce If Other (please provide details): System Integration
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 22. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. 23. Minimise instances of poor quality and unwarranted variations of care and follow up. 28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> Improve care coordination, integration and navigation of the primary health care sector
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 Hospital in the Northern Adelaide Local Health Network.
Description of Activity	<p>The activity will work in the following domains to strengthen the interface of acute-primary care in the northern region:</p> <p>Engagement and Relationship Building</p> <ul style="list-style-type: none"> Identifying and engaging general practices with patients in the cohort group <p>Communication and Collaboration</p> <ul style="list-style-type: none"> Working between inpatient and outpatient services and general practice to ensure patient information is exchanged in a timely and appropriate manner as part of the clinical handover process

	<p>Access and Navigation</p> <ul style="list-style-type: none"> Promoting and disseminating referral and management guidelines and resources as part of HealthPathways <p>Capacity and Capability Building</p> <ul style="list-style-type: none"> Supporting general practice and hospital clinicians to enable improved management of the patient cohort in primary care through peer to peer mentoring and education <p>Integration</p> <ul style="list-style-type: none"> Linking relevant hospital specialist areas, staff and resources and liaison services with general practice to support management of the patient cohort. <p>The activity will be jointly funded by APHN and the Northern Adelaide Local Health Network (NALHN) and undertaken at the Lyell McEwin Hospital. The activity will employ a 0.6FTE General Practitioner and a 0.6FTE care coordinator in the hospital. Additional in-kind funding will be provided by the hospital to cover administrative and accommodation related expenses.</p>
Target population cohort	The target population will be adults and/or children with chronic conditions who have frequent contact with hospital services.
Consultation - HSI Component	<ul style="list-style-type: none"> This activity is being established in consultation with general practitioners and clinicians and administrative staff from Lyell McEwin Hospital <p>This activity is governed by a Steering Group, involving participants from APHN, Lyell McEwin Hospital to oversee the performance monitoring and evaluation functions of the unit.</p>
Collaboration - HSI Component	<ul style="list-style-type: none"> This activity will be jointly implemented in collaboration with NALHN and will be undertaken at the Lyell McEwin Hospital. <p>This activity will engage and collaborate with general practice and clinicians and administrative staff from the Lyell McEwin Hospital to improve communication and build sustainable working relationships to ensure systems and processes support the quality and timeliness of clinical handover and the coordination of care for patients across the hospital/community interface.</p>
HSI Component – Other	N/A
Indigenous Specific	Not specific but may include Aboriginal and Torres Strait Islander people
Duration	<ul style="list-style-type: none"> Commenced in February 2018

	<ul style="list-style-type: none"> Activity implementation began in July 2018.
Coverage	Northern Adelaide Local Health Network region
Commissioning method (if known)	Direct approach with Northern Adelaide Local Health Network
Decommissioning	N/A

CF 11.1 Southern Adelaide General Practice Liaison Unit

Proposed Activities – CF 11.1 Southern Adelaide General Practice Liaison Unit	
Activity Title / Reference (e.g. CF 1)	CF 11.1 Southern Adelaide General Practice Liaison Unit (SAGPLU)
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Select one of the following: Workforce If Other (please provide details): System Integration
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 22. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. 23. Minimise instances of poor quality and unwarranted variations of care and follow up. 28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> Improve care coordination, integration and navigation of the primary health care sector
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 Hospital in the Southern Adelaide Local Health Network.
Description of Activity	<p>The activity will work in the following domains to strengthen the interface of acute-primary care in the northern region:</p> <p>Engagement and Relationship Building</p> <ul style="list-style-type: none"> Identifying and engaging general practices with patients in the cohort group <p>Communication and Collaboration</p> <ul style="list-style-type: none"> Working between inpatient and outpatient services and general practice to ensure patient information is exchanged in a timely and appropriate manner as part of the clinical handover process

	<p>Access and Navigation</p> <ul style="list-style-type: none"> Promoting and disseminating referral and management guidelines and resources as part of HealthPathways <p>Capacity and Capability Building</p> <ul style="list-style-type: none"> Supporting general practice and hospital clinicians to enable improved management of the patient cohort in primary care through peer to peer mentoring and education <p>Integration</p> <ul style="list-style-type: none"> Linking relevant hospital specialist areas, staff and resources and liaison services with general practice to support management of the patient cohort. <p>The activity will be jointly funded by APHN and the Southern Adelaide Local Health Network (SALHN) and undertaken at the Flinders Medical Hospital. The activity will employ a 0.6FTE General Practitioner and a 0.6FTE care coordinator in the hospital. Additional in-kind funding will be provided by the hospital to cover administrative and accommodation related expenses.</p>
Target population cohort	The target population will be adults and/or children with chronic conditions who have frequent contact with hospital services.
Consultation - HSI Component	<ul style="list-style-type: none"> This activity is being established in consultation with general practitioners and clinicians and administrative staff from Flinders Medical Hospital <p>This activity is governed by a Steering Group, involving participants from APHN, Flinders Medical Hospital to oversee the performance monitoring and evaluation functions of the unit.</p>
Collaboration - HSI Component	<ul style="list-style-type: none"> This activity will be jointly implemented in collaboration with NALHN and will be undertaken at the Flinders Medical Hospital. <p>This activity will engage and collaborate with general practice and clinicians and administrative staff from the Flinders Medical Hospital to improve communication and build sustainable working relationships to ensure systems and processes support the quality and timeliness of clinical handover and the coordination of care for patients across the hospital/community interface.</p>
HSI Component – Other	N/A
Indigenous Specific	Not specific but may include Aboriginal and Torres Strait Islander people
Duration	<ul style="list-style-type: none"> Planning commenced in February 2018

	<ul style="list-style-type: none"> Activity will start in July 2018
Coverage	Southern Adelaide Local Health Network region
Commissioning method (if known)	Direct approach with Southern Adelaide Local Health Network
Decommissioning	N/A

CF 12.1 Infusion and Pharmacy Care Program

Proposed Activities – CF 12.1 Infusion and Pharmacy Care Program	
Activity Title / Reference (e.g. CF 1)	CF 12.1 Infusion and Pharmacy Care Program
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details):
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.</p> <p>8. Selected APHN LGAs have higher rates of a range of chronic conditions (respiratory disease, diabetes, circulatory system disease, chronic kidney disease, musculoskeletal) and multi-morbidities.</p> <p>10. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.</p> <p>13. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis).</p> <p>14. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.</p> <p>28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	<ul style="list-style-type: none"> Develop a communication system between specialists and primary care setting that encompasses key processes including referrals, handover, and clinical documentation between acute care and primary care sector Ensure primary care providers are sufficiently trained to administer infusion therapies

	<ul style="list-style-type: none"> Implement and evaluate an innovative model of infusions in the community pharmacy setting
Description of Activity	<p>The rapid rise in conditions requiring treatment with parenteral medications (infusions), such as infections, iron deficiencies, immune and inflammatory disorders has resulted in an increased demand for acute care hospitals to provide these services.</p> <p>The Infusion and Pharmacy Care program is a hospital avoidance program where selected Pharmacists will be commissioned to deliver infusion therapies that are deemed suitable for community-based infusions directly to patient for examples treatments for infections, iron deficiencies, dehydration, immune and inflammatory disorders.</p> <p>It provides a community-based option which reduces demand on hospital services while supporting integrated care across the system, increasing patient experience and maximising opportunity for positive health outcomes.</p>
Target population cohort	<p>The target population includes:</p> <ul style="list-style-type: none"> patients currently being treated with infusion therapies that are deemed suitable for community-based infusions; including treatment of infections, iron deficiencies, dehydration, immune and inflammatory disorders. patients in residential aged care facilities (RACF) residing in pre-defined postcodes in the Western suburbs of Adelaide, who are primarily under the clinical responsibility of medical teams from both The Queen Elizabeth Hospital (TQEH) and Royal Adelaide Hospital (RAH). patient eligibility for inclusion will be established by the clinical governance committee and will include only those patients currently treated through ambulatory infusion clinics and Hospital in the Home (HITH) services.
Consultation - HSI Component	<p>Consultation with appropriate stakeholders, including LHN, community pharmacy, general practice and nursing will be conducted to ensure appropriate input in to a service model.</p> <p>It is expected as the piece of work progresses, a steering committee will be established as an ongoing pathway to consult and engage with the relevant parties.</p>
Collaboration - HSI Component	<p>In addition to our own community, hospital and aseptic compounding pharmacy, the intervention will be conducted in collaboration with key stakeholders in metropolitan Adelaide that have been</p>

	engaged and indicated willingness to participate in this feasibility study. These include: community pharmacists and pharmacies, Health Partners and Health Alliance (private health insurers), Central Adelaide Local Health Network (CALHN), general practitioners, Western Hospital, HITH[1] nursing services (MedVet and Your Health Navigator), specialists (infectious diseases, oncology, rheumatology), Helping Hand (RACF), and emergency (paramedical) services (SA Ambulance).
HSI Component – Other	N/A
Indigenous Specific	No, but there is potential to include Aboriginal or Torres Strait Islander patients
Duration	July 2018 – June 2019
Coverage	Western suburbs of Adelaide
Commissioning method (if known)	Direct approach
Decommissioning	N/A
Funding from other sources	Other funding sources currently being confirmed.

