Adelaide - Core Funding
2023/24 - 2027/28
Activity Summary View

CMDT-Admin - 202424 - O202424 - Commissioning Multidisciplinary Teams - Administration

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CMDT-Admin

Activity Number *

202424

Activity Title *

O202424 - Commissioning Multidisciplinary Teams - Administration

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Other Program Key Priority Area Description

Aim of Activity *

Description of Activity *

Needs Assessment Priorities *

Needs Assessment

Priorities

Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region

Activity Consultation and Collaboration

Consultation

Collaboration

Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Co-design or co-commissioning comments

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

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF-COVID-VVP

Activity Number *

202207

Activity Title *

A202207 - COVID19 - Vaccination of Vulnerable Populations

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

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

Description of Activity *

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

Utilising targeted, short-term local solutions to supplement existing activities and arrangements (such as state and territory focussed approaches and other vaccination pathways and sites (if applicable and in accordance with local legislative frameworks).

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

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	82
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate workforce and primary health care services	90
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access timely, culturally safe and appropriate primary health care services	81
Families, children and young people can access timely early intervention, prevention and support services	81

Activity Demographics

Target Population Cohort

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

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

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

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Collaboration

Activity Milestone Details/Duration

Activity Start Date

31/12/2021

Activity End Date

30/12/2024

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

No

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

No

Co-design or co-commissioning comments

CF-COVID-VVP - 202505 - A202505 – Vaccination of Vulnerable Populations Primary Care Support

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF-COVID-VVP

Activity Number *

202505

Activity Title *

A202505 – Vaccination of Vulnerable Populations Primary Care Support

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

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

Description of Activity *

The activity aims to increase uptake of and access to COVID-19 immunisation for at-risk population groups utilising targeted, short-term local solutions to supplement existing activities and arrangements (such as state and territory) focussed approaches and other vaccination pathways and sites (if applicable and in accordance with local legislative frameworks).
This activity will support:
- Commissioining COVID-19 vaccination service delivery in areas of need for at-risk populations. This could include support financial support with expenses incurred to reach at-risk populations (in excess to the current flag fall item);
- Reimburse health professionals and/or commission appropriate services to provide COVID vaccination to at-risk populations.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
People in the Adelaide PHN region have awareness of, and timely access to person centered models of comprehensive care across the care continuum	82
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate workforce and primary health care services	90
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access timely, culturally safe and appropriate primary health care services	81
Families, children and young people can access timely early intervention, prevention and support services	81

Activity Demographics

Target Population Cohort

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

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Collaboration

Activity Milestone Details/Duration

Activity Start Date

31/12/2024

Activity End Date

29/06/2026

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

No

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

No

Co-design or co-commissioning comments

WIP-PS - 202417 - A202417 - Workforce Incentive Program - Practice Stream

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

WIP-PS

Activity Number *

202417

Activity Title *

A202417 - Workforce Incentive Program - Practice Stream

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

Support General Practices to understand and utilise WIP-PS to its full potential.

Description of Activity *

• Explore the current utilization in General Practice

- o which additional workforce has been employed under the WIP-PS
  • Explore the potential barriers to WIP-PS, including the limitations or perceived limitations of the initiative.
- Explore the potential enablers of the WIP-PS program Support understanding in General Practice of WIP-PS stream through market analysis, including but not limited to
  - o Health Economist interviews with general practice to support market analysis
  - o Survey issued to general practice
  - o Consultations with small and solo general practices.
- Support General Practice to understand which health professionals could be employed based on patient needs by
  - o providing information and resources that support decision making
  - o Supporting practices to understand their data and to utilise data in decision making

•

• Encourage General Practices to utilise WIP-PS to bolster access for patients to additional services such as allied health professionals.

- A dedicated team supports general practice. This team will support understanding and where appropriate, uptake of WIP-PS through site visits, attendance at clinical meetings, telephone support and networks.
- Supporting general practices in identifying potential workforce gaps and how the WIP-PS could support additional workforce.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Support practitioners to improve communication and build relationships with other health care providers	177
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177

Activity Demographics

Target Population Cohort

General Practice

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

PHN data demonstrates the uptake of the WIP-PS is lowest for the small and solo General Practices in the region. Engagement undertaken as part of the Core – MyMedicare activity will include education regarding the WIP-PS, and an understanding of the barriers to using it for Allied Health.
The PHN will also work closely with a small number of practices to undertake an in-depth interview to understand how they use the WIP-PS, leading to some case studies.
The PHN will undertake market analysis to understand:
• the types of practices
• the barriers to using the WIP-PS for Allied Health
• their capacity to participate in future APHN procurement activities (such as commissioning Allied Health).

Collaboration

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2026

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Other Approach (please provide details): No

Is this activity being co-designed?

No

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

No

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

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

No

Co-design or co-commissioning comments

GPACI-GPM - 202418 - A202418 – General Practice in Aged Care – GP Matching

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

GPACI-GPM

Activity Number *

202418

Activity Title *

A202418 – General Practice in Aged Care – GP Matching

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The My Medicare - General Practice in Aged Care Incentive (GPACI) aims to improve access to quality, proactive general practice care for older people who live in aged care homes by incentivising proactive visits, regular, planned reviews and coordinated care planning.
APHN aims to improve the coordination and delivery of primary care services to RACH residents in place of residence through building relationships between Residential Aged Care Homes (RACH) and general practices/Aboriginal Community Controlled Health Services (ACHHS), and capacity building activities to enhance the local adoption of GPACI.

