Australian Government
Department of Health

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Primary Health Network

Needs Assessment Reporting Template (2015/16)

This template was used to submit the Primary Health Network's (PHN's) Needs Assessment report to the Department of Health (the Department) on **30 March 2016** as required under Item E.5 of the PHN Core Funding Schedule under the Standard Funding Agreement with the Commonwealth. This template includes the needs assessment of primary health care after hours services.

To streamline reporting requirements, the Initial Drug and Alcohol Treatment Needs Assessment Report and Initial Mental Health and Suicide Prevention Needs Assessment Report is included in this template.

Name of Primary Health Network

Adelaide PHN

Overview

This template was provided to assist Primary Health Networks (PHNs) to fulfil their reporting requirements for Needs Assessment.

The information provided by PHNs in this report may be used by the Department to inform programme and policy development.

Reporting

The Needs Assessment report template consists of the following:

Section 1 – Narrative

Section 2 – Outcomes of the health needs analysis

Section 3 – Outcomes of the service needs analysis

Section 4 – Opportunities, priorities and options

Section 1 – Narrative

This section provides PHNs with the opportunity to provide brief narratives on the process and key issues relating to the Needs Assessment.

Needs Assessment process and issues (500-1000 words)
– in this section the PHN can provide a summary of the process undertaken; expand on any issues that may not be fully captured in the reporting tables; and identify areas where further developmental work may be required (expand this field as necessary)

This needs assessment process/report will form the basis by which the Adelaide PHN (APHN) will undertake a comprehensive needs assessment in FY 2016/17 and beyond.

This report brings together the Comprehensive Needs Assessment (CNA) work undertaken by the previous Medicare Locals – Northern Adelaide, Central Adelaide and Hills, and Southern Adelaide-Fleurieu-Kangaroo Island, in the APHN region. The PHN acknowledges the information gathered by the former Medicare Locals in understanding the local population in their respective catchments. It also summarises the current quantitative and qualitative analysis of the health and service needs of the region in the Metropolitan Adelaide region undertaken by the PHN since July 2015 including the recent Mental Health and Alcohol and Other Drugs needs assessment requirements.

The APHN is undertaking detailed analysis of the existing quantitative data sets from a variety of sources including those on the PHN website. To this extent, the APHN has produced a demographic and health matrix to guide its health needs analysis (see Appendix A).

In December 2015, the APHN obtained Emergency Department and Inpatient hospital data from South Australia (SA) Health (department) and the South Australian Monitoring & Surveillance System (SAMSS) health and risk factor profile for its catchment. These data sets are currently being analysed and consequently findings from such data may not be sufficiently captured in the reporting tables.

More recently, the APHN engaged the Family Medicine Research Centre at the University of Sydney to produce a custom report from the Bettering the Evaluation and Care of Health (BEACH) study to better understand patient encounters with General Practitioners in the region. Key data from the BEACH study has been reported in the health needs analysis table.

The change in boundaries from the three Medicare Locals (MLs) to the APHN has changed the geographic area of the APHN as some parts of the previous MLs have now moved within the Country SA PHN. Accordingly, this, has presented some challenges in interpreting service needs data. Nevertheless, the APHN has actively engaged service providers, health professionals and consumers across the entire region through its various engagement strategies (i.e. online surveys, face-to-face/online forums and targeted workshops).

While the establishment of the governance structures is complete, the engagement of Community Advisory Committees (CACs) and Clinical Councils (CCs) for the Needs Assessment process are ongoing. The APHN has three CACs and CCs each to align with the three geographical sub-regions: Northern, Central and Southern, within its catchment.

In addition to this, the APHN has seven Health Priority Groups (HPGs) and together with the CACs and CCs, they play a crucial role in the organisational governance processes. The HPGs bring together health professionals, service providers and consumers focused on population

groups to work collaboratively to provide input into the strategic direction and work of the APHN. The HPGs represent population health priority areas and include mental health; Aboriginal health, consumers and carers; disability; childhood; older people and aged care; and palliative care. Current information from the CACs, CCs and HPGs has been included in the reporting tables. It is envisioned that any further detailed data analysis and information from engagement processes will be fed into the forthcoming commissioning process and the comprehensive needs assessment in FY 2016/17 (due March 2017). The APHN will aim to work with the LHNs and Local Government Areas in its catchment to further inform its needs assessment process.

MENTAL HEALTH AND ALCOHOL AND OTHER DRUGS (AOD)

The APHN has undertaken an extensive health and service needs analysis of the region, specific for mental health and alcohol and other drugs. Quantitative data sourced from the Medicare Benefits Scheme (MBS), Pharmaceutical Benefits Scheme (PBS), SA Health, Public Health Information Development Unit (PHIDU) and the ATAPS Minimum Data Set (MDS) provided an understanding of prevalence, service usage and service access for people requiring treatment for a mental health and/or mental illness concern. The APHN found a lack of quantitative data describing local level prevalence, service usage and service access for people requiring treatment for an Alcohol and Other Drugs (AOD) concern. An exception to this was the prevalence of 'at risk to health' alcohol consumption sourced from PHIDU. Population level rates of AOD use across South Australia was sourced from the AIHW and the Drug and Alcohol Service South Australia (DASSA) quality, safety, activity and state population publications (2015).

In addition to the mapping of data described above, the APHN initiated an extensive consultation process with providers, referrers to, and consumers of mental health and AOD treatment services. Specifically, online surveying and/or facilitated workshops were carried out with all APHN governance groups, including Northern, Central and Southern CCs/CACs and all HPGs. Separate online surveying was conducted with General Practice (GPs, Practice Nurses and Practice Managers), outcomes from which were themed in parallel with governance groups. Externally facilitated targeted workshops (conducted by the Enzyme Group, which will be referred to as "Enzyme workshops") were also held with special interest groups, including psychiatrists, GPs, community service organisations and consumers and carers (recruited from the northern, central and southern Adelaide metropolitan regions). A workshop was also conducted with Aboriginal and Torres Strait Islander community members living in or accessing services from the region. Analysis from these consultations has been themed and along with the quantitative data, form the basis for the mental health and AOD needs analysis. Finally, an Advisory Working Group was selected and met three times including an Enzyme Group workshop to reflect the views of mental health professional and alcohol and other drug service providers. The deliberations of this Group was incorporated into the Enzyme Group workshops.

Additional Data Needs and Gaps (approximately 400 words)

– in this section the PHN can outline any issues experienced in obtaining and using data for the needs assessment. In particular, the PHN can outline any gaps in the data available on the PHN website, and identify any additional data required. The PHN may also provide comment on data accessibility on the PHN website, including the secure access areas. (Expand field as necessary).

The change in boundary from the former Medicare Local catchments to the new PHN region has provided challenges in obtaining and interpreting relevant quantitative data. The prominent data custodians (e.g. Public Health Information Development Unit (PHIDU), National Health Performance Authority (NHPA), and Department of Human Services: Medicare Statistics) did not readily provide PHN specific data sets. Nevertheless, the APHN was able to analyse existing data sets to produce a matrix based on degree of prevalence or concern for a series

of socio demographic and health related data to aid design of (local) programs/services for commissioning and needs assessment purposes.

Additionally the APHN obtained Emergency Department and Inpatient hospital data from SA Health in early 2016 and only recently commissioned a custom report from the BEACH study. Consequently findings from the aforementioned hospital/clinical data may not be sufficiently captured in the reporting tables.

While the APHN has direct access to the Australian Childhood Immunisation Register (ACIR), engagement with service providers identified data quality issues with the register. The APHN is working with SA Health and service providers in updating the records in the register for South Australia.

The process involved in the establishment of the APHN CCs, CACs and HPGs proved challenging in gathering all the necessary information in a timely fashion as per the Needs Assessment Guide (for consultation with CCs and CACs). Nevertheless the PHN managed to obtain necessary qualitative information from its CACs and CCs to feed into the reporting tables. Priority setting by the HPGs is ongoing and will be considered during any program/service design stage and reported in the comprehensive needs assessment.

Most of the data available on the Commonwealth's PHN website provided sufficient base reference for the APHN. However, in order to effectively commission localised programs/services to meet the needs of vulnerable populations and fill any gaps in services, a lower level of data granularity (e.g. by Statistical Area Level 2) is required. Service utilisation data sets such as Medicare and hospital emergency department and Aboriginal and Torres Strait Islander specific data sets are other examples of additional data required.

MENTAL HEALTH AND ALCOHOL AND OTHER DRUGS (AOD)
The APHN found limitations in local level AOD data specific to the region, e.g. no separate coding of AOD issues for ED presentations and hospital admissions in SA as they are coded under mental health. In addition, there was a challenge to source information regarding current AOD treatment service capacity and activity at a local level. The APHN has planned further consultation with AOD treatment service providers to better understand service usage and needs across the region. The APHN also found limitations associated with mental health and AOD service usage and access behaviour for young people, in particular, limitations associated with accessing Headspace MDS datasets for the region.

Additional comments or feedback (approximately 500 words)
– in this section the PHN can provide any other comments or feedback on the needs assessment process, including any suggestions that may improve the needs assessment process, outputs, or outcomes in future (expand field as necessary).

The APHN would welcome the addition of data sets to the PHN website including tools to aid the priority setting process in the needs assessment. The APHN commends the collaborative approach the Commonwealth has undertaken in the needs assessment process and would welcome a continuous engagement with the Department for future processes.