HSI 1.1 South Australia (SA) PHNs Immunisation Hub

Proposed Activities – HSI 1.1 South Australia (SA) PHNs Immunisation Hub	
Activity Title / Reference (e.g. CF 1)	HSI 1.1 South Australia (SA) PHNs Immunisation Hub
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details): Immunisation, Aboriginal and Torres Strait Islander Health, Culturally & linguistically diverse communities, Children & Youth
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	1. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non-Aboriginal and Torres Strait Islander children. 3. The CALD community are disproportionally affected by Hepatitis B 5. Identified areas of the Adelaide PHN (APHN) region have childhood immunisation rates below the national average 24. Prevention and early intervention strategies for childhood and youth health conditions
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • Provide equitable and easy access to primary health services for Aboriginal and Torres Strait Islander communities • Provide timely, early and equitable access to appropriate services
Aim of Activity	Provide a service across South Australia which will reduce the incidence of vaccine preventable disease in children, reduce the incidence and severity of influenza/pneumonia in adults and reduce hospitalisations from vaccine preventable disease. The Hub targets geographic regions of low vaccination compliance with a focus on Aboriginal and Torres Strait Islander communities, Culturally and Linguistically Diverse communities and low-income groups.
Description of Activity	The Adelaide and Country SA PHNs have jointly implemented the SA PHN Immunisation Hub, a multi-faceted approach to bridge gaps in immunisation service provision, support the skill base of immunisation providers, improve accessibility to after-hours immunisation services and promote the need for a well immunised community. The Hub engages with SA Health to monitor Aboriginal childhood immunisation rates and with immunisation providers to ensure communities are assisted to overcome barriers leading to under-immunisation.

	<p>The objectives are:</p> <ol style="list-style-type: none"> 1. Bridge gaps in immunisation service provision for targeted population groups 2. Support the skill base of immunisation providers to provide safe, accessible and high-quality local immunisation initiatives through education, training and targeted practice support. 3. Improve accessibility to after-hours services and home immunisation services for disadvantaged groups 4. Raise awareness of the need for a well immunised community, augment the voice of immunisation supporters and increase community confidence in vaccines and the childhood, adolescent and adult immunisation programs <p>There are five domains of the SA PHN Immunisation Hub are listed below. Previous, current and future activities completed/commissioned/planned are described accordingly.</p> <ol style="list-style-type: none"> 1. Australian Immunisation Register (AIR) Data Cleansing (2016/17-current) <p>This domain examines AIR data and identifies under immunised children. Once identified, the last known immunisation provider is contacted and reminded to recall the child.</p> <ol style="list-style-type: none"> 2. Champion Immunisation Nurse Program (CNIP) (2017/18 -current) (see CF1.2) <p>This domain is currently commissioned to Health and Immunisation Management Services (HAIMS). CNIP nurses are available to provide clinical advice, support and mentoring to providers, educate providers and community about the benefits of immunisation and counsel vaccine hesitant parents.</p> <ol style="list-style-type: none"> 3. Service Delivery (Ongoing since 2015/16) <p>This domain examines if low immunisation coverage or outbreaks of disease correlates with inadequate immunisation service delivery. Strategies to improve immunisation service delivery gaps include possible expansion of Local Government immunisation services, extended GP services, nurse-led clinics or home immunisation services</p> <ol style="list-style-type: none"> 4. Stakeholder Engagement (Ongoing since 2015/16) <p>This domain consists of:</p>
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	<ul style="list-style-type: none"> • engagement with commissioned and non-commissioned stakeholders who provide service or support to providers of immunisation and 'at risk' community groups and who can disseminate immunisation information to their key stakeholders or communities • providing Secretariat support and regular communication to the Immunisation Provider Network (IPN), a 366-member strong network consisting of various types of immunisation providers • communicating updated immunisation information to providers in a timely manner via PHN newsletters/communique <p>5. Provider Support (Ongoing since 2015/16)</p> <p>This domain provides clinical advice and immunisation program support and guidance via phone and email, immunisation information and immunisation education sessions and workshops.</p>
Target population cohort	All children overdue for immunisation and all individuals (specifically those with medical risk factors) who risk significant illness from vaccine preventable disease
Consultation - HSI Component	<ul style="list-style-type: none"> • Australian Immunisation Register (AIR) data for Aboriginal and Torres Strait Islander children under 7 years of age is actively monitored and cleaned by the SA Health Immunisation Section. The Hub will engage regularly with SA Health to develop strategies to respond to identified data and/or provider issues. • The Hub has engaged and consulted with the Local Government Association, SA Health, Country Health SA, State Department of Education and Child Development (DECD), (State) Migrant Health Service, (State) Child and Family Health Service (CaFHS), Aboriginal Community Controlled Health Organisation(s) (ACCHO), Aboriginal Health Council SA, Hepatitis SA, General Practitioners and Local Councils in targeted areas of both APHN and Country SA PHN regions to enable sharing of information, resources and innovative ideas across the State. • The Hub is represented on the Hepatitis Action Plan Implementation Group – Hep B, to work with key stakeholders to ensure appropriate information is communicated and appropriate resources developed and to develop strategies to improve awareness of hepatitis B treatment and pathways.

	<ul style="list-style-type: none"> The activity has engaged and consulted with the 366 members of the South Australian Immunisation Provider Network (IPN) by providing secretarial support to enable facilitation of meetings with stakeholders and relevant partners.
Collaboration - HSI Component	<ul style="list-style-type: none"> 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 organisation (HAIMS) commissioned to deliver the Champion Immunisation Nurse project – this co-designed activity will ensure all key elements of the Champion Immunisation Nurse project are undertaken in a timely manner and objectives met. Immunisation service providers, including General Practice, Aboriginal Health Organisations, Local Councils, Child and Family Health Services and Hospitals – this activity will collaborate and support providers through providing clinical advice, face to face education and information through newsletter articles. Country SA PHN (CSAPHN) – a partner in the SA PHN Immunisation Hub. CSAPHN will support delivery of provider education, AIR data cleaning activities, community engagement activities to increase awareness of the immunisation program and networking with key stakeholders to ensure there remains a united focus on immunisation across the state. SA Health Immunisation Section – the Hub regularly engage with the Immunisation Section to ensure consistent messaging, monitoring of Aboriginal children immunisation data and ensure providers receive appropriate support. SA Health – this activity will require hospital presentation and admission data for vaccine preventable diseases to be articulated to the APhN. Analysing this data will enable targeted activities with providers and communities This activity will collaborate with specific Local Health Networks (LHNs) to investigate opportunities for the identification of children and adults in target groups in areas with low immunisation rates who present to Emergency Departments or on discharge summaries (after hospitalisation) as under-immunised. Country Health SA – will assist the Hub to recognise service delivery gaps and requests for support in rural SA. This group enlists representation from General Practice, Aboriginal Health, Department of Education and Child Development, Migrant Health, SA Health, Country Health SA and the Women's and Children's Hospital and focusses on ensuring a cross sector approach to increasing immunisation rates and decreasing vaccine preventable disease.

	<ul style="list-style-type: none"> SAHMRI (South Australian Health and Medical Research Institute) – The Hub is represented on the SA Immunisation Strategic Alliance. Hepatitis SA – continues collaboration to ensure Hepatitis B disease rates reduce and the community receives appropriate advice, resources, treatment and support. <p>Migrant Health – along with the Hub, this collaboration will ensure CALD and emerging communities are aware of immunisation recommendations and services.</p> <p>Local Government Association – collaboration continues with Local Councils delivering immunisation programs including the School Immunisation Program (SIP). Most SIP providers are members of the Immunisation Provider Network (IPN).</p>
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	<p>The five elements of the SA PHN Immunisation Hub are in various stages of development and implementation:</p> <p>Element 1: AIR data interrogation: Commenced and will be ongoing for the duration of the program</p> <p>Element 2: Champion Immunisation Nurse Network: commenced in January 2017 and contracted to June 30th 2019 (see CF1.2)</p> <p>Element 3: Service Delivery (identifying gaps): commenced in March 2017 and will be ongoing for the duration of the program</p> <p>Element 4: Stakeholders: commenced July 2015 and will be ongoing for the duration of the program</p> <p>Element 5: Provider support: commenced July 2015 and will be ongoing for the duration of the program</p>
Coverage	Entire APHN and CSAPHN regions
Commissioning method (if known)	<ul style="list-style-type: none"> Immunisation Hub – APHN providing direct project coordination. Champion Nurse Incentive Program – Open approach to market; Expression of Interest; Commissioned in whole (see CF1.2)
Decommissioning	NA

Funding from other sources	Country SA PHN
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HSI 2.1 Aboriginal and Torres Strait Islander Community Peer Support for Cancer Screening

Proposed Activities – HSI 2.1 Aboriginal and Torres Strait Islander Community Peer Support for Cancer Screening	
Activity Title / Reference (e.g. CF 1)	HSI 2.1 Aboriginal and Torres Strait Islander Community Peer Support for Cancer Screening (previously known as NP6.1 <i>A coordinated approach to increase cancer screening participation</i>)
Existing, Modified, or New Activity	Modified Activity (previously known as NP6.1)
Program Key Priority Area	Select one of the following: Aboriginal and Torres Strait Islander Health If Other (please provide details): Population Health – Cancer Screening
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>4. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people.</p> <p>15. Early screening of selected cancers (cervix, bowel, breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy.</p> <p>16. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</p> <p>17. Lack of easily understood and accessible referral pathways across systems and settings.</p> <p>18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>19. Lack of community awareness about existing health care services for different population groups, consumers and providers.</p> <p>20. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</p> <p>21. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures.</p>