Description of Activity *

This activity will inform, support and capacity build general practice, ACCHS and RACH to uptake and participate in GPACI by:
- Communicating the incentive to the APHN region Residential Aged Care/Primary Care sectors
- Supporting people, GPs, general practice/ACCHS staff, and RACH staff to understand the incentive
- Building APHN knowledge and understanding of primary care service delivery in RACH located in the Adelaide metro region to inform targeted initiatives that support stakeholder participation in GPAC and facilitate enhancement in local systems and processes to enable matching of resident and appropriate GP service.
- Supporting building capacity of GPs, general practice and ACCHS to facilitate delivery of regular, coordinated and quality care for

residents in RACH, with additional assistance for supporting matching residents and GP

This activity is phased over 3 years:
FY24/25 Phase 1: Explore, inform and engage
APHN will undertake a comprehensive communication and engagement project to inform the market of the incentive, facilitate a consultative needs assessment and service mapping activity across the region, and establish and enhance existing relationships with relevant stakeholders.
APHN will commission design and development of an engagement and education plan to enable dissemination and uptake of resources including Best Practice Guidelines (GP Toolkit), and engage in localised communication opportunities to support local system enhancement between GP/RACH, and assist with coordination of resident/GP matching as required.
FY25/26 Phase 2: Inform, Build and Develop
Working within a Quality Improvement (QI) framework, APHN will facilitate direct outreach support through practice visits and individualised practice support for general practices and ACCHS's across the region to build understanding and capacity in GPACI, and establish systems to uptake and participate in GPACI, and work with RACH.
Informed by the needs assessment process in Phase 1, APHN will design and implement a pilot activity (Pilot 1) with general practices new to delivering care to residents living in RACH, and facilitate establishing formalised local working arrangements with identified RACH including an agreed care delivery model.
APHN will facilitate regional forums with general practices and RACHs to facilitate local opportunities to establish effective/formalised reciprocal arrangements for care delivery, enhance local processes for enabling systems for matching residents with GPs and showcase effective approaches.
APHN will commission delivery of a locally relevant Best Practice Guideline education program across primary care providers to support providers to operationalise GPACI, and deliver quality care in RACH.
FY26/27 Phase 3: Build, Develop and Sustain
Working within a QI framework, APHN will continue to facilitate direct outreach support through practice visits and individualised practice support for general practices and ACCHS's in the region to improve and build on capacity, and systems to participate in GPACI in an effective and sustainable way.
Informed by Phase 1 needs assessment, and Pilot 1 learnings, APHN will implement a second pilot activity with general practices new to delivering care to residents living in RACH, and facilitate establishing formalised working arrangements with identified RACH including an agreed care delivery model.
APHN will continue to facilitate regional forums with general practices and RACHs to facilitate local opportunities to establish effective/formalised working arrangements for care delivery in RACH and showcase effective approaches including learnings from Pilot 1 and 2.
APHN will continue commissioning and delivery of a locally relevant Best Practice Guideline education program across primary care providers to support providers to operationalise and deliver care in RACH, and build capability to enable local systems and processes for matching residents with GPs. In building sustainability beyond end of funding, pilots 1 and two will inform APHN ongoing QI activity approach to support maintaining uptake and participation in GPACI by general practice/ACCHS beyond end of funding.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Identify and support the capacity and capability of the Primary Healthcare Workforce to work with cohorts of patients in need of equitable access to healthcare services	178
Older people living in the community and residential aged care are supported by timely, accessible, coordinated primary care services in and out of hours	109

Older people requiring community and residential aged care services are supported by a skilled, motivated, and empowered workforce	109
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care	109
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177

Activity Demographics

Target Population Cohort

Older persons

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation occurs with existing Adelaide PHN commissioned service providers and membership groups. This activity also includes targeted consultation with RACH, general practice and ACCHS as well as broad local consultation strategies with but not limited to State Health, Local Health Networks, local primary care clinicians, allied health professionals and advocacy groups along with relevant peak organisations including ACCPA.

Collaboration

APHN will engage with the National PHN Collaborative – MyMedicare Implementation project to support APHN deliver an effective local response that aligns with the national MyMedicare roadmap.

Activity Milestone Details/Duration

Activity Start Date

29/02/2024

Activity End Date

29/12/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Co-design or co-commissioning comments

CMDT - 202425 - A202425 – Commissioning of Multidisciplinary Teams

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CMDT

Activity Number *

202425

Activity Title *

A202425 – Commissioning of Multidisciplinary Teams

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Provide comprehensive and coordinated multidisciplinary care by utilising an integrated approach, whilst building the capacity and understanding of the health workforce and consumer of the benefits of integrated multidisciplinary care.

Description of Activity *

Utilising a Place Based, data informed approach, focusing on areas of High Need and Low Access to deliver the following.
• Northern Adelaide Wrap Around Care Pilot – Collaborative project with Northern Adelaide Local Health Network to deliver care coordination and tailored MDT care to those who are frequent presenters to NALHN ED.
Utilising a Place Based, data informed approach, focusing on areas of High Need and Low Access to deliver the following.
• Southern Adelaide Wrap Around Care Pilot – Collaborative project with Southern Adelaide Local Health Network to deliver care coordination, self-management and tailored MDT care to those with cardiac conditions.
• Consultation with Solo and Small General Practices and allied health professionals to co-design commissioning of allied health MDT in:
o Small and Solo General Practice
o General Practice
• Increase Allied Health engagement across the APHN
• Implementation of the National Allied Health Toolkit

• Support services to understand the benefits of team-based care
• Development of Multidisciplinary Care Community of Practice
• Education and Training
o Implementation of the National Allied Health Toolkit
o MyMedicare
• Commissioning Allied Health for priority areas
• Multidisciplinary