Section 2 – Outcomes of the health needs analysis

This section summarises the findings of the health needs analysis in the table below.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Mental Health and Suicide Prevention Needs Analysis		
Mental health	**Prevalence of mental health conditions** • High prevalence of mental health issues in Local Government Areas (LGAs) of: Playford, Salisbury, Port Adelaide Enfield, Adelaide, Marion, and Onkaparinga in the Adelaide PHN (APHN) region. *Long-term mental and behavioural problems* • An estimated 14 out of every 100 people aged 15 years and over living in the APHN region have a long term mental or behavioral problem, equivalent to 169,635 people in 2011-13. This is 11% higher than the average of other Australian capital cities. • Within the APHN region, the rates of mental and behavioural problems were marginally higher for females, 15.7 per 100, compared to males, with 13.4 per 100. • In the northern APHN region, the highest rates were in Davoren Park (19.8 per 100), Elizabeth/ Smithfield - Elizabeth North (19.8 per 100), Enfield-Blair Athol (18.6) and Elizabeth East (17.7). Adelaide with 19.2 per 100 had the highest in the central region. Rates were also high in the southern areas of Christies Beach/ Lonsdale (18.1), Christie Downs/ Hackham	Evidence from datasets available on DoH PHN website, Public Health Information Development Unit (PHIDU) Social Health Atlas of Australia – Population Health Areas (PHAs), SA Health Emergency Department hospital data, ATAPS data, SAMSS Survey findings, Australian Commission on Safety and Quality – Atlas of Healthcare Variations, BEACH data (2011-2015) for the Adelaide PHN (APHN) region, ABS Survey of Disability, Ageing & Carers, interpretation of Medicare Statistics and targeted CCs, CACs, and HPG, stakeholder and community consultations on mental health needs in the APHN region.

Outcomes of the health needs analysis		
	West - Huntfield Heights (17.8) and Mitchell Park/ Warradale (17.1). • In 2012, an estimated 20% of South Australians were living with a disability, and 28% of South Australians with a profound or severe activity limitation, had a mental or behavioural disorder. *Psychological distress* • An estimated 11 out of every 100 people aged 18 years and over living in the APHN region had high or very high psychological distress, equivalent to 103,592 people in 2011-13. This is 8% higher than the average of all other Australian capital cities. • Rates of psychological distress were 40-50% higher than the Australian rate in a number of areas in the northern APHN region, specifically Elizabeth/ Smithfield - Elizabeth North (17.1 per 100), Davoren Park (16.3), Salisbury/ Salisbury North (15.2), and Enfield - Blair Athol (15.0). The rate of 14.1 in Adelaide was 30% higher than the Australian average. **Mental health-related emergency department presentations** • In 2014-15, there were 21,109 emergency department presentations to public hospitals due to mental and behavioural conditions for APHN residents, a rate of 1,206 presentations per 100,000 population. • The local government areas with the highest admission rates to public hospitals in the Adelaide PHN region were Adelaide (4,041 per 100,000 population), Walkerville (1,770 per 100,000) and Playford (1,738 per 100,000).	

Outcomes of the health needs analysis		
	Mental health-related hospital admissions • In 2011-12, there were 11,350 admissions of residents of the APHN to public hospitals due to mental health–related conditions, a rate of 950 admissions per 100,000 population. • The LGAs of Adelaide (a rate of 2,203 per 100,000), Port Adelaide Enfield (1,423), Marion (1,308), Unley (1,211) and Mitcham (1,200) had the highest rates in the APHN region. **Accessing mental health-related services** • Comparatively high rates of people accessing MBS-funded psychological services under the Better Access initiative in the outer-metropolitan areas of the APHN region, including the Statistical Areas Level 3 (SA3s) of Onkaparinga, Playford and Tea Tree Gully. Mitcham in the inner-south also had a higher rate than the APHN average. • Almost a half of all clients from the APHN region accessing ATAPS funded services are residents of Salisbury and Playford LGAs, and along with Adelaide City have the highest rate of clients per 1,000 population in the region. • High prevalence of people experiencing psychological distress in north-western metropolitan areas, including Enfield-Blair Athol, Port Adelaide-The Parks, coupled with comparatively low service provision and low rates of people referred to MBS-funded services in the same areas. • Highest numbers of mental health treatment plans completed in Onkaparinga and Salisbury, however highest rates per	

Outcomes of the health needs analysis		
	1,000 population are in Adelaide city, Unley, and Norwood-Payneham-St Peters. • High rates of mental health consultations provided by GPs in Playford, Adelaide City and Unley (SA3s). **Accessing primary health services (General Practitioners)** • According to the BEACH data, depression is the third most frequent problem managed per 100 encounters by General Practitioners in the APHN region. • According to the BEACH data, the APHN had a higher rate (14.8) of psychological problems (all) managed per 100 encounters when compared to Other Capital cities (12.7) and nationally (13.1) ○ The APHN had a slightly higher rate (4.9) of depression managed per 100 encounters when compared to Other Capital cities (4.4) and nationally (4.6) ○ The APHN had a slightly higher rate (2.1) of anxiety managed per 100 encounters when compared to Other Capital cities (1.9) and nationally (1.8) ○ The APHN had a slightly higher rate (0.7) of dementia managed per 100 encounters when compared to Other Capital cities (0.5) and nationally (0.6). • With regards to psychological management, the BEACH study reported that the APHN had significantly higher psychological counselling management action rate (29.4) per 100 psychological problem contacts when compared to Other Capital cities (24.5) and nationally (24.0) ○ The APHN had a lower referral management action rate (13.0) per 100 psychological problem contacts when compared to Other Capital cities (16.3) and nationally (15.7).	

Outcomes of the health needs analysis		

	Mental health-related medication use
	• Between 2011-2015, the BEACH study reported that the APHN had slightly higher rate (45.7) of psychotropic medication prescribed to patients when compared to other capital cities (45.4) in the country.
	• In 2011, 12.6% of the APHN population, an estimated 141,856 people, accessed PBS subsidized mental health-related prescription medication:
	  ○ Three-fifths (62%) were female
	  ○ Over a third of persons aged 75 years and over (36.6%) and over a quarter (28.4%) aged 65-74 years accessed mental health-related medication
	  ○ Over a half (54%) lived in the most disadvantaged areas of the region (IRSD Quintiles 1 & 2).
	Antidepressants
	• In 2011, 8.9% of APHN residents, an estimated 100,068 people accessed PBS subsidized anti-depressants.
	• By age group, the highest proportions were in people aged 75 years and over, 21.9%, and 65-74 years, 18.2%.
	• Within the APHN region, the LGAs of Playford and Onkaparinga had the highest rates of dispensing of antidepressants across all age groups in 2013-14.
	Anxiolytics
	• In 2011, 3.3% of APHN residents, an estimated 37,215 people accessed PBS subsidized anxiolytics.	

Outcomes of the health needs analysis		
	• By age group, the highest proportions were in people aged 75 years and over, 11.9%, and 65-74 years, 8.5%. • Within the APHN region in 2013-14, the LGA of Playford had the fourth highest rate in Australia of anxiolytic medicines for people aged 18-64 years, and the 2nd highest rate in Australia for people aged 65 years and over. *Antipsychotics* • In 2011, 1.9% of APHN residents, an estimated 21,292 people accessed PBS subsidized antipsychotics. • By age group, the highest proportions were in people aged 75 years and over, 4.7%, with 2.4% for both 25-34 year olds and 35-44 year olds. • Within the APHN region, the high rates of anti-psychotic medicines dispensing occurred in the LGAs of Playford, Salisbury, Adelaide City, Onkaparinga, Port Adelaide-West and Norwood-Payneham-St Peters across varying age groups. *Psychostimulants and nootropics (medicines used for Attention deficit hyperactivity disorder (ADHD))* • In 2011, 0.2% of APHN residents, an estimated 2,405 people accessed PBS subsidized ADHD medicines. • Approximately half (53%) of were age 0-14 years, with 23% aged 15-24 years old. • Almost three-quarters (74%) were male. • Within the APHN region, the LGAs of Onkaparinga, Playford and Salisbury had highest rates of dispensing for ADHD medicines for people aged 17 years and under in 2013-14.	

Outcomes of the health needs analysis		
Suicide Prevention	• In Greater Adelaide, which includes the APHN, rates of deaths from intentional self-harm have increased by 19% in the five years from 2010 to 2014, from 11.6 per 100,000 population in 2010 to 13.8 deaths per 100,000 population in 2014. • Between 2008-2012, the annual average age-standardised rate of deaths from suicide and self-inflicted injuries was 13 deaths per 100,000 population for the APHN. This was 23% higher than the average rate of death from suicide and self-inflicted injuries for all other Australian capital cities. • In 2014, rates of deaths from intentional self-harm in South Australia were over three times higher for males (19.5 per 100,000 population) compared to females (5.6 per 100,000 population). • In 2014, rates of death from intentional self-harm in South Australia by age were highest in the 35-44 years age group, 28.1 per 100,000, followed by 45-54 years (21.0), 25-34 years (16.8) and 15-24 years (11.4). The rates for males were higher than females across all age groups. • From 2010-2014 in Greater Adelaide, there were 17 deaths caused by intentional self-harm in children aged 5-17 years, a rate of 1.8 deaths per 100,000 population. • The Population Health Areas of Elizabeth/ Smithfield - Elizabeth North (22.8 deaths per 100,000) and Adelaide (22.2 per 100,000) had rates of death from suicides and self-inflicted injuries almost double the rates in Greater Adelaide (12.0) between 2009-2012. Christie Downs/ Hackham West - Huntfield Heights (20.7) and West Lakes (19.9) had the next highest rates within the APHN region.	Evidence from datasets available on Australian Bureau of Statistics, DoH PHN website, PHIDU Social Health Atlas of Australia – PHAs and previous Medicare Locals CNAs in the APHN catchment.