	<p>25. Accessibility to primary health services for Aboriginal and Torres Strait Islander people</p> <p>26. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people, CALD, and those in low socio-economic areas</p> <p>27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers</p>
<p><i>APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)</i></p>	<ul style="list-style-type: none"> • <i>Provide equitable and easy access to primary health services for Aboriginal and Torres Strait Islander communities</i> • <i>Provide timely, early and equitable access to appropriate services</i> • <i>Improve health literacy and education for consumers and primary health care providers</i>
Aim of Activity	<p>This project aims to increase participation in breast, bowel and cervical screening for Aboriginal and Torres Strait Islander people living in metropolitan Adelaide, through community peer support approaches.</p>
Description of Activity	<p>Through community peer support approaches the project which will:</p> <ul style="list-style-type: none"> • Develop and implement activities to increase Aboriginal and Torres Strait Islander people's awareness and understanding of cancer prevention and improve cancer screening health literacy • Work collaboratively with cancer screening services to increase accessibility for Aboriginal and Torres Strait Islander people in culturally appropriate ways • Promote coordinated and consistent approaches to cancer screening pathways for Aboriginal and Torres Strait Islander people <p>The project will enable service providers to engage Aboriginal peer workers as "peer ambassadors" to deliver culturally appropriate messages and information about cancer screening and advocate with primary health care services for improved, culturally appropriate approaches to promoting and providing cancer screening.</p> <p>The project will comprise activities which assist with the implementation of recommendations from both the National Aboriginal and Torres Strait Islander Cancer Framework and the South Australian</p>

	<p>Aboriginal Cancer Control Plan regarding screening and early detection of cancer in Aboriginal and Torres Strait Islander people.</p> <p>The desired outcome of this project is to reduce the impact of cancer in Aboriginal communities, by empowering Aboriginal people to improve their cancer screening literacy and support their decisions and actions in relation to cancer screening.</p> <p>The intended outcomes of the Aboriginal Cancer Screening Project are:</p> <ul style="list-style-type: none"> • Aboriginal people have improved health literacy for cancer screening including changing attitudes toward participating in screening (e.g. intention to be screened and actual screening), increased knowledge of causes and risk / protective and wellbeing factors, the benefits and importance of screening and where and how to access services; • Cancer screening service providers have increased confidence and ability to deliver culturally sensitive and appropriate services to Aboriginal People; • A coordinated and consistent cancer screening message is provided to Aboriginal people.
Target population cohort	Aboriginal and Torres Strait Islander population
Consultation - HSI Component	<p>Adelaide PHN consulted with the Aboriginal Health HPG in the scoping and design stage of the activity. Key questions that were discussed with the group were:</p> <ul style="list-style-type: none"> • What do you observe happening in the cancer screening space for the Aboriginal community? What programs currently exist locally, and who is delivering them? • What linkages, partnerships do Adelaide PHN need to make to design a successful cancer screening project for the local Aboriginal community • What do you think are the gaps in access to cancer screening? • What's appropriate, what's not? <p>Key themes that arose from this consultation, included:</p> <ul style="list-style-type: none"> • Service delivery models must be supported by community leaders to ensure success of the program • Gender specific activities are essential in order to respect men and women's business and be culturally appropriate

	<ul style="list-style-type: none"> • Aboriginal Well Health Checks – don't talk about cancer screening – there is a need to focus primary health care services on this issue • There is a need for 'myth busting' in the community – for example 'cancer is contagious' • Ambassador programs are successful as they can 'normalise' the discussion about difficult topics <p>These themes were incorporated into both the design of the project and considered in the assessment of applicants who responded to the Request For Proposal (RFP).</p>
Collaboration - HSI Component	<p>One of the key desired outcomes of this program will be to promote coordinated and consistent approaches to cancer screening pathways for Aboriginal people in the Adelaide PHN region. To support this, the Adelaide PHN will facilitate bi-monthly meetings with the project's service provider and other key stakeholders to build relationships, address barriers and enablers and seek collaborative solutions to a coordinated approach to cancer screening for Aboriginal people.</p> <p>There is also scope to encourage collaboration through the coordination and integration the cancer screening peer ambassador workforce with the Closing the Gap integrated care teams, once established – enhancing the Closing the Gap's programs ability to access culturally appropriate supports to address the cancer screening requirements of its clients, and increasing the reach of the peer ambassadors into the community.</p>
HSI Component – Other	N/A
Indigenous Specific	Yes
Duration	Feb 2018 – Jan 2019
Coverage	The Local Government Areas (LGAs) of Adelaide, Playford, Salisbury, Port Adelaide Enfield, West Torrens and Onkaparinga.
Commissioning method (if known)	<p>Open approach to market; Request for Proposal.</p> <p>Cancer Council SA has been contracted for a 12-month period to deliver on the key objectives/outcomes of the project.</p>
Decommissioning	N/A

HSI 3.1 HealthPathways South Australia

Proposed Activities – HSI 3.1 HealthPathways South Australia	
Activity Title / Reference (e.g. CF 1)	HSI 3.1 HealthPathways South Australia
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Select one of the following: Workforce If Other (please provide details): System Integration
Needs Assessment Priority Area (e.g. 1, 2, 3)	17. Lack of easily understood and accessible referral pathways across systems and settings. 18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 23. Minimise instances of poor quality and unwarranted variations of care and follow-up.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> Improve care coordination, integration and navigation of the primary health care sector
Aim of Activity	This activity aims to address the key PHN objective of improving coordination of care, 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	<p>The primary health care system in South Australia currently has few agreed models of care and clinical referral pathways at a whole of State, Adelaide PHN region, regionally or locally. The lack of system integration and agreed referral pathways has resulted in inconsistencies in patient care.</p> <p>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 local pathways to ensure patients receive the right care in the right place at the right time.</p>

	<p>This activity sees APHN in a collaborative partnership with SA Health and Country South Australia PHN (CSAPHN) to implement HealthPathways across South Australia, and involves:</p> <ul style="list-style-type: none"> • Identification of clinical priorities for delivery of care in South Australia • Development of clinical and referral pathways tailored to the local context • Promotion of health professional use of HealthPathways in South Australia <p>- 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 services and improve the patient journey through our local health system.</p>
	<p>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. It also encompasses State Health, public and private hospital staff, South Australian universities and tertiary training institutions and their health profession student cohorts. The online tool is free and easy to access for health professionals and is an enabler to providing consistent quality care to patients (right care, right time, right place).</p>
Consultation - HSI Component	<p>Consultation will be planned with existing Adelaide PHN commissioned service providers and membership groups</p>
Collaboration - HSI Component	<p>This is a partnership activity with SA Health and CSAPHN and reflects HealthPathways activities undertaken by local health jurisdictions and PHNs in other Australian States or Territories.</p> <ul style="list-style-type: none"> • Collaborations for the activity are many and varied and are inclusive of both the public and private space. Collaborations include, but are not limited to; State Health, Local Health Networks, General Practices, allied health professionals, consumer groups and relevant peak organisations.
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	Duration: 1 July 2018 – 30 June 2021 - ongoing

	<ul style="list-style-type: none"> Key Milestones: Localisation and Development of a minimum of 30 clinical pathways per annum.
Coverage	Focus of this activity is for entire APHN region and metropolitan based providers of health care to the APHN region.
Commissioning method (if known)	N/A
Decommissioning	N/A

HSI 4.1 Navigating the Steps to Primary Mental Health Care

Proposed Activities – HSI 4.1 Navigating the Steps to Primary Mental Health Care	
Activity Title / Reference (e.g. CF 1)	HSI 4.1 Navigating the Steps to Primary Mental Health Care (previously a component of OP1.1 Primary Health Care Provider Support)
Existing, Modified, or New Activity	Existing Activity (previously a component of OP1.1 Primary Health Care Provider Support)
Program Key Priority Area	Select one of the following: Workforce If Other (please provide details):
Needs Assessment Priority Area (e.g. 1, 2, 3)	<p>2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non-Aboriginal and Torres Strait Islander people.</p> <p>4. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people.</p> <p>22. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>23. Minimise instances of poor quality and unwarranted variations of care and follow up.</p> <p>28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • Improve health literacy and education for consumers and primary health care providers • Provide timely, early and equitable access to appropriate services • Improve care coordination, integration and navigation of the primary health care sector
Aim of Activity	The aim of the project is to increase the workforce capacity to navigate the primary mental health care system to facilitate the referral pathways for patients to manage their mental health and co-morbidities better.
Description of Activity	The APHN will provide a range of professional development events, focusing specifically on supporting providers to understand, navigate and support patients the primary mental health care systems (Stepped Care Model).