Outcomes of the health needs analysis		
	• Suicides accounted for 4.2% of all registered deaths of people identified as Aboriginal and Torres Strait Islander in 2010, compared with 1.6% for all Australians. • There is a need to understand the correlation between psychological distress, and other risk factors such as alcohol consumption and drug use with suicide.	
Drug and Alcohol Treatment Needs Analysis		
Alcohol and other drugs	**Comorbidity** • Comorbidities exist between AOD use and mental health, with national statistics indicating that almost twice as many illicit drug users have been diagnosed with or treated for a mental illness compared to non-users. A survey of illicit drug users living in South Australia supported this finding, with respondents reporting high levels of psychological distress, at more than twice the APHN average rate. • The proportions of certain chronic conditions are also higher amongst illicit drug users in South Australia compared to the South Australia average, with 37% surveyed having asthma, 36% liver disease and 23% gout, rheumatism or arthritis. • A 2013 survey of South Australians who inject drugs found that 49% had Hepatitis C, and 3% had Human Immunodeficiency Virus (HIV). **Problematic use of alcohol** • A recent survey of key South Australian AOD experts nominated alcohol as the drug they consider most problematic	Evidence from the National Drug and Alcohol Research Centre (NDARC), Australian Research Council (ARC) - SA Drug Trends 2014; Australian Institute of Health and Welfare (AIHW) – National Drug Strategy Household Survey (NDSHS) 2013; The National Centre for Education and Training on Addiction (NCETA) Knowledge database 2016; BEACH data (2011-2015) for the APHN region; AIHW - Alcohol and other drug treatment services in South Australia 2009–10: findings from the National Minimum Data Set. Cat. Number AUS 148. Canberra: AIHW; South Australian AOD Strategy report 2011-2016, 2014 Annual Progress report; Acute inpatient utilisation comparisons (Hardes via DOH portal);

Outcomes of the health needs analysis		
	given the social acceptability and danger associated with binge drinking and withdrawal. • In South Australia in 2013, two in ten people aged 14 years and over consumed alcohol at risky levels (based on 2009 NHMRC guidelines). Rates were higher for males (29%), compared to females (9%). • A quarter of South Australians aged 35-49 years old consumed alcohol at risky levels, while almost 40% of 15-29 year olds consumed alcohol at levels that put them at risk of harm at least once a month. • Risky lifetime levels of alcohol use are evident across much of the APHN region, but highest in western Adelaide (22.3%). • The BEACH study reported that 47%of patients within the APHN could be classified as drinking responsibly, while 22% could be classified as hazardous drinkers. **Illicit drug use** • In South Australia in 2013, 16% of people aged 14 years and over used an illicit drug in the past 12 months. Rates were higher for males, 18%, compared to females, 13%. • Over a quarter, 29%, of South Australians aged 20-29 years old in 2013, had used an illicit drug in the past 12 months, higher than the Australian average. • Within the APHN region, estimated rates of illicit drug use in people aged 14 years and over were highest in southern Adelaide (20.2%), which includes the areas of Holdfast Bay, Marion, Mitcham and Onkaparinga. • The most common illicit drugs used by South Australians according to the 2013 National Drug Strategy Household	

Outcomes of the health needs analysis		
	Survey were cannabis, pain killers/analgesics, ecstasy and methamphetamine. • A recent survey of key South Australian AOD experts nominated methamphetamine as the most problematic illicit drug due to being highly addictive, and because of the physical, mental and social impacts of individuals and family/friends. The development of dependence on over-the-counter medicine, particularly codeine, after legitimate use was also highlighted as an ongoing problem. **Drug and alcohol related hospital separations and utilisation** • In 2013-14, there were 4,204 separations for drug and alcohol related services for residents in the Adelaide PHN region. This equated to a relative utilisation (RU) rate of 71.4, lower than the national average relative utilisation rate (100). • Although Adelaide PHN had a lower RU rate overall, rates for some diagnosis-related group (DRG) were higher than the national average RU: o Poisoning/Toxic Effects of Drugs & Other Substances (110.7, 2,226 separations), o Drug Intoxication & Withdrawal (109.6, 425 separations) o Alcohol Intoxication & Withdrawal (106.9, 590 separations), and o Injury, Poisoning &Toxic Effects Drug with Ventilator (101.7, 49 separations) *By place of residence within APHN region* • Adelaide City SA3 had the highest relative utilisation for all drug and alcohol related hospital services in the APHN region in	

Outcomes of the health needs analysis		

	2013-14 (112.5, 151 separations). The RU was also high in the SA3 of Marion, but lower than the national average (96.0, 423 separations)
	
	• Across the region separations and relative utilisation rates varied by SA3 depending on the specific DRG.
	  ○ The majority of SA3s in the APHN region had RUs that were higher or consistent with the national average for **poisoning/toxic effects of drugs & other substances**.
	  ○ Similarly, for **alcohol and drug intoxication & withdrawal** type services, the majority of RUs at SA3 level were higher or consistent with the national average, with the exclusion of a few SA3s in the east of the APHN region.
	  ○ In contrast, **alcohol use disorder & dependence** RUs were highest in the SA3s in the eastern APHN region, and lowest in the north and west. The majority of SA3s had a lower RU than the national average.
	  ○ With the exception of Adelaide City SA3, the RUs for **sameday treatment for alcohol disorders** were considerably lower the national average across the APHN region. RUs for **sameday treatment for drug disorders** were also considerably lower than the national RU.
	  ○ RUs for **injury, poisoning, toxic effects of drug with ventilator** varied across the region, with approximately half of SA3s being higher or consistent with the national average.	

Outcomes of the health needs analysis		

	• The 5 SA3s with the highest RUs for each DRG are below:
	  ○ *Alcohol Intoxication & Withdrawal (V60)* – Adelaide City (269.8, 33 separations), Marion (169.3, 70 seps.), Port Adelaide-East (156.74, 46 seps.), Holdfast Bay (131.9, 22 seps.), Onkaparinga (125.3, 98 seps.)
	  ○ *Drug Intoxication & Withdrawal (V61)* – Prospect-Walkerville (168.0, 16 seps), Adelaide City (158.1, 17 seps), Salisbury (147.1, 65 seps), Marion (146.8, 42 seps), Playford (136.5, 43 seps)
	  ○ *Alcohol Use Disorder & Dependence (V62)* – Adelaide City (134.3, 17 seps), Norwood-Payneham-St Peters (107.7, 19 seps), Burnside (79.2, 17 seps), Unley (79.0, 15 seps), Prospect-Walkerville (77.9, 11 seps)
	  ○ *Opioid Use Disorder & Dependence (V63)** – Holdfast Bay (78.9, 2 seps), Salisbury (48.7, 5 seps), Norwood-Payneham-St Peters (35.2, 1 seps), Unley (33.9, 1 seps), Tea tree Gully (27.6, 2 seps)
	  ○ *Other Drug Use Disorder & Dependence (V64)** – Holdfast Bay (68.7, 4 seps), Unley (57.5, 4 seps). Tea Tree Gully (53.3, 9 seps), Port Adelaide-West (47.5, 5 seps), West Torrens (43.4, 5 seps)
	  ○ *Treatment for Alcohol Disorders, Sameday (V65)* – Adelaide City (81.7, 26 seps), Marion (48.6, 55 seps), Charles Sturt (41.0, 56 seps), Port Adelaide –West (35.5, 27 seps), Holdfast Bay (35.1, 16 seps)
	  ○ Treatment for Drug Disorders, Sameday (V66) – Adelaide City (37.4, 5 seps), Charles Sturt (35.8, 16	

Outcomes of the health needs analysis		
	seps), Holdfast Bay (28.6, 4 seps), Port Adelaide-West (28.0, 7 seps), West Torrens (26.1, 7 seps) ○ X40, Injury,Poisoning,Toxic Eff Drug w Vent ○ X62, Poisoning/Toxic Effects of Drugs & Other Substances *low rates therefore RU less statistically meaningful **Treatment** • Alcohol was the principal drug of concern in 36% of all treatment episodes South Australia in 2013-14, 4,636 episodes out of 12,979 across the State. Amphetamines accounted for 27% of treatment episodes, followed by cannabis (17%) and heroin (5%). • The most common types of treatment in South Australia in 2013-14 were assessment (44% of episodes), counselling (22%) and withdrawal management (13%). • The rates of counselling in South Australia (27% of all treatments) are significantly lower than the Australian average (42%). Counselling as a treatment had the highest rate of clients ceasing treatment due to non-compliance (47.6%), compared to other treatment types including withdrawal management, rehabilitation, assessment only and pharmacotherapy. • When surveyed, key South Australian AOD experts suggested that treatment options are limited for methamphetamine dependency, and it is difficult to treat successfully. In 2013-14, 64% of treatment for methamphetamine was assessment only, followed by counselling (19%), and rehabilitation (7%).	

Outcomes of the health needs analysis		
Population Health and Primary Health Care After Hours Services Needs Analysis		

After Hours	• The following data is for After Hours services provided (in the former ML regions) during the period July 2014 – June 2015:
	  • In the **northern** region:
	  ○ 2,088 **urgent** services (1.2%) provided in the after hours period
	  ○ 157,855 **non urgent** services (90.4%) provided in **consulting rooms** in the after hours period
	  ○ 2,709 **NON urgent** services (1.6%) provided in the **home** in the after hours period
	  ○ 11,987 **non urgent** services (6.9%) provided in a **RACF** in the after hours period.
	  ○ A grand total of 174,639 (100%) after hours services were provided in the Northern region.
	  • In the northern region, the Medical Deputising Services (MDS) provided:
	  ○ 207,414 **urgent** services (70.9%)
	  ○ 85,076 **non urgent** services (29.1%)
	  ○ A grand total of 292,490 MDS services were provided in the Northern region.
	  • In the **central** region:
	  ○ 199,441 **urgent** services (48.5%) provided in the after hours period
	  ○ 145,369 **non urgent** services (35.3%) provided in **consulting rooms** in the after hours period
		Evidence from Medicare Benefit Scheme (MBS) Statistics and analysis of Health Direct Health Map.

Outcomes of the health needs analysis		
	○ 35,465 **non urgent** services (8.6%) provided in the **home** in the after hours period ○ 31,344 **non urgent** services (7.6%) provided in a **RACF** in the after hours period. ○ A grand total of 411,416 (100%) after hours services were provided in the Central region. • In the central region, the Medical Deputising Services (MDS) provided: ○ 197,792 **urgent** services (76.1%) ○ 62,060 **non urgent** services (23.9%) ○ A grand total of 259,852 MDS services were provided in the Central region. • In the **southern** region: ○ 7,534 **urgent** services (4.6%) provided in the after hours period ○ 143,064 **non urgent** services (87.6%) provided in **consulting rooms** in the after hours period ○ 2,286 **non urgent** services (1.4%) provided in the **home** in the after hours period ○ 10,423 **non urgent** services (6.4%) provided in a **RACF** in the after hours period ○ A grand total of 163,307 (100%) after hours services were provided in the Southern region • The Medical Deputising Services (MDS) provided: ○ 7,534 **urgent** services (42.5%) ○ 10,203 **non urgent** services (57.5%) ○ A grand total of 17,737 MDS services were provided in the Southern region.	

Outcomes of the health needs analysis		

	• The following postcodes (and corresponding suburb names) had a higher percentage of nurse triage episodes resulting in GP afterhours transfers when compared to the APHN average (20.2%):
	  ○ 5127 (25.5%): Wynn Vale (Northern Adelaide Local Health Network (NALHN))
	  ○ 5062 (24.7%): Brown Hill Creek, Clapham, Mitcham, Netherby, Springfield, Torrens Park, Hawthorn, Kingswood, Lower Mitcham, Lynton (Southern Adelaide Local Health Network (SALHN))
	  ○ 5089 (24.5%): Highbury (NALHN)
	  ○ 5081 (24.5%): Collinswood, Gilberton, Medindie, Medindie Gardens, Vale Park, Walkerville (all Central Adelaide Local Health Network (Central Adelaide Local Health Network (CALHN))
	  ○ 5052 (24.1%): Belair, Glenalta (SALHN)
	  ○ 5039 (24.0%): Clarence Gardens, Edwardstown, Melrose Park (SALHN)
	  ○ 5017 (23.4%): Osborne, Taperoo (NALHN)
	  ○ 5045 (23.6%): Glenelg North (CALHN)
	  ○ 5044 (23.4%): Glengowrie, Somerton Park (SALHN)
	  ○ 5121 (22.1%): Macdonald Park, Penfield, Penfield Gardens (NALHN).
	
	• The following postcodes (and corresponding suburb names) had higher percentage of nurse triage/GP afterhours episodes resulting in needing to go to Emergency Department (due to	

Outcomes of the health needs analysis		
	no GP available) when compared to the APHN average (7.8%): ○ 5069 (14.1%): College Park, Evandale, Hackney, Maylands, St Peters, Stepney (CALHN) ○ 5081 (13.8%): Collinswood, Gilberton, Medindie, Medindie Gardens, Vale Park, Walkerville (CALHN) ○ 5118 (12.6%): Bibaringa (NALHN) ○ 5095 (12.3%): Mawson Lakes, Pooraka (NALHN) ○ 5169 (11.8%): Moana, Seaford, Seaford Meadows, Seaford Rise (SALHN) ○ 5042 (11.6%): Bedford Park, Clovelly Park, Pasadena, St Marys (SALHN) ○ 5076 (11.4%): Athelstone (CALHN) ○ 5086 (11.1%): Gilles Plains, Greenacres, Hampstead Gardens, Hillcrest, Manningham, Oakden (NALHN).	
Aboriginal and Torres Strait Islander (ATSI) health	• There is clear disparity in the health outcomes (e.g. life expectancy, prevalence of chronic conditions, potentially preventable hospitalisations, risk factors and immunisation) between the Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or Torres Strait Islander population in the APHN region. • The following areas have the highest proportions of Aboriginal and/or Torres Strait Islander residents: Davoren Park, Elizabeth/ Smithfield - Elizabeth North and Christie Downs/ Hackham West - Huntfield Heights.	Evidence from datasets available on DoH PHN website, PHIDU Social Health Atlas of Australia – PHAs, NPHA analysis of immunisation rates from the Australian Childhood Immunisation Register (ACIR), ABS Australian Health Survey, ABS Australian Aboriginal and Torres Strait Islander Health Survey, National Health Performance Authority (NPHA) analysis of ABS Causes of Deaths and Australian Institute of Health and Welfare (AIHW) analysis of chronic conditions including Aboriginal and Torres Strait Islander Health Performance Framework, BEACH data (2011-2015) for the APHN region, previous Medicare Locals CNAs in the

Outcomes of the health needs analysis		

	• The BEACH study reported that 0.6 per cent of patients visiting General Practitioners in the APHN region identified as of Aboriginal and Torres Strait Islander background.
	
	Immunisation
	• For Aboriginal and/or Torres Strait Islander children, the APHN region has lower immunisation rates than non-Aboriginal and/or Torres Strait Islander children for all age groups.
	
	Chronic conditions
	• For **respiratory disease**, after adjusting for differences in age structures, Indigenous population in South Australians had 1.3 times higher incidence compared with non- non-Indigenous population in the State.
	• Data from the 2012–13 suggest that 11% of Indigenous Australians aged 18 and over had **diabetes** as determined by the fasting plasma glucose test, the same as the national proportion of 11%.
	• After adjusting for differences in age structure, the hospitalisation rate for **diabetes** for Indigenous population was 4.3 times higher than for the non-Indigenous population in South Australia.
	• For **circulatory system diseases**, considerable gaps exist between Indigenous and non-indigenous population:
	  ○ The hospitalisation rate for circulatory disease for Indigenous Australians was 28 per 1,000, compared with a rate of 19 per 1,000 for non-Indigenous Australians
	  ○ By comparison, at the national level the gap in the rates was at a similar level (31 and 20 per 1,000,
		Adelaide PHN catchment, and targeted CCs, CACs, and HPG, stakeholder and community consultations on mental health needs in the APHN region.

Outcomes of the health needs analysis		
	respectively). The rate difference between Indigenous and non-Indigenous Australians in South Australia was similar to that at the national level (9 and 11 per 1,000, respectively) ○ Indigenous Australians had lower rates in ages 5–14 and 65+ than non-Indigenous Australians, but higher rates in all other age groups and in total than non-Indigenous Australians. • After adjusting for differences in age structure, the rate of **chronic kidney disease** among Indigenous population aged 18 and over in South Australia was 21 per 100, compared with 8 per 100 for non-Indigenous Australians in the State. Indigenous Australians were 2.6 times as likely as non-Indigenous Australians to have chronic kidney disease. This was similar to results at the national level. **Alcohol and Other Drugs:** • In 2012/13, hospital admission rates attributable to alcohol among the Aboriginal and Torres Strait Islander population were four times the rate of the non- Aboriginal and Torres Strait Islander population. • Estimates from the 2012/13 ABS Health Survey indicate that 23% of Aboriginal and Torres Strait Islander people in the Adelaide region have an estimated lifetime of risky alcohol consumption according to 2009 NHMRC guidelines. • Aboriginal and Torres Strait Islander people are overrepresented in AOD treatment services, with10.8% of all people in treatment being Aboriginal or Torres Strait Islander, compared to 1.2% of people living in the APHN region. • 27% of Aboriginal and Torres Strait Islander persons have reported using an illicit drug in the last 12 months (2012-13),	

Outcomes of the health needs analysis		
	higher than the rate of total persons in South Australia which is around 16%. • Where reported, 1 in 10 (10%) opioid pharmacotherapy clients identified as Aboriginal and/or Torres Strait Islander. • Aboriginal and/or Torres Strait Islander Australians were around 3 times as likely to have received opioid pharmacotherapy treatment as non- Aboriginal and/or Torres Strait Islander Australians.	
Culturally and Linguistically Diverse (CALD) and New and emerging communities	• There is a need to understand the cultural backgrounds and language barriers of communities in navigating the health system, accessing services and managing health conditions. • The highest proportion of people born overseas in predominantly Non-English Speaking (NES) countries are in the LGAs of Adelaide city, Campbelltown, Port Adelaide Enfield and West Torrens while those resident for less than five years or more are in Adelaide city, West Torrens, Prospect and Port Adelaide Enfield. • The top 10 birthplaces of people from NES countries in the APHN region are: Italy, India, China, Vietnam, Greece, Germany, Philippines, Malaysia, Poland and Netherlands with Port Adelaide Enfield having the majority of residents from these birth places. • The Top 10 languages spoken (by people from NES country) in the APHN region are: Italian, Greek, Mandarin, Vietnamese, Cantonese, Arabic, Polish, German, Spanish and Hindi with Port Adelaide Enfield and Marion having the majority of residents who speak these languages. • Since 2005, an estimated 55% of all refugee new arrivals in South Australia have settled in the northern Adelaide region.	Evidence from PHIDU Social Health Atlas of Australia – PHAs, ABS Census, Department of Immigration Settler Arrivals data, National Notifiable Diseases Surveillance System (NNDSS), estimates from the Hepatitis B Mapping Project National Report 2012/13, ABS Census, BEACH data (2011-2015) for the APHN region and targeted CCs, CACs, and HPG, stakeholder and community consultations on mental health needs and alcohol and other drugs and previous Medicare Locals CNAs in the APHN catchment.