	<p>The proposed activities include</p> <ul style="list-style-type: none"> - Tailored GP education sessions via an external provider (such as Blackdog Institute) - Mental Health Skills (training Level 1 Accreditation) - Health Pathways training and intersection - Intersection with other APHN professional development providers to support broader capacity building of the primary health care sector. <p>The intended outcomes are</p> <ul style="list-style-type: none"> - Increased participation of primary health care providers in mental health workforce professional development - A strategic and streamlined approach to professional development in primary mental health care services - Adoption and effective use of the stepped care model and associated pathways and services - Increased knowledge, attitude and confidence of primary health care providers in primary mental health care services model of care - High satisfaction by attendees in professional development service delivery with learning outcomes consistently met
	<p>The target audience for the training will be Adelaide PHN commissioned service providers and the broader primary health care workforce. Focusing on mainstream service providers, such as general practitioners, practice managers and nursing staff, reception staff, allied health professionals, pharmacists and pharmacy assistants.</p>
Consultation - HSI Component	<p>Consultation will be planned with existing Adelaide PHN commissioned service providers and membership groups</p>
Collaboration - HSI Component	<p>This activity will engage and collaborate with the following:</p> <ul style="list-style-type: none"> • Health Care Homes and Care Connection - General Practices • Adelaide PHN commissioned services • Allied Health professionals • Education providers • Peak bodies • APHN membership

	<ul style="list-style-type: none"> • Mental Health System
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	<ul style="list-style-type: none"> • Planning undertaken in 2017/18 • Training packages to be delivered between July 2018 – June 2019.
Coverage	Entire Adelaide PHN region
Commissioning method (if known)	Each component of the project will either involve direct engagement and or open approach to market, Request for Proposal.
Decommissioning	N/A

HSI 5.1 Digital Health Support

Proposed Activities – HSI 5.1 Digital Health Support	
Activity Title / Reference (e.g. CF 1)	HSI 5.1 Digital Health Support
Existing, Modified, or New Activity	Existing activity
Program Key Priority Area	Select one of the following: Digital Health If Other (please provide details):
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 23. Minimise instances of poor quality and unwarranted variations of care and follow up. 28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> Improve care coordination, integration and navigation of the primary health care sector
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 appropriate digital health technologies in an effort to increase the communication and collaboration between service providers, improve clinical hand over, and improve timely accessibility to consumer health information
Description of Activity	<p>The Digital Health activity will provide the following:</p> <ul style="list-style-type: none"> Work with health care providers to increase their understanding and utilisations of secure messaging technologies to assist with timely and secure sharing of information between health care providers. Provide assistance and access to data extraction tools and importance of correct clinically coded records.

	<ul style="list-style-type: none"> • 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. • Work with local hospitals, hospital networks and the private hospital sector to increase the uptake of My Health Record and assist with utilising digital health technologies such as the My Health Record and Secure Messaging Delivery. The APHN will focus on public hospitals and private hospitals to increase the uptake of sending discharge summaries and information pertinent to a consumer health care needs direct to their health care providers utilising digital health technologies such as the My Health Record and Secure Messaging and as such ensuring timely and secure transfer of consumer health information. • Raise awareness and educate health care providers of the My Health Record Expansion (opt out) and the benefits of the system. • Increase the use of digital technology's in a health care setting such as 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, the completeness of patient records and provide a means to recall patients in a timely manner. • Increase the use of clinical audit tools in a health care setting to assist in analysis of patient cohorts to improve population health outcomes. • Assist practice staff to understand digital health and assist consumers with sign up and how to access their health care information through the My Health Record. • Assist practice staff to understand the My Health Record Expansion (opt-out) and options for consumers to Opt-out. • Raise awareness and engage with consumers around the My Health Record Expansion. • Continue to support primary health care providers adoption of the My Health Record system post opt-out.
Target population cohort	All health care providers and health care provider organisations working across all sectors of health care.
Consultation - HSI Component	<p>Stakeholder engagement and consultation are currently ongoing with the following peak bodies;</p> <ul style="list-style-type: none"> • Digital Health Agency – ongoing consultative process with Webinars to assist with ongoing changes that are needed, feedback and advice.

	<ul style="list-style-type: none"> • SA Health to support the implementation of the MyHR system across all SA Health sites. • Pharmacy Guild – ascertain barriers to access of Digital Health specifically the My Health Record and electronic sending of prescriptions. • Primary Health Group – advice on the best way to implement digital health technologies across services and systems run by the Primary Health Group, to ensure uptake and consistency across the Primary Health Care practices. • Pen Computing Systems – implementation, roll out and ongoing support of the PenCS clinical audit tool to General Practices across the APHN region. • Enhance OT - ascertaining the barriers to Allied Health providers in accessing digital health, ongoing discussion and assistance to the APHN around digital health systems and implementation of Digital Health to Allied Health Providers. • Referral Net (Global Health secure messaging system (SMD)) – Roll out and assistance of SMD to those interested in sending and receiving information via SMD platform, ongoing discussions to engage further providers.
Collaboration - HSI Component	<ul style="list-style-type: none"> • 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.
HSI Component – Other	N/A
Indigenous Specific	No
Duration	1 July 2016 – 30 June 2019
Coverage	Entire APHN region
Commissioning method (if known)	N/A
Decommissioning	N/A

HSI 6.1 Winter Wellness and Integrated Care Strategy

Proposed Activities – HSI 6.1 Winter Wellness and Integrated Care Strategy	
Activity Title / Reference (e.g. CF 1)	HSI 6.1 Winter Wellness and Integrated Care Strategy
Existing, Modified, or New Activity	Existing Activity (previously a component of OP1.1 Primary Care Provider Support)
Program Key Priority Area	Select one of the following: Population Health If Other (please provide details): Immunisation
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>10. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.</p> <p>11. Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations.</p> <p>13. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.</p> <p>16. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</p> <p>17. Lack of easily understood and accessible referral pathways across systems and settings.</p> <p>18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>19. Lack of community awareness about existing health care services for different population groups, consumers and providers.</p> <p>20. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</p> <p>21. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures.</p> <p>28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
Aim of Activity	The Winter Wellness Strategy aims to develop an integrated and coordinated strategy with SA Health, the LHNs and General Practice to support patients, particularly those with chronic and complex conditions, in the lead up to winter season and beyond, to maintain wellness and prevent deterioration of their existing chronic conditions. Demand on our hospitals is

	growing in the winter season and targeted strategies to assist people to stay well and out of hospital are a key element to this activity. Further integration of these activities to ensure that they are foundation components of a person centred, collaborated and integrated system – ensuring that people stay well and out of hospital and are able to access the right care, in the right place and at the right time. This activity brings together a number of current key activities, such as HealthPathways, Health Care Homes, My Health Record, Care Connections etc.
Description of Activity	<p>While co-design workshops and ongoing discussions are currently planned or underway with SA Health and the LHNs the following are commissionable activities:</p> <ul style="list-style-type: none"> • Commissioning flu vaccination clinics in areas of high need, based on population health and hospital data to increase vaccination of vulnerable people with chronic conditions • Commissioning workshops and education sessions for primary health care providers including general practice to identify and support patients likely to be at high risk of hospitalisations due to flu related illness. • Identifying opportunities to partner with LHNs to commission activities that support patients particularly those at risk of re-admission or exacerbation due to influenza or vaccine preventable conditions and targeted conditions that result in potential avoidable admissions or presentations. • Supporting community wide messaging about ways to keep well during winter by commissioning health promotion activities to help people better understand how to maintain health and wellbeing and options for care during winter months and beyond. <p>Country SA PHN is an equal partner in the Keeping Well in Winter Strategy. There is no agreement or funds contributed to Adelaide PHN to cover the Country SA PHN. Any activity conducted by CSAPHN will be contributed directly to the contractor and complement APHN activities.</p>
Target population cohort	Vulnerable populations with preventable hospitalisation condition(s)

Consultation - HSI Component	It is anticipated as part of planning for this project, community engagement and consultation could be included as part of developing winter wellness messages for the 2019 winter.
Collaboration - HSI Component	The winter strategy is part of a broader state-wide strategy with representation from SA Health, all LHNs, CHSAPHN, with potential to include broader stakeholders such as NGOs, ACCHOs, commissioned service providers and others.
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	The planning for 2019 winter (period) and integrated care strategy will commence July 2018, with intended activities to be confirmed by December 2018 and implementation to start early 2019.
Coverage	Entire APHN and CSAPHN regions
Commissioning method (if known)	As part of co-design of activities with SA Health and other partners, commissioning (including co-funded options) will be discussed and deliberated on.
Decommissioning	N/A

HSI 7.1 South Australia PHNs Conference

Proposed Activities – HSI 7.1 South Australia PHNs Conference	
Activity Title / Reference (e.g. HSI or GPS)	HSI 7.1 South Australia PHNs Conference / SA PHN Conference
HSI/GPS Priority Area	Select one of the following: Other Practice Support If Other, please provide details: System Integration, Workforce
Existing, Modified, or New Activity	New Activity
Aim of Activity	The key aim of the activity is to engage Primary Health Care Professionals (General Practitioners and Practice Teams, Allied Health Professionals, Pharmacy, Mental Health Professionals and SA Health staff etc.) in innovative conversations around different models of care, integrated teams and referral pathways.
Description of Activity	The APHN in conjunction with Country SAPHN will run the (second) South Australian Primary Health Care Conference for all Primary Health Care Professionals with a focus on multidisciplinary teams, chronic disease and integrated care.
Supporting the primary health care sector	The activity will provide: <ul style="list-style-type: none"> • An opportunity for primary health care providers to engage in knowledge sharing, collaboration and partnership building to enhance their ability to work collaboratively within our primary health care system • Quality education, professional development, referral pathways and linkages on a range of topics • General Practitioners with RACGP accredited CPD events
Collaboration	This activity will collaborate with: <ul style="list-style-type: none"> • General Practitioners, Practice Teams, Allied Health Professionals and other Primary Health Care Professionals to provide targeted education and facilitation of collaboration and partnerships • Royal Australian College of General Practitioners (RACGP) to facilitate/approve accredited education for General Practitioners attending the conference • SA Health and other APHN partners