Outcomes of the health needs analysis		
	This percentage equated to a total of 2,905 people in 2006 and increased by 178% to 8,061 persons from the same countries of birth in 2011. • Members of CALD communities, in particular from Asia and the Pacific are disproportionately affected by Hepatitis B. • Salisbury, Playford, Tea Tree Gully, Adelaide city and Port Adelaide Enfield LGAs have high rates of Chronic Hepatitis B notifications per 100,000 population. • The BEACH study reported that 8.2 per cent of patients visiting General Practices were of Non-English speaking background (NESB).	
Childhood Immunisation	• Low prevalence (below the national rate) of childhood immunisation rates in the APHN region for the following age groups and Statistical Areas Level 3 (SA3s): ○ For 1 year old children in SA3s of: Unley, Prospect-Walkerville, Port Adelaide-West, Port Adelaide-East, Campbelltown, Norwood-Payneham-St Peters, West Torrens, Playford, Charles Sturt, Holdfast Bay and Adelaide City ○ For 2 year olds: Norwood-Payneham-St Peters, Onkaparinga, Marion, Playford, West Torrens, Campbelltown, Port Adelaide-East, Port Adelaide-West, Burnside, Charles Sturt, Holdfast Bay and Adelaide City ○ For 5 year olds: Marion, Tea Tree Gully, Onkaparinga, Port Adelaide-West, Burnside, Campbelltown, Mitcham, Prospect-Walkerville, Holdfast Bay, Charles Sturt, Unley, West Torrens, Port Adelaide-East, Norwood-Payneham-St Peters and Adelaide City.	Evidence from datasets available on DoH PHN website, PHIDU Social Health Atlas of Australia – PHAs, NPHA analysis of immunisation rates from the Australian Childhood Immunisation Register (ACIR), and data directly from the ACIR for the APHN region.

Outcomes of the health needs analysis		
Healthy lifestyles	• Lifestyle and risk factors like nutrition, physical activity, smoking and during pregnancy, overweight and obesity impact on the development of identified chronic diseases. • When compared to other LGAs in the APHN region, there was a high proportion of both male and female **smokers** in the LGAs of: Playford, Salisbury, Port Adelaide Enfield and Onkaparinga, and high proportion of females **smoking during pregnancy** in: Playford, Salisbury, Onkaparinga and Port Adelaide Enfield LGAs. • The BEACH study reported a higher percentage (13.7) of patients reported **smoking** daily to their General Practitioners when compared to other capital cities (12.8). • When compared to other LGAs in the APHN region, **physical activity** was low in the following LGAs: Playford, Salisbury, Port Adelaide Enfield, Charles Sturt, Marion and Onkaparinga. • There is a high proportion of people who are **obese** in the LGAs of: Playford, Salisbury, Tea Tree Gully, Port Adelaide Enfield, Charles Sturt and Onkaparinga. • A slightly higher percentage of APHN patients tend to be **Obese** I (30-<35); 17.6%, **Obese** II (35-<40); 6.7% and **Obese** III (>=40); 4.4%, when compared to Other Capital cities and nationally. • Eating healthy foods, especially more **fruit and vegetables** helps to reduce the risk of obesity and chronic diseases. However, residents in Port Adelaide Enfield, Playford, Salisbury and Onkaparinga ate the least amount of fruit and vegetables when compared to the national guidelines/APHN average.	Evidence from PHIDU analysis of ABS Australian Health Survey and NPHA analysis of ABS Patient Experience Survey, BEACH data (2011-2015) for the APHN region, and previous community and stakeholder consultations from Medicare Locals CNA in the APHN catchment.

Outcomes of the health needs analysis		
Healthy Ageing	**Age distribution** • When compared to other capital cities, the Adelaide PHN has a higher proportion of the elderly population and particularly in the LGAs of Campbelltown, Burnside, Walkerville and Holdfast Bay, when compared to the APHN average. • An ageing population has implications for the health system especially increased co-morbidity, potentially preventable hospitalisations and potential need for residential aged care facilities. **Chronic disease** • Prevalence of chronic disease increases with age. According to the ABS National Health Survey, 99% of people aged 75 years and over reported at least one long term condition, compared with 87% of those aged 15 years and over. It is estimated that two-thirds of people aged 60 years and over, and 80% of people aged 75 years and over experience multimorbidity. • In 2012, approximately 41% of 65-74 year olds in South Australia had a disability (a limitation, restriction or impairment, which has lasted, or was likely to last, for at least six months and restricts everyday activities), increasing to 62% of 75-84 year olds and 80% of people 85 years and over. • Estimates from the 2012 ABS Survey of Disability, Ageing & Carers, indicated that 29% of primary carers, and 21% of all carers, in South Australia are aged 65 years and over. • The top three leading causes of death in South Australia by age group in 2014 were:	Evidence from datasets available on DoH PHN website, PHIDU Social Health Atlas of Australia – PHAs, AIHW National Aged Care Data Clearinghouse, AIHW admitted patient care data, ABS Census, Health Direct National Health Service Directory, Health Performance Council of South Australia, BEACH data (2011-2015) for the APHN region and previous Medicare Locals CNAs in the APHN catchment; RACF and primary care literature scan.

Outcomes of the health needs analysis		
	○ Ages 65-74 years: Malignant neoplasms of digestive organs (154.1 deaths per 100,000), Ischaemic heart diseases (132.9 deaths per 100,000) and Malignant neoplasms of respiratory and intrathoracic organs (113.7 per 100,000) ○ Ages 75-84 years: Ischaemic heart diseases (484.4 deaths per 100,000), Malignant neoplasms of digestive organs (336.3 deaths per 100,000) and Cerebrovascular diseases (265.0 deaths per 100,000) ○ Ages 85-94 years: Ischaemic heart diseases (2,097.8 deaths per 100,000), Organic, including symptomatic, mental disorders (1,440.2 deaths per 100,000) and Cerebrovascular diseases (1,162.3 deaths per 100,000) ○ Ages 95 years and over: Ischaemic heart diseases (5,677.9 deaths per 100,000), Organic, including symptomatic, mental disorders (4,439.1 deaths per 100,000) and Cerebrovascular diseases (3,750.9 deaths per 100,000) **Use of health and hospital services** • A high proportion of residents living in the outer metropolitan regions are presenting to the emergency department in the afterhours period. • From the BEACH study, 33.6% of patients (visiting their General Practitioners) were aged 65 and above years. • Access to After Hours primary care services can play a significant role in avoidable emergency department admissions and potential hospital (re)admissions, especially	

Outcomes of the health needs analysis		
	for those that reside in a residential aged care facility (RACF). RACF residents often fall through the gaps, due to the complexity of care required and are more likely to be transferred to hospital via ambulance for care. • For residents of metropolitan Adelaide in 2014-15, 18 out of every 1,000 hospital patient days were used by those eligible and waiting for residential aged care. For Indigenous South Australian, this increased to 36 days. **Residential and community care** • At 30 June 2014, 12,686 people were in residential aged care in Adelaide, 12,497 in permanent care, 189 in respite care; 89% of residents are aged 75 years and over. • Only 21% of general practitioners are regularly engaged in residential aged care in Australia • Residents of RACFs experience complex chronic health problems and high medical needs and although only representing 4% of the general population account for 9% of hospital admissions • Between 2- 3% of hospital admissions from RACFs are medication related placing a large cost burden on the health expenditure • Research indicates that the main problems for RACFs included over prescription of psychotropic drugs, lack of comprehensive acute and chronic care for residents, underuse of advanced care directives, poor family support, inappropriate transfers to hospital, poor on the job support for staff and inadequate palliative care	

Outcomes of the health needs analysis		

Chronic conditions and multimorbidity	• When compared with Other Capital cities (52.5) and the National rate (56.3), the BEACH study reported that the APHN had a higher rate of chronic problems managed per 100 encounters (60.9).
	• Variations of prevalence of estimated population with respiratory system diseases with high proportions in Playford, Salisbury, Tea Tree Gully, Mitcham and Onkaparinga, including variations for the following respiratory conditions:
	  ○ Asthma – High proportions in Playford, Tea Tree Gully, Marion and Onkaparinga
	  ○ Chronic Obstructive Pulmonary Disease (COPD) – High proportions in Playford
	  ○ High premature mortality rates for COPD in Playford, Salisbury, Port Adelaide Enfield, Norwood Payneham St Peters, Adelaide and Onkaparinga.
	• Estimated rates of population with diabetes was higher in Playford, Salisbury, Port Adelaide Enfield, Campbelltown, Norwood Payneham St Peters and Charles Sturt LGAs.
	• Diabetes was reported in the BEACH study as the third most frequent problem managed per 100 GP encounters in the APHN region
	  ○ Higher rate in the APHN region (5.0) when compared with Other Capital cities (4.4) and the National rate (4.6).
	• High proportions of estimated population with high blood cholesterol in Adelaide and Mitcham LGAs.
	• For circulatory system diseases there are fairly similar variations across the APHN region.
		Evidence from PHIDU analysis of ABS Australian Health Survey and NPHA analysis of ABS Patient Experience Survey, Aboriginal and Torres Strait Islander Health Performance Framework, BEACH data (2011-2015) for the APHN region and previous Medicare Locals CNAs in the APHN catchment.