	<ul style="list-style-type: none"> • APHN commissioned service providers to promote their programs and services to primary health care professionals
Duration	Planning period: July 2018 – December 2018 Planned Event Date: April 2019 Evaluation: May 2019
Coverage	Outline coverage of the activity. Whole PHN region.
Expected Outcome	Outline the expected outcome of this activity as it relates to the PHN objectives. <ul style="list-style-type: none"> • To improve the partnerships and collaboration between the disciplines of Primary Health Care Professionals so that they can provide more efficient and effective health services to the South Australian Community • Provide high quality workforce education to increase the knowledge and skills of primary health care professionals, improving integrated and co-ordinated care to our health care consumers • Increased awareness by PHC professionals of the Adelaide and Country SA PHN roles, functions and commissioned services to enhance and strengthen collaboration and partnership between providers and the PHNs • Increased knowledge about new resources and current best practices, changes, updates and reform within primary health care
Funding from other sources	CountrySA PHN

HSI 8.1 Workforce, professional development, networking, capacity building and quality improvement

Proposed Activities – HSI 8.1 Workforce, professional development, networking, capacity building and quality improvement	
Activity Title / Reference (e.g. CF 1)	HSI 8.1 Workforce, professional development, networking, capacity building and quality improvement (previously known as NP 9.1 Workforce, education, networking, capacity building and quality improvement)
Existing, Modified, or New Activity	Existing Activity (title change)
Program Key Priority Area	Select one of the following: Workforce If Other (please provide details):
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	14. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations. 22. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. 23. Minimise instances of poor quality and unwarranted variations of care and follow up.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • <i>Improve health literacy and education for consumers and primary health care providers</i> • <i>Improve care coordination, integration and navigation of the primary health care sector</i>
Aim of Activity	The aim of this project is to develop focussed and co-ordinated quality improvement action across the primary health care sector, utilising local expertise as needed, quality improvement organisations, professional development providers, health professional organisations and standards (e.g. RACGP Standards) and to integrate these areas in all primary health care programs and services.
Description of Activity	<p>The APHN will provide a range of professional development events and quality improvement supports for primary health care providers to enhance their ability to work as part of a primary health care system to provide the right care in the right time and the right place.</p> <p>Professional development, networking and quality improvement actions and methods of disseminating best practice will focus on identified areas of need including empathic system and</p>

	<p>service level responses to health care consumers/patients, culturally diverse consumers, and quality use of medicines.</p> <p>Aspects of this activity will be integrated in the General Practice support activities.</p> <p>The intended outcomes are:</p> <ul style="list-style-type: none"> • 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 <p>Sharing of best practice business skills and leadership development</p>
Target population cohort	All Primary Health Care practitioners/providers
Consultation - HSI Component	<p>Engagement with various Medical, Pharmacy, Allied Health Professional Associations/Peak Bodies; Feedback via previous professional development service delivery providers; APHN membership groups.</p> <p>Collect Learning Needs Assessment survey of primary health care providers.</p>
Collaboration - HSI Component	<p>To ensure high-quality, evidence based professional development and capacity building methods are used in delivering this activity, the activity will collaborate with:</p> <ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> 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. <p>Collaboration and consultation with the Aboriginal Community via the metropolitan ACCHO, Aboriginal Health Councils of SA and appropriate community forums tot in the development of professional development to support culturally appropriate services for Aboriginal and Torres Strait Islander people.</p>
HSI Component – Other	N/A
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	<p>The activity commenced 01 January 2017 (with an 18-month evaluation and review process) and be completed in June 2018 – the contract process will include the ability to review and redesign as necessary, contracts continuing in line with funding received by APHN under this schedule.</p> <p>Further 18 months' activity will commence 01 July 2018</p>
Coverage	Entire APHN region
Commissioning method (if known)	Open approach to market, Request for Proposal. The successful applicants to receive funding to implement this initiative include South Australia Postgraduate Medical Education Association [sapmea] and Northern Health Network [NHN].
Decommissioning	N/A

3. (a) Planned PHN activities - Core Operational Funding Stream: Health Systems Improvement 2018-19, - General Practice Support Funding 2018-19

Please complete this table for Core Operational Funding Stream b) Health Systems Improvement (HSI)³ and planned activities under the General Practice Support Funding Schedule only. Stream a) Corporate Governance, should not be included. Do not include HSI activities previously specified in 1. (b) Planned PHN activities – Core Flexible Funding 2018-19.

³ HSI funding is to be used to deliver core functions within the PHN program such as population health planning, system integration and stakeholder engagement, as well as support to general practice which is not funded under the General Practice Support Funding Schedule. PHNs are able to use flexible funding to commission referral or health pathways activities (including non-staff costs such as 'Streamliners') but all associated PHN staff costs must be funded from HSI funding. HealthPathways activity to be undertaken by commissioned services should be separately identified as a Core Flexible Activity in 1. (b) Planned PHN activities – Core Flexible Funding Stream 2018-19.

PHNs cannot commission frontline services using HSI funding. PHNs may use HSI funding to subcontract specific activities under this stream, for example a health data analyst or consultant may be contracted to identify priorities for improved care coordination. Contracted or consultant arrangements are particularly appropriate for time-limited and specialist projects.

Practice support is to be provided through HSI funding and must be primarily delivered through PHN employees. Practice support cannot be commissioned out to a third party. Practice Support includes general practice support not funded under the General Practice Support Funding Schedule and support provided by your PHN to other practices, e.g. allied health practices.

GPS 1.1 Primary Health Care Provider Support

Proposed Activities – GPS 1.1 Primary Health Care Provider Support

Activity Title / Reference (e.g. HSI or GPS)	GPS1.1 Primary Health Care Provider Support
HSI/GPS Priority Area	Select one of the following: General Practice Support If Other, please provide details:
Existing, Modified, or New Activity	Modified Activity
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>15. Early screening of selected cancers (cervix, bowel, breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy.</p> <p>16. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</p> <p>18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>20. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</p> <p>21. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures.</p> <p>22. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</p> <p>23. Minimise instances of poor quality and unwarranted variations of care and follow up.</p> <p>28. A coordinated approach to improve navigation and pathways for patients to manage their conditions</p>

APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • <i>Improve care coordination, integration and navigation of the primary health care sector</i>
Aim of Activity	<p>The aim of the activity is to:</p> <ul style="list-style-type: none"> • Increase the awareness by the general practice and primary health care sector of the APHN and increase the capacity of general practices to engage and participate in primary health care reform and thereby provide quality health services to their communities. • Increase General Practice understanding and actions to improve population health outcomes including immunisation, cancer screening, and targeting high risk/vulnerable populations and groups • Increase the capacity of the General Practice to understand, respond to and better meet the needs of their communities • Increase the use of quality improvement tools and implementation of quality improvement projects
Description of Activity	<p>The APHN supports General Practice and the wider community of Primary Health Care professionals in the adoption of best practice processes, increased awareness of appropriate referral pathways for patients, use of local clinical care pathways, improve communication, Quality Improvement activities and engagement across sectors.</p> <p>Promote and support collaboration between the general practice and the broader primary health care community. Provide education and quality improvement support to enhance understanding and ability to use quality improvement tools and to implement quality improvement activities, specifically those activities that support better health outcomes and integration of care.</p>
Supporting the primary health care sector	<p>General practice and primary healthcare providers in the APHN region will be offered:</p> <ul style="list-style-type: none"> • Enquiries line: an enquiries support model, which facilitates the timely response to requests from general practice and other primary health care providers • Provision of updates and information: various mediums utilised (website, regular primary health care e-Newsletter called Primary Links, quarterly newsletter, direct mail, emails and face-to-face) to meet needs of General Practice

	<ul style="list-style-type: none"> • Education, engagement and networking events: Attend events as support, networking and engagement opportunities by staff and build partnerships with health professional organisations • Capacity building support: engagement of General Practice and primary health care providers in reform programs • Needs assessment: survey of General Practice • Supporting General Practice to implement quality Improvement activities and understand the need for Quality Improvement programs. • Supporting General Practice to undertake accreditation and understand the accreditation requirements.
Collaboration	<ul style="list-style-type: none"> • Primary health care providers - to facilitate continued provision of quality care to their patients • Primary health care provider organisations – to engage and facilitate reform activities • Integrated Team Care (ITC) program; collaborate with Aboriginal Community Controlled Health Organisation(s) (ACCHO) to support culturally appropriate services for Aboriginal and Torres Strait Islander people. • PHC accreditation providers - promotion and support for quality improvement and best practice • Promotion of Initiatives and Programs – Integrated Care including Health Care Homes (HCH), My Health Record (MHR) and Health Pathways (HP)
Duration	This activity commenced from 01 July 2016 (with a 12-month evaluation and review process) and will continue until June 2019.
Coverage	Entire APHN region
Expected Outcome	<p>Outline the expected outcome of this activity as it relates to the PHN objectives.</p> <ul style="list-style-type: none"> • Increased awareness by general practices and primary health care providers of the APHN role and functions and the reform agenda • Build a strong collaborative relationship with general practices and primary health care providers in the APHN region to achieve the PHN strategic vision. • Increase the efficiency and effectiveness of general practices and primary health care providers to provide best practice services for patients, particularly those at risk of poor health outcomes.

	<ul style="list-style-type: none"> • Improve the coordination of care for patients particularly those with chronic conditions and multi-morbidity to reduce potentially preventable hospitalisations and improve health outcomes.
Funding from other sources	N/A

4. (a) Strategic Vision for After Hours Funding

Please outline, in no more than 500 words, an overview of the PHN's strategic vision for the period covering this Activity Work Plan that demonstrates how the PHN will achieve the After Hours key objectives of:

- increasing the efficiency and effectiveness of After Hours Primary Health Care for patients, particularly those with limited access to Health Services; and
- improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care.

In 2018-19 and onwards, your organisation is required to:

- Implement innovative and locally-tailored solutions for after hours services, based on community need; and
- Work to address gaps in after hours service provision.

The APHN will undertake initiatives for the After Hours which aim to support and enhance existing services whilst building new and more flexible mechanisms of service navigation and service innovation for people in the community, primary health care providers including general practice and Residential Aged Care. These initiatives will engage and collaborate with key stakeholders to build sustainable working relationships and models which promote integration and coordination between service providers and optimise outcomes for people in the community. It is anticipated these initiatives will lead to improved access and knowledge of after-hours services and a reduction in potentially preventable hospitalisations in the targeted areas of activity of the APHN region in the after-hours period.

4. (b) Planned PHN Activities – After Hours Primary Health Care Funding 2018-19

AH 1.1 After Hours Consumer Awareness Resource

Proposed Activities – AH 1.1 After Hours Consumer Awareness Resource	
Activity Title / Reference (e.g. AH 1)	AH 1.1 After Hours Consumer Awareness Resource
Existing, Modified, or New Activity	Existing Activity
National & Local Key Priority Area(s) (Please refer to our Strategic Plan available on our website)	Population Health, Digital Health
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>11. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations.</p> <p>19. Lack of community awareness about existing health care services for different population groups, consumers and providers.</p> <p>27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</p>
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> Improve health literacy and education for consumers and primary health care providers
Aim of Activity	This project focuses on the development of community awareness raising tools of after-hours medical services to ensure that residents in the APHN region will have access to, or information to support self-triage, whilst raising awareness of available and appropriate after-hours services.
Description of Activity	The development of the tools involves working with organisations such as medical deputising services [MDS], general practice and other primary health practitioners i.e. Dentist and pharmacy, providing after hours services within the APHN region, to ensure that appropriate information is provided to community whilst raising awareness about the most appropriate and available services. Strategies involve the use of information technology, consumer resource development and expanded care

	<p>options. The intended outcomes are a reduction in preventable hospitalisations and improvements in the delivery and management of care to all community members in order to receive the right care at the right time in the right place.</p> <p>Stage 1 of the project saw the successful development, distribution and promotion of a hard copy flip chart for residents in the Playford City Council area and a tri-fold brochure for use in Lyell McEwin and Modbury Hospital Emergency Departments. The After Hours Online Directory of General Practices, Hospitals and Allied Health (e.g. Pharmacies) available outside of normal business hours was developed and successfully launched, available to all Adelaide residents.</p> <p>Stage 2 is currently underway and will see an expansion of this successful project including;</p> <ul style="list-style-type: none"> • Adaption of the previously developed hard copy flip chart for residents in the Port Adelaide Enfield council area – this western Adelaide area has been selected in response to the greater health needs and high emergency department presentation based on most current data; • A consumer tri-fold brochure will be adapted from the previously developed one for use in Queen Elizabeth Emergency Departments for patients triaged as level 4 or 5. • A translated magnet and flyer to promote the Adelaide After Hours Online Directory (and its translation function) to our Culturally and Linguistically Diverse communities to improve health literacy, understanding of primary care services and reduce hospital presentations. • Promotion of the website through radio advertising campaigns <p>The After Hours Online Directory will continue to be promoted to consumers and health professionals through; APHN newsletter and website, General Practice, local councils and membership groups.</p>
Target population cohort	<p>In Stage 1 the hard copy resources targeted residents in Playford and those who attend the Lyell McEwin and Modbury Hospital Emergency Departments. Expansion to stage 2 will include residents in City of Port Adelaide Enfield and attendees of The Queen Elizabeth Hospital Emergency Departments classified as triage 4 or 5. Translated resources will target Culturally and Linguistically Diverse communities.</p>
Consultation	<p>Consultation with relevant LGAs, LHNs, key stakeholders in the multicultural sector and membership and community groups.</p>
Collaboration	<ul style="list-style-type: none"> • Stage 1 - previously Northern Local Health Network (NALHN) and Playford LGA • Stage 2:

	<ul style="list-style-type: none"> ○ Central Adelaide Local Health Network (CALHN) to assist with promotion of the hard copy resource and ED specific resource to encourage Port Adelaide Enfield City Council residents receive the right care from the right place at the right time. ○ Port Adelaide Enfield Local council to assist with promotion of the hard copy resource through channels available to them ○ Relevant stakeholders in the multicultural sector for promotion of the translated resource and website.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	<p>This project initially commenced in August 2016, after design concept, consultation, printing and packaging took place, dissemination of the hard copy flip chart to Playford City Council residents took place in March 2017.</p> <p>Expansion of this project commenced in March 2018, with ongoing maintenance and promotion of the website and other tools.</p>
Coverage	<p>Stage 1</p> <ul style="list-style-type: none"> • Playford LGA in APHN region • Emergency Department (ED) tri-fold brochure distributed to Lyell McEwin (Playford LGA) and Modbury Hospital (Salisbury LGA) for ED attendees (triaged level 4 or 5) <p>Stage 2</p> <ul style="list-style-type: none"> • Port Adelaide Enfield LGA in APHN region • Emergency tri-fold brochure to be distributed to The Queen Elizabeth Hospital for ED attendees (triaged level 4 or 5) • Website is targeted to the entire APHN region
Commissioning method (if relevant)	Production and distribution of promotional materials – Direct engagement
Decommissioning	N/A

AH 2.1 Extended Primary Care for RACF (Dandelion Project)

Proposed Activities – AH 2.1 Extended Primary Care for RACF (Dandelion Project)	
Activity Title / Reference (e.g. AH 1)	AH 2.1 Extended Primary Care for RACF (Dandelion Project) (previously a component of AH2.1 After Hours Innovation Grants)
Existing, Modified, or New Activity	Modified Activity (previously known as AH2.1)
National & Local Key Priority Area(s) (Please refer to our Strategic Plan available on our website)	<i>Aged Care, Population Health</i>
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p><i>11. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations.</i></p> <p><i>12. RACFs have a low capacity to support their residents in the afterhours setting leading to increased transportation to emergency departments and medical deputising services.</i></p> <p><i>19. Lack of community awareness about existing health care services for different population groups, consumers and providers.</i></p> <p><i>27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</i></p>
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> <i>• Provide timely, early and equitable access to appropriate services</i> <i>• Improve care coordination, integration and navigation of the primary health care sector</i>
Aim of Activity	<p>The aims of the activity are to:</p> <ul style="list-style-type: none"> • Provide Residential Aged Care Facility residents proactive in hours primary health care to reduce hospital presentations in the after-hours period. • Provide Residential Aged Care Facility residents with proactive in hours primary health care to reduce General Practitioner attendance in the after-hours period.

	<ul style="list-style-type: none"> Enhance the capacity and capability of Residential Aged Care Facilities to coordinate 24-hour care and clinical services for residents, particularly in relation to the management of complex/chronic conditions, palliative care and end of life care
Description of Activity.	<p>The activity will provide extended primary health care and care coordination services and enhanced linkages and resident centred response pathways between primary health, allied and acute health care providers in Residential Aged Care. This will include:</p> <ul style="list-style-type: none"> Clinical care and care coordination, and clinical mentorship to support training and upskilling of staff. Working closely with visiting general practitioners to identify and ensure optimum management of residents at risk of hospitalisation Working closely with visiting general practitioners to enable timely visits on-site during in hours to reduce after hours visits. Development of relationships and pathways with local hospitals to facilitate an early discharge process for residents admitted to hospital Development of protocols, tools and resources to ensure best practice, standardised clinical care, proactive risk identification inclusive of training materials and information for staff, residents and their families/carers/. Developing formalised arrangements with the South Australian Ambulance Service (SAAS) in relation to Extended Care Paramedics on site assistance in palliation and end of life care. Raising awareness for Residents (and their families/carers) choosing to register with My Health Record and work with primary health care providers to encourage uploading of relevant information <p>The activity will be conducted across two Eldercare Inc., Residential Aged Care sites located in the southern Adelaide suburbs of Glengowrie and Seaford.</p>
Target population cohort	Residents of Residential Aged Care Facilities with chronic complex conditions and at end of life who are at risk of hospitalisation.
Consultation	The APHN has undertaken a series of community and health care professional consultations as part of the needs assessment process. Based on this feedback and analysis of population health data, hospital emergency department presentation data and After Hours intelligence and reporting from, the APHN

	has identified gaps in After Hours service provision and developed a strategic focus for After-Hours funding in Residential Aged Care.
Collaboration	<p>To provide innovative after hours services that meet identified community needs, the activity collaborated with:</p> <ul style="list-style-type: none"> • Eldercare Residential Aged Care management, staff and residents • General Practitioners with residents in participating Eldercare sites • Clinicians and hospital staff from the Southern Adelaide Local Health Network • South Australian Ambulance Service
Indigenous Specific	No
Duration	<p>Planning for the activity commenced February 2016, an invitation to apply was released 15 April 2016 with implementation of services from 01 July 2016 (with an evaluation and review process) to 30 June 2019.</p> <p>The successful applicant to receive funding to implement this initiative was Eldercare Incorporated.</p>
Coverage	Southern Adelaide. The activity will be conducted across two Residential Aged Care sites in the suburbs of Glengowrie and Seaford.
Commissioning method (if relevant)	Open approach to market, Request for Proposal, commissioned in whole.
Decommissioning	N/A