Outcomes of the health needs analysis		

	• Variations of prevalence of musculoskeletal system diseases across the APHN region with Playford LGA with estimated high rates of population with the condition.
	• Hypertension was reported in the BEACH study as the most frequent problem managed per 100 GP encounters in the APHN region.
	• With regards to population prevalence of multimorbidity, the BEACH study reported that the APHN has a:
	  ○ higher percentage of multimorbidity (2+ chronic conditions) (25.4) when compared with Major cities (23.5) in Australia
	  ○ higher percentage of multimorbidity (3+ chronic conditions) (15.7) when compared with Major cities (15.3) in Australia
	  ○ higher percentage of multimorbidity (2+ body systems affected) (22.9) when compared with Major cities (21.0) in Australia
	  ○ higher percentage of complex multimorbidity (3+ body systems) (12.1) when compared with Major cities (10.7) in Australia.	

Persistent Pain	• Due to the subjective nature of pain, it is difficult to diagnose the actual prevalence of (persistent) pain in the population. Persistent pain however impacts on overall health and wellbeing, including management of existing chronic conditions and medications to treat them. • The most recent reported prevalence rate for persistent pain in Adelaide was 18%. SA Health acknowledges the waiting time to access tertiary pain services are the longest in the country.	Evidence from NPHA analysis of PBS prescription medicines and previous stakeholder consultations from Medicare Locals CNA, Currow D, Agar M, Plummer JL et al. 2010. Chronic pain in South Australia: population levels that interfere extremely with activities of daily living. Aust NZ Public Health 34(3):232–239, BEACH data (2011-2015) for the APHN region

Outcomes of the health needs analysis		
	This means around 80% of South Australians living with persistent pain are not receiving treatment and support to improve their health and quality of life • According to the BEACH study, the APHN had a higher percentage (31.6) of new back complaint management (with imaging test request) when compared to Other Capital cities (25.0) and nationally (26.2).	
Potentially Preventable Hospitalisations (PPH)	• Management of chronic conditions and lifestyle and risk factors can play a role in avoidable emergency department admissions and hospital (re)admissions. • COPD, Congestive heart failure, Diabetes complications, Angina, Iron deficiencies were the top chronic conditions for PPH in the APHN region for 2013-14. • For acute conditions, dental, kidney and urinary tract infections (UTI), and cellulitis were the top PPH conditions in the APHN region for 2013-14. • In 2013-14, Heart failure, COPD and Kidney and UTI had the highest proportion in total bed days. • Playford, Port Adelaide-West and Salisbury had the highest PPH rate per 100,000 people. • Onkaparinga, Salisbury and Charles Sturt had the highest number of PPH and PPH total bed days. • Medication related hospital admissions comprise between 2-3% of all hospital admissions in Australia, rising to an estimated 20-30% in population aged over 65 years. Another paper reports that around half of medication related hospital admissions are classified as 'definitely avoidable'.	Evidence from NHPA analysis of Admitted Patient Care National Minimum Data Set 2013–14, Australian Commission on Safety and Quality in Health Care (2013), Literature Review: Medication Safety in Australia. ACSQHC, Sydney, Elliott R, Booth J Problems with medicine use in older Australians: a review of recent literature Journal of Pharmacy Practice and Research (2014) 44, 258–271.

Outcomes of the health needs analysis		

Cancer screening	• Early screening of selected cancers (cervix, bowel and breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy including diagnostic follow-up procedures and treatment.
	• While APHN participation rates are higher than the Australian rates for bowel and cervical cancer screening, breast cancer screening participation rates are lower than the national average (APHN ranks 22nd out of 31 PHNs nationally
	• Colorectal Cancer (Incidence and Screening):
	  ○ Incidence (new cancer cases) of colorectal cancer (age standardised) within the APHN is 61.4 per 100,000 people compared with the Australian rate of 62.7 per 100,000 people and ranks 21st (out of 31) when compared with all other PHNs
	  ○ APHN has the third highest bowel cancer screening participation rate in Australia with 43.6% and is higher than the Australian comparative rate of 37.3%.
	• Breast Cancer (Incidence and Screening):
	  ○ Incidence (new cancer cases) of breast cancer (age standardised) within APHN is 116.1 per 100,000 people, higher than the Australian rate of 114.1 per 100,000 people and ranks as having the 7th (of 31) highest rate of incidence of breast cancer when compared with all other PHNs
	  ○ National breast cancer screening rates for women within the APHN (53.8%) are lower than the Australian standard rate (54.2%) and ranks 22nd out of all (31) PHNs.
	• Cervical Cancer (Incidence and Screening):
		AIHW analysis of incidence of cancer rates Australia data by Primary Health Network, 2005-2009, AIHW analysis of cancer screening rates Australia data by Primary Health Network, 2013-14.

Outcomes of the health needs analysis		
	○ Incidence (new cancer cases) of cervical cancer (age standardised) within APHN is 6.3 per 100,000 people, lower than the Australian rate of 6.9 per 100,000 people. Adelaide PHN ranks as having the 22nd (of 31) highest rate of incidence of cervical cancer out of all PHNs. ○ Adelaide PHN cervical screening participation rates are at 58.0% - 11th highest rate amongst all PHNs, the rate is also higher when compared with the Australian rate of 57.3%.	

Section 3 – Outcomes of the service needs analysis

This section summarises the findings of the service needs analysis in the table below.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence

Access to services	• Physical/ Geographical:
	  ○ Mental Health and AOD mal-distribution of services-two-thirds of providers are in the central PHN region, resulting in gaps in services in the northern, western and southern areas.
	  ○ Lack of transport, geographical limitations.
	• Flexibility:
	  ○ Lack of 24/7 access to primary health care services
	  ○ Lack of awareness of appropriate, existing afterhours services that can respond to the level of care required/needed
	  ○ Insufficient funding and government support
	  ○ Lack of flexibility in funding arrangements- not responsive to community needs.
	• Service gaps:
	  ○ ATSI -The right service is not available to meet needs; lack of appropriately targeted suicide prevention services
	  ○ Mental Health and AOD - Lack of crisis and after hours support in the community; finding a service that is appropriate and can respond to the level of need
	• Timeliness (wait times):
	  ○ Timely access to appropriate services.
		Evidence from APHN Clinical Councils (CC): Southern & Northern Baseline Needs Assessment (BNA) consultations; APHN Community Advisory Councils (CAC); Central, Northern & Southern BNA consultations, Mental Health, Alcohol and Other Drugs (MHAOD) Needs Assessment (NA) APHN online surveys, MHAOD CAC consultations, MHAOD Enzyme workshops.

Outcomes of the service needs analysis		

	• Affordability:
	  ○ Lack of affordable services.
	• Navigation:
	  ○ Invisibility of service systems to community and primary health referrers
	  ○ Unclear entry pathways into treatment
	  ○ Limited understanding of the available after hours services in the metropolitan region, especially in the outer northern and southern metropolitan suburbs and for those residing in aged care facilities
	  ○ Difficulties navigating the system.
	• Client/carer support and advocacy
	  ○ Lack of support for carers.	

Access to information/Health literacy/Education	• Lack of awareness of existing services including alternative service options for different population groups, consumers and providers. • MH&AOD – Increased access to self-help resources.	Evidence from CC: Southern, Northern BNA consultations; CAC: Central, Northern and South BNA consultations, MHAOD NA APHN online surveys, MHAOD NA CAC consultations, MHAOD NA Enzyme workshops.
Care coordination	• AOD - Engaging with family/significant others without alienating client and impacting on treatment. • No central repository for service information and referral options. • Lack of easily understood and accessible referral pathways across systems and settings and providers to decrease avoidable hospital (re)admissions for patients with chronic condition(s). • Discontinuity of care between services and sectors (e.g. Acute services to Primary health services).	Evidence from CC: Southern, Central, Northern BNA consultations; CAC: Central, Northern and South BNA consultations, MHAOD NA APHN online surveys, MHAOD NA CAC and CC consultations, MHAOD NA Enzyme workshops.

Outcomes of the service needs analysis		
Integration (system)	• Lack of communication between service providers and sectors (e.g. primary to tertiary/acute - clinical handover, social factors & health services, Local and State). • End of Life Palliative care – poorly integrated, gaps in care often lead to unwanted hospital transfers. • Mental Health and AOD - Disconnect between Mental Health and AOD services. • Disconnect between GPs and Specialists and the MHAOD sector. • Inability to collaborate with other agencies and decisions on who should be the lead agency. • Inflexible systems and processes.	Evidence from CC: Southern, Central, Northern BNA consultations; CAC: Central, Northern and South BNA consultations, MHAOD NA APHN online surveys, MHAOD NA CAC and CC consultations, MHAOD NA Enzyme workshops.

Appropriate and person-centred care	• Co-morbidity:
	  ○ Inability to address comorbid presentations
	  ○ Program funding criteria is inflexible and restricts ability to address comorbidity issues – i.e. when client has AOD/MH/Gambling therefore excluding clients from treatment.
	• Targeted and appropriate services for at-risk groups:
	  ○ ATSI - Engaging with family across cultural and generational divide; Lack of appropriate culturally appropriate services in specific locations
	  ○ CALD - Lack of appropriate Culturally and Linguistically Diverse (CALD) appropriate services in specific locations.
	  ○ Lack of appropriate targeted services (e.g. child, youth, perinatal, ATSI, Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning (LGBTIQ), CALD, elderly).
	• Stigma
		Evidence from CAC: Northern BNA consultation, MHAOD NA APHN online surveys, MHAOD NA Enzyme workshops, analysis of Health Direct NHSD.

Outcomes of the service needs analysis		
	○ Stigma associated with diagnosis and the impact on help seeking ○ Stigma experienced when accessing a service. • Lack of responsiveness to individual circumstances.	
Early intervention and prevention	• Inadequate focus on preventative health. • MH & AOD – 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; improving access to resources promoting well-being and recovery orientated measures.	Evidence from CC: Central BNA consultation; CAC: Northern BNA consultation; MHAOD NA APHN online surveys, MHAOD NA Enzyme workshops.
Workforce	• Aptitude/skills, and attitude ○ Lack of staff awareness, poor attitude and lack of empathy. ○ ATSI - Lack of compassion and understanding. • MH and AOD - Fostering peer support workforce • ATSI - lack of Aboriginal Health Staff. • Changing dynamics of health (including allied health) workforce requirements in specific locations and for different population groups.	Evidence from CC: South BNA consultation, MHAOD NA APHN online surveys, MHAOD NA Enzyme workshops, analysis of Health Direct NHSD.
Quality and clinical governance	• Unwarranted variation in care. • Quality use of medicines. • Inadequate poor quality care and follow up.	Evidence from CC: Southern and Central BNA consultations.

Section 4 – Opportunities, priorities and options

This section summarises the priorities arising from the Needs Assessment and options for how they will be addressed.

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
Mental Health and Suicide Prevention			
1. High prevalence of mental health/behavioural issues and psychological distress in selected areas across the region.	• Target commissioning of mental health treatment services in areas of need along a stepped-care model	• Better targeting and re-distribution of services to high needs areas • People getting the right care, at the right time in the right place • Improved data collection around people's journey, experience and outcomes using mental health treatment services	• Outcomes for people accessing mental health treatment services using selected measures • Waiting list times for people accessing mental health treatment services in areas of high need • Self-reported satisfaction ratings from people accessing mental health treatment services • Referral action management rate
2. Provision of psychological services comparatively low in areas of highest need.	• Target commissioning of mental health treatment services in areas of need along a stepped-care model	• Better targeting and re-distribution of services to high needs areas • People getting the right care, at the right time in the right place	• Waiting list times for people accessing mental health treatment services in areas of high need

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
3. Comparatively high numbers of people attempting to access psychological services in areas with minimal psychological service provision.	• Coordinate existing and new services to more effectively meet need	• Improved data collection around people's journey, experience and outcomes using mental health treatment services	• Numbers of people accessing digital mental health treatment services in the APHN region
4. Disproportionate quantities of mental health related medicines prescribed in women, disadvantaged areas and population groups such as people aged 75 and over.	• Implementation of stepped care model of mental health through mental health and alcohol and other drugs reform. • Ensure quality use of medicines programs are available and utilised appropriately	• Improved prescribing practices of mental health related medicines • Improved quality use of medicines. • Improved capacity of health providers to identify opportunities to improve medication management	• Reduced numbers of prescriptions for women, people aged 75 years and over and in low SEIFA areas, in line with expected national rates
5. Difficulty in identifying and accessing appropriate mental health treatment services.	• Integrate existing and new services to more effectively manage and monitor people's mental health treatment needs • Integrate and coordinate existing and potential referrers and service providers of mental health treatment services	• People getting the right care, at the right time in the right place • Improved data collection around people's journey, experience and outcomes using mental health treatment services • Increased community understanding of service system	• Outcomes for people accessing mental health treatment services using selected measures • Waiting list times for people accessing mental health treatment services in areas of high need • Numbers of people accessing self help and digital mental health treatment services in the APHN region

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
	• Promote access points and availability of mental health treatment services across the region		• Self-reported satisfaction ratings from people accessing mental health treatment services
6. Greater prevalence of intentional self-harm and suicide in selected areas and specific population groups across the region including Aboriginal and Torres Strait Islander people.	• Implement improved, culturally relevant, suicide prevention strategies • Coordinate and complement acute mental health services and activities to more effectively address self-harm behaviour, people at risk of suicide and/or people who have recently attempted suicide • Commission mental health treatment services in areas of need along a stepped-care model • Coordinate existing and new services to more effectively target mental health treatment access for populations in need,	• Evidence based, consistent suicide prevention strategies in place appropriate to high risk groups • Increased support for people at risk of suicide and/or who have recently attempted suicide • Increased number of Aboriginal people accessing suicide presentation programs	• Reduction in rates of suicide and self-harm behavior (in identified areas and groups and in Aboriginal and Torres Strait Islander people in the region)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
	particularly Aboriginal and Torres Strait Islander people		
Drug and Alcohol Treatment			
7. Alcohol is the most common principal drug of concern in particular areas of the APHN region and for population group including Aboriginal and Torres Strait Islander people.	• Support the targeted coordination and integration of treatment services, particularly for identified populations in need • Health promotion activities supporting lifestyle and behavioural changes	• People receiving the right care, at the right time in the right place • Decreased rates of risky alcohol use, particularly in identified populations	• Reduced rates of risky alcohol consumption • Increased alcohol treatment rates • Increased treatment services for alcohol use in Aboriginal and Torres Strait Islander people
8. Significantly less South Australians with AOD problems access counselling as a treatment than the Australian average.	• Coordination of services and activities in collaboration with stakeholders and service providers to improve access to counselling services • Support integration of treatment services across the region	• Increased rates of people receiving counselling for AOD problems	• SA treatment rates closer to Australian average

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
9. Higher prevalence of illicit drug use in selected areas and specific population groups, particularly Aboriginal and Torres Strait Islander populations.	• Targeted services and activities in collaboration with stakeholders and service providers for illicit drug users. • Support the integration and targeted delivery of treatment services across the region, particularly for services working with Aboriginal and Torres Strait Islander people	• Decreased use of illicit drugs, particularly in identified populations. • Increased culturally relevant supports available for Aboriginal and Torres Strait Islander people. • Increased Aboriginal community awareness of illicit drug rehabilitation services available.	• Rates of illicit drug use within cultural groups • Number of Aboriginal and Torres Strait Islander people accessing illicit drug rehabilitation or recovery programs.
Population Health and Primary Health Care After Hours Services			
10. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non- Aboriginal and Torres Strait Islander children.	• Coordinated approach with partners and stakeholders to educate and promote the uptake of immunisation through the development of a virtual immunisation hub	• Increased numbers of Aboriginal and Torres Strait Islander children are receiving the full program of childhood immunisation and at the recommended time.	• Increased rates of child immunisation in the Aboriginal and Torres Strait Islander population
11. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes,	• Programs supporting the provision of care coordination and supplementary services.	• Increase uptake of Aboriginal and Torres Strait Islander specific MBS items • Improved capacity of mainstream primary care	• Number of Aboriginal and Torres Strait Islander people referred to Closing the Gap programs • Number of General Practices registered with Practice Incentive

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.	• Regionalised, service provider-directed chronic condition integration and coordination approach (APHN Health Care Hubs concept). • Targeted commissioning of community based chronic disease coordination programs in locations with higher numbers of Aboriginal and Torres Strait Islander residents. • Commission cultural awareness training programs for General Practice from RACGP accredited training programs	services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people. • Increased number of general practice staff who have completed cultural awareness training programs	Payment Indigenous Health Incentive program. • Number of MBS item 715 -Aboriginal and Torres Strait Island people health assessments.
12. The CALD community are disproportionately affected by Hepatitis B.	• Coordinated approach with partners and stakeholders to educate and promote the uptake of immunisation through	• CALD community receive appropriate prevention and intervention services to reduce rates of chronic hepatitis B infection	• Increased testing and identification of hep b positive clients • Increased referrals to viral hepatitis nurse network

Opportunities, priorities and options			
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	the development of a virtual immunisation hub called the SA PHN Immunisation Hub.		• Increased notification of hepatitis to SA Health • Number of referrals to viral hepatitis nurse network • Increased rates of hepatitis B treatment
13. 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.	• Programs aimed at increasing access to mainstream primary healthcare for Aboriginal and Torres Strait Islander people. • Programs aimed at increasing access to appropriate primary health care services for CALD and refugee populations in identified locations.	• Primary Health Care Services are providing care which supports the health of people from a variety of backgrounds • People of all backgrounds are receiving the right care, at the right time in the right place • Improved practices of PHC to provide culturally appropriate and safe services	• Increased numbers of Aboriginal and Torres Strait Islander people accessing mainstream primary care services • Increased numbers of diverse communities accessing mainstream primary care services • Number and percent of education session attended • Reported satisfaction of community members receiving appropriate care
14. Identified areas of the APHN region have childhood immunisation rates below the national average.	• Coordinated approach with partners and stakeholders to educate and promote the uptake of immunisation through the development of a	• Increased numbers of children are receiving the full program of immunization and at the recommended time.	• Increased rates of child immunisation in all children under 20 years of age, particularly those <5 years of age

Opportunities, priorities and options			
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	virtual immunisation hub called the SA PHN Immunisation Hub.		
15. Selected areas of the APHN region have high rates of smoking which correlates with areas of high prevalence of COPD.	• Partnership-based activities focused on smoking cessation and respiratory disease management activities in identified areas. • Health promotion activities supporting lifestyle and behavioural changes. • Regionalised, service provider-directed chronic condition integration and coordination approach (APHN Health Care Hubs concept).	• Decreased rates of smoking • Improved awareness of smoking related harms • Decreased rates of hospitalisations due to respiratory conditions	• Increased rates of people accessing the Quitline • Increase in referrals to Quitline • Decrease in the number of respiratory related presentations/hospitalisations.
16. Selected areas of the APHN region have high rates of obesity and overweight and correlate with areas of low physical activity and poor nutrition.	• Obesity interventions in primary care • Health promotion activities supporting lifestyle and behavioural changes.	• Obesity interventions result in weight loss and maintenance weight loss • Increased coordination of health promotion and health	• Number of health providers participating in lifestyle modification programs • Number of people participating in primary care obesity programs

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
	• Regionalised, service provider-directed chronic condition integration and coordination approach (APHN Health Care Hubs concept).	literacy activities across the region • Improved alignment of coordinated support around specified lifestyle risk factors to areas of high need • Improved capacity of general practice to identify at-risk patients and implement behavioural modification strategies	• Number of health promotion activities being undertaken in the APHN region.
17. 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.	• Regionalised, service provider-directed chronic condition and multi-morbidity integration and coordination approach (APHN Health Care Hubs concept). • APHN-wide general practice support with a focus on quality and safety. • Health promotion activities supporting	• Improved alignment of coordinated support around specified chronic conditions and multi-morbidities to areas of high need • Improved capacity of general practice to manage patients with chronic conditions and multi-morbidity in the APHN population • Increased coordination of health promotion and health literacy activities across the region	• Number of general practices signed up to participate in the Health Care Hub concept. • Participation of health providers in other quality improvement programs, such as accreditation, Practice incentive programs and other programs specific to their service • Number of general practices that sign up for the Practice Support and Improvement Program.