AH 2.2 Extended Primary Care for RACF (Camellia Project)

Proposed Activities – AH 2.2 Extended Primary Care for RACF (Camellia Project)	
Activity Title / Reference (e.g. AH 1)	AH 2.1 Extended Primary Care for RACF (Camellia Project) (previously a component of AH2.1 After Hours Innovation Grants)
Existing, Modified, or New Activity	Modified Activity (previously known as AH2.1)
National & Local Key Priority Area(s) (Please refer to our Strategic Plan available on our website)	<i>Aged Care, Population Health</i>
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>11. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations.</p> <p>12. RACFs have a low capacity to support their residents in the afterhours setting leading to increased transportation to emergency departments and medical deputising services.</p> <p>19. Lack of community awareness about existing health care services for different population groups, consumers and providers.</p> <ul style="list-style-type: none"> 27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> Provide timely, early and equitable access to appropriate services Improve care coordination, integration and navigation of the primary health care sector
Aim of Activity	<p>The aims of the activity are to:</p> <ul style="list-style-type: none"> Provide Residential Aged Care Facility residents proactive in hours primary health care to reduce hospital presentations in the after-hours period. Provide Residential Aged Care Facility residents with proactive in hours primary health care to reduce General Practitioner attendance in the after-hours period.

	<ul style="list-style-type: none"> • <i>Build the capacity and capability of Residential Aged Care Facilities to coordinate 24 hour care and clinical services for residents, particularly in relation to the management of complex/chronic conditions, palliative care and end of life care</i>
Description of Activity	<p>This activity will optimise onsite primary health care for people residing in Residential Aged Care Facilities (RACF) through the establishment of a resident-centred, evidence based multi-disciplinary primary health care model</p> <p>The activity will implement an "Assess Treat Stay" model within the RACF, which will enable early identification of residents at risk of hospitalisation and the delivery of proactive onsite 24/7 clinical care. Where resident hospitalisation cannot be avoided the activity will facilitate early discharge and coordinate transition of care back to the RACF. The model will be fully integrated into existing services delivered by the RACF and underpinned by standardised protocols to guide clinical care, education and training for staff and a resource toolbox.</p> <p>The activity will be conducted over three Southern Cross Care (SA & NT) Inc., sites in Adelaide's north western suburbs – namely Largs Bay, West Beach and Rosewater</p>
Target population cohort	RACF residents with chronic complex conditions and at end of life who are at risk of hospitalisation
Consultation	APHN has undertaken a series of community and health care professional consultations as part of the needs assessment process. Based on this feedback and analysis of population health data, hospital emergency department presentation data and After Hours intelligence and reporting from the three South Australian Medicare Locals, APHN has identified gaps in the After Hours service provision and developed a strategic focus for After Hours funding in Residential Aged Care.
Collaboration	<p>To provide innovative after hours services that meet identified community needs the activity will collaborate with:</p> <ul style="list-style-type: none"> • Southern Cross Care Residential Aged Care management, staff and residents • General practitioners with residents in participating Southern Cross Care sites • Clinicians and hospital staff the Northern and Central Adelaide Local Health Networks • South Australian Ambulance Service extended care paramedics
Indigenous Specific	No
Duration	The activity will commence in July 2018 for a period of two years

Coverage	North western APHN region. The Activity will be conducted over three Southern Cross Care (SA & NT) sites in APHN's north and western suburbs - specifically in the suburbs of Largs Bay, West Beach and Rosewater.
Commissioning method (if relevant)	Request for Proposal opened 25 October 2017 and closed 23 November 2017. Southern Cross Care (SA & NT) were the successful applicant. It is anticipated services will commence 1 July 2018.
Approach to market	Open approach to market, Request for Proposal, commissioned in whole
Decommissioning	N/A

AH3.1 Self Presentation Assessment and Referral Service (SPARS)

Proposed Activities – AH3.1 Self Presentation Assessment and Referral Service (SPARS)	
Activity Title / Reference (e.g. AH 1)	AH7.1 Self Presentation Assessment and Referral Service (SPARS) (previously a component of AH4.1 <i>Mental Health After Hours Services</i>)
Existing, Modified, or New Activity	Modified Activity (previously known as AH4.1)
National & Local Key Priority Area(s) (Please refer to our Strategic Plan available on our website)	<i>Mental Health</i>
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>4. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people4.</p> <p>11. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations.</p> <p>19. Lack of community awareness about existing health care services for different population groups, consumers and providers.</p> <p>21. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventive health measures.</p> <p>27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</p>
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • Provide timely, early and equitable access to appropriate services • Provide equitable and easy access to primary health services for Aboriginal and Torres Strait communities • Improve care coordination, integration and navigation of the primary health care sector • Address mental health, alcohol and other drug and physical health issues
Aim of Activity	The SPARS Program will contribute to the provision of high quality, timely and responsive mental health assessment and care for people experiencing mental health concerns and/or associated

	<p>difficulties predominately residing in Outer Northern and Outer Southern regions of metropolitan Adelaide in the sociable after hours period.</p> <p>The aims of the Project are:</p> <ul style="list-style-type: none"> • Provide people experiencing low acuity mental health symptoms and/or associated difficulties and their carers/families with improved access to primary mental health care services in the after hours period • Improve primary mental health care service integration and follow-up for people experiencing low acuity mental health symptoms and/or associated difficulties and their carers/families • Reduce the number of potentially presentable emergency department presentations and hospital admissions for people experiencing low acuity mental health symptoms and/or associated difficulties.
Description of Activity	<p>The SPARS will predominately provide services to people residing in the Outer Northern and Outer Southern regions of metropolitan Adelaide (but will be accessible to all within the entire Adelaide metropolitan region). SPARS will offer free mental health services in the after hours period on a 'no appointment necessary' basis. The SPARS will also act as a referral gateway relevant to the presenting mental health condition and is based on a stepped integrated model approach with clear escalation and de-escalation procedures intrinsic at all levels.</p> <p>SPARS will provide comprehensive mental health assessment and recovery focussed support services for any individual who presents for help and is able to be assessed in a safe way for the consumer and professional alike.</p> <p>The SPARS will be delivered from two key locations, identified as of high demand and low resourced, namely Playford in the Outer Northern region and Onkaparinga in the Outer Southern region of metropolitan Adelaide.</p> <p>The SPARS will provide a face to face mental health assessment and immediacy plan in keeping with the client's needs, with the requirement the client is signposted or referred to follow-up services as required to support the consumer's recovery journey. In addition, SPARS will:</p> <ul style="list-style-type: none"> • Provide points of contact for client and carer centric, proactive, responsive and supportive services to people requiring mental health support and/or advice at time of crisis • Provide a stepped approach to mental health crisis that is in keeping with the need of the presenting mental health crisis

	<ul style="list-style-type: none"> • Provide potential options for managing the mental health crisis until access to main stream services are available • Enable access to mainstream assessment, treatment and support for mental health that is appropriate to the mental health crisis presentation • Provide a follow up service to ensure that the consumer or carer has resolved the crisis or accessed services as required
Target population cohort	<ul style="list-style-type: none"> • The SPARS will generally provide services for individuals over the age of 16 whose presentation would meet the minimum criteria of triage Level 4 & 5 under the Australian Mental Health Triage Tool, and their carers/families, but will provide a service to any individual seeking low acuity mental health support. • Individuals over the age of 16 presenting with more serious or complex mental health concerns would be referred to other services as appropriate. Children, parents or carers presenting will be directed to appropriate CAMHS services as required
Consultation	<ul style="list-style-type: none"> • Consultation has and continues to occur with all accessible consumer and carer stakeholder representatives, including Aboriginal and Torres Strait Islander and Cultural and Linguistically Diverse populations • Consultation has and continues to occur with Adelaide LHNs and NGOs. • Consultation and partnering is planned for SAPOL
Collaboration	<ul style="list-style-type: none"> • The SPARS involves collaboration with: <ul style="list-style-type: none"> ○ LHNs in the design and implementation of the service to ensure smooth consumer centred pathways to and from acute services ○ LHNs, NGOs and PHN commissioned services and other primary health care providers to enable timely access to required services post assessment ○ SAPOL to offer an alternative pathway for clients in distress but not requiring ED presentation
Indigenous Specific	Not specific but may include Aboriginal and Torres Strait Islander people
Duration	<ul style="list-style-type: none"> • Planning, consultation, collaboration and model development between Jul 2017 – Jun 2018 • Commencement of services as of 1 July 2018, funded for a period of two years

	<ul style="list-style-type: none"> Ongoing funding beyond 30 June 2020 subject to project evaluation outcomes and funding availability
Coverage	Primarily targeting individuals residing in the Outer Northern and Outer Southern regions of metropolitan Adelaide, but accessible to all in the Adelaide metropolitan-wide region
Commissioning method (if relevant)	Approach to Market by direct engagement for 2 year contract
Decommissioning	N/A

AH 4.1 Lived Experience Telephone Support Service (LETSS)

Proposed Activities – AH 4.1 Lived Experience Telephone Support Service (LETSS)	
Activity Title / Reference (e.g. AH 1)	AH 3.1 Lived Experience Telephone Support Service (LETSS) (previously a component of AH4.1 <i>Mental Health After Hours Services</i>)
Existing, Modified, or New Activity	Modified Activity (previously known as AH4.1)
National & Local Key Priority Area(s) (Please refer to our Strategic Plan available on our website)	<i>Mental Health</i>
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>11. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations.</p> <p>19. Lack of community awareness about existing health care services for different population groups, consumers and providers.</p> <p>21. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventive health measures.</p> <p>27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.</p>
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • Provide timely, early and equitable access to appropriate services • Provide equitable and easy access to primary health services for Aboriginal and Torres Strait communities • Improve care coordination, integration and navigation of the primary health care sector • Address mental health, alcohol and other drug and physical health issues
Aim of Activity	<p>The Lived Experience Telephone Support Service (LETSS) has been developed to help meet the local mental health service needs, of the metropolitan Adelaide region in the after-hours period. The aim of the activity is to provide consumers who have mental health service needs with real-time information, navigation, and support in the sociable after-hours time period that:</p> <p>(a) is timely</p>

	<p>(b) is appropriate to their need</p> <p>(c) is focused on engagement and an empathetic consumer experience (non-clinical)</p> <p>(d) supports de-escalation of mental health distress</p> <p>(e) potentially diverts attendance at an emergency department</p> <p>(f) assists with access to mainstream in-hours mental health services and other services as required.</p>
Description of Activity	<p>The LETSS will be delivered as a one-to-one, non-clinical telephone service optimising the mental health lived-experience of peer support workers to enable callers to feel understood and respected by the support, honesty and authentic lived experience of the worker.</p> <p>Specifically, the LETSS will provide a lived experience, real-time telephone helpline as a support and potential signposting (or referral) service that provides, advice, guidance/navigation, support and information to individuals experiencing mental health issues, as well as their family, friends and carers.</p> <p>All personnel (staff delivering the service) will be targeted as having a lived experience of mental illness whether personal, or as someone who cares for a family member or friend.</p> <p>This service will provide a seven day per week after-hours only service (public operating hours of 5pm to 11.30pm) but have key links with current services offered by Non-Governmental Organisations, State and commonwealth funded services during normal business hours (e.g. for follow-up, referrals).</p>
Target population cohort	<p>The service will support any individual across the metropolitan Adelaide community who may be feeling socially isolated, seeking information about mental health or services, or simply needing someone to talk to. An eligible individual may be a person with a mental health presentation, or their family, friend, carer or significant other. The service priority is to support and guide any individual:</p> <ul style="list-style-type: none"> • seeking general mental health advice or information • seeking general mental health help and support • seeking to navigate and access available mental health services • someone with an exacerbation of mental health symptoms or escalating emotional dysregulation including feelings of suicide. • someone with a severe and complex mental illness that is seeking support in the implementation of care plan strategies

	<ul style="list-style-type: none"> • someone with a mental health presentation needing someone to talk to relieve isolation and loneliness • who may need a welfare check following hospital admission or Emergency Department attendance • someone requiring support when experiencing difficulties or frustrations in accessing a specific service. • Someone requiring support reflecting on early warning signs or trigger behaviours. <p>In addition, the following populations have been identified as experiencing greater health challenges whilst receiving disproportionately lower levels of service. As such, these populations may require specific support strategies to maintain engagement and support in accessing the LETSS. They can include, but are not limited to:</p> <ul style="list-style-type: none"> • individuals on a lower income, • individuals experiencing homelessness, • Culturally and Linguistically Diverse, • Aboriginal and Torres Strait Islander individuals, • Lesbian, Gay, Bisexual, Transgendered, Queer and Intersex (LGBTQI), • socially isolated new and emerging populations, • peri-natal women, and • individuals with comorbid presentations.
Consultation	<p>Draft Communication and Marketing Plan developed supporting service partnerships and community awareness.</p> <ul style="list-style-type: none"> • Consultation has and continues to occur with all accessible consumer and carer stakeholder representatives, and the Mental Health Coalition of SA • Consultation and partnering is planned for ATSI service providers, CALD service providers, LHNs (including emergency departments), and SAAS services • Consultation and partnering is planned with NGO's, local government, community services. • Consultation and partnering is planned with Consumer and Carer groups including ATSI and CALD representatives.

Collaboration	<p>The LETSS initiative has collaborated closely in the co-design on the service with NGO's, Local Health Networks and consumers and carers, this includes the Mental Health Coalition of SA. Achieving an 80% consumer carer input into the final design.</p> <p>Through planning and implementation phases, the LETSS will collaborate with Local Health Networks (including emergency departments across metropolitan Adelaide), the Mental Health Coalition of SA, NGO's, broader social and community service providers (e.g. across mental health, AOD, disability, youth, domestic violence, CALD, ATSI local government sectors) and PHN commissioned services to link this service with established mental health pathways to enable timely access to required services in either the in or after hours' time frame</p>
Indigenous Specific	Not specific but will help and support Aboriginal and Torres Strait Islander people who contact the service
Duration	<ul style="list-style-type: none"> • Planning, Consultation, Collaboration and model development; March 2017 – Jan 2018 • Procurement of new services; Feb – June 2018 • Commencement of Services; July 2018 • Review of effectiveness; January 2019 • Evaluation of service impact; April 2019 • Ongoing beyond 30th June 2019 subject to project evaluation outcomes and funding availability
Coverage	Entire APHN area with particular targeting of metro Outer Northern and Outer Southern with some additional impact on Country communities in proximity of the service sites
Commissioning method (if relevant)	<p>Open Market Request for Tender.</p> <p>Preferred provider selected based on an evaluation panel that included external assessors.</p>
Decommissioning	N/A

AH 5.1 Northern and Southern Paediatric Partnership Program

Proposed Activities – AH 5.1 Northern and Southern Paediatric Partnership Program	
Activity Title / Reference (e.g. AH 1)	AH 4.1 Northern and Southern Paediatric Partnership Program
Existing, Modified, or New Activity	Existing Activity
National & Local Key Priority Area(s) (Please refer to our Strategic Plan available on our website)	Population Health, Children & Youth
Needs Assessment Priority(s) (Please refer to Section 4 in the 2017/18 Needs Assessment template available on our website)	<p>18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</p> <p>28. A coordinated approach to improve navigation and pathways for patients to manage their conditions.</p>
APHN Membership Identified Themes (Please refer to our Strategic Plan available on our website)	<ul style="list-style-type: none"> • Provide timely, early and equitable access to appropriate services • Improve care coordination, integration and navigation of the primary health care sector
Aim of Activity	<p>The Program will contribute to the provision of quality, timely and responsive paediatric services, and care coordination supports for children and young people aged 0-18 years in the Outer Northern and Outer Southern regions of metropolitan Adelaide.</p> <p>The aims of the Project are:</p> <ol style="list-style-type: none"> 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/carers health care experiences.
Description of Activity	This activity will be a collaborative partnership model in both the Northern Metropolitan region and Southern Metropolitan region of Adelaide. The activity will aim 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 will be achieved by working closely with the Northern Adelaide Local Health Network (NALHN) and Southern Adelaide Local Health Network (SALHN) and a group of private Paediatricians, APHN will commission a Care Coordination role in each region to assist with the triaging of the Paediatrics wait list in both Lyell McEwin and Flinders Medical Centre, and
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.
Consultation	<ul style="list-style-type: none"> • This activity was established in consultation with general practitioners and clinicians and administrative staff from NALHN and SALHN • This activity will be governed by a Steering Group, involving participants from APHN, NALHN and SALHN to oversee the performance monitoring and evaluation functions of the unit.
Collaboration	<ul style="list-style-type: none"> • This activity is jointly implemented in collaboration with Northern and Southern Health Networks and will be undertaken at the Lyell McEwin Hospital and Flinders Medical Centre respectively. • This activity will engage and collaborate with general practice and clinicians and administrative staff from the hospitals to improve communication and build sustainable working relationships to ensure systems and processes support the quality and timeliness of clinical handover and the coordination of care for patients across the hospital/community interface.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	Planning for this activity has been completed for the Outer Northern region, with the Program due to commence from 1 July 2018. Planning for the Outer Southern region is in progress, with the Program expected to commence by 1 September 2018.
Coverage	Northern Adelaide and Southern Adelaide Local Health Network regions in APHN region
Commissioning method (if relevant)	Direct approach with identified hospitals
Approach to market	Approach to market by direct engagement
Decommissioning	N/A