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
	lifestyle and behavioural changes.	• Improved capacity of health providers to implement self-management support strategies	
18. Services for people living with persistent pain are limited with long delays to access hospital-based services.	• Implementing persistent pain management programs and strategies in primary care settings • Statewide coordination of referral pathways in primary care and into the acute sector	• Improved access to persistent pain management in primary care • Improved health provider understanding of options for primary care management of persistent pain	• Participants of primary care pain management programs report increased understanding, skills and ability to address their pain • Health providers report increased awareness of referral options for persistent pain management
19. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.	• Regionalised, service provider-directed chronic condition and multi morbidity management including integrated and coordinated approach (APHN Health Care Hubs concept). • APHN-wide general practice support with a focus on quality and safety	• Improved management of multi morbidity in ageing population • Improved capacity of general practice to manage patients with multi morbidity in the ageing population • Decreased PPH for ageing population in the APHN region • Improved access to multidisciplinary care for patients with multi morbidity	• Number of general practices participating in the APHN Health Care Hubs • Number of and % of eligible patients with Over 75 Health Assessment • Patients express high levels of satisfaction with care provided by their general practice • General practice staff report improved knowledge and confidence in the management of multi morbidity in their ageing population

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
	• Integrated pathways and service finding across primary, secondary and tertiary health care		• Number of and type of PPH by age of patient, hospital and LHN in APHN region • Number of general practices participating in APHN safety and quality led initiatives • Number of and % of accredited general practices in the APHN region
20. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations.	• Promotion of alternative service options to reduce inappropriate emergency department presentations. • Community awareness resources. • After hours innovation grants for primary care providers.	• Improved awareness of available and appropriate after hours primary care services. • Improved integration amongst primary care practitioner in the after hours period. • Decreased rates of inappropriate ED after hours presentations.	• Number of resources delivered to Playford LGA residents. • Number of After Hours Innovation grants administered. • Reduction in inappropriate after hours emergency department presentations.
21. RACFs have a low capacity to support their residents in the afterhours setting leading to increased transportation to emergency departments and medical deputising services.	• Capacity and Capability building in RACFs to support management of chronic and complex conditions, including preventive and end of life care	• Residents receive appropriate and timely chronic and clinical care in their RACF • Residents are not transported to hospital in the after hours period when this is inappropriate	• Number of Multi Disciplinary Care plans provided for RACF residents in the APHN region • Number of Residential Medication Management Reviews for RACF residents in the APHN region

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
	• Pathways for those living in RACFs to access after-hours health services. • Coordination of after-hours services and activities in collaboration with stakeholders, services providers.	• RACF staff have an increased knowledge and understanding of chronic and clinical care needs and interventions to reduce inappropriate hospitalizations for residents in the after hours period	• Number and type of general practitioner (or MDS) attendance for RACF residents in the APHN region • Number of and type of presentations from RACFs to hospitals by LHN in the APHN region • RACF staff report improved knowledge and confidence in managing chronic and clinical care needs and interventions to reduce inappropriate hospitalisations for RACF residents in the after hours period
22. 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).	• Regionalised, service provider directed chronic condition integration and coordination approach (APHN Health Care Hubs concept). • APHN-wide general practice support with a focus on quality and safety.	• Improved alignment of coordinated support around specified chronic conditions and multi-morbidities to areas of high need • Improved capacity of general practice to manage patients with chronic conditions and multi-morbidity in the APHN population	• Number of general practices signed up to participate in the Health Care Hub concept. • Number of general practices that sign up for the Practice Support and Improvement Program.

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
23. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.	• Ensure quality use of medicines programs are available to health providers and are utilised appropriately. • Identify opportunities to have pharmacists working within APHN programs, particularly those involving RACFs, and other multi-disciplinary teams • Improve access to medicines used in palliative care to avoid unnecessary hospital presentation	• Improved capacity of health providers to identify opportunities to improve medication management • Reduction in preventable hospitalisations due to medication misadventure • Increased collaboration between pharmacists, general practice and other health providers	• Increased number of health providers participating in quality use of medicines programs such as the QUM PIP • Increased number of pharmacists working with RACFs • Increased numbers of pharmacists working in collaboration with general practice • Increased utilisation of Home Medicine Reviews within appropriate guidlelines
24. 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.	• Increasing participation in screening programs through collaboration with private and public programs. • Coordinated approach with partners and stakeholders to educate consumers and	• Improved capacity of health providers to identify opportunities for cancer screening. • Increased community understanding of screening services.	• Health providers report increased awareness of referral options for screening and cancer intervention measures. • Number of screening services provided.

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
	promote screening in specified populations and locations.		
25. 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.	• Implementation of stepped care model of mental health through mental health and alcohol and other drugs reform. • Single point of entry ”no wrong door“ approach for mental health and alcohol and other drugs services. • Regionalised, service provider directed chronic condition integration and coordination approach (APHN Health Care Hubs concept). • Central repository for service options and referral pathways. • Community Education (e-news, education sessions, service provider education)	• People getting the right care, at the right time in the right place • Improved data collection around people’s journey, experience and outcomes using treatment services • understanding of service system Increased community	• Patients report increase in health literacy • Number and percent of attendance at education sessions • Increased use of resources and tools

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
26. Lack of easily understood and accessible referral pathways across systems and settings.	• Regionalised, service provider directed chronic condition integration and coordination approach (APHN Health Care Hubs concept). • Central repository for service options and referral pathways.	• Improved alignment of coordinated support around specified chronic conditions and multi-morbidities to areas of high need • Improved capacity of general practice to manage patients y in the APHN population. • Improved access to regional clinical guidelines and referral pathways.	• Number of general practices signed up to participate in the Health Care Hub concept. • Increased use of resources and tools. • Health providers report increased awareness of referral options
27. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.	• Dedicated health professional liaison roles to facilitate inter-sector communication (APHN/CSAPHN/WCH GP Liaison Officer program).	• Improved communication between primary and acute care providers. • Timely separation summaries provided at point of discharge.	• Number of interactions between GP liaison Officer and general practice.
28. Lack of community awareness about existing health care services for different population groups, consumers and providers.	• Promotion of alternative service options to reduce inappropriate emergency department presentations.	• People getting the right care, at the right time in the right place • Improved data collection around people's journey, experience and outcomes using treatment services	• Numbers of people accessing Healthdirect service • Reduction in inappropriate after hours emergency department presentations.

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
		• Increased community understanding of service system	
29. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.	• Regionalised, service provider directed chronic condition integration and coordination approach (APHN Health Care Hubs concept).	• People getting the right care, at the right time in the right place • Improved data collection around people's journey, experience and outcomes using treatment services • Increased community understanding of service system	• Number of general practices signed up to participate in the Health Care Hub concept. • Patients express high levels of satisfaction with care provided by their general practice
30. 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.	• Promotion of alternative service options to reduce inappropriate emergency department presentations and increase promotion of preventive health activities.	• People getting the right care, at the right time in the right place • Improved data collection around people's journey, experience and outcomes using treatment services • Increased community understanding of service system	• Health direct service usage • Reduction in inappropriate after hours emergency department presentations. • Patients express high levels of satisfaction with care provided by their general practice
31. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of	• Workforce training and education programs, including networking,	• Health providers attending training and education sessions that provide access to best practice evidence based	• Number of education and training sessions held

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Possible Performance Measurement
health care staff across a range of sectors and settings as well as increase workforce capacity.	mentoring and capacity building activities. • Increased diversity of workforce roles to meet community need.	guidelines for use in primary care • Provision of care which supports the health of people from a variety of backgrounds • People of all backgrounds are receiving the right care, at the right time in the right place • Improved practices of PHC to provide culturally appropriate, safe and empathic services	• Number of attendees/disciplines at training and education sessions.
32. Minimise instances of poor quality and unwarranted variations of care and follow up.	• Advocating for and supporting strong clinical governance. • APHN-wide PHC/general practice support with a focus on quality and safety.	• Reduced instances of unwarranted variations of care • Improved quality of care and follow up • Health providers accessing and using best practice evidence based guidelines for use in primary care	• Number of general practices participating in APHN safety and quality led initiatives • Participation of health providers in other quality improvement programs, such as accreditation, Practice incentive programs and other programs specific to their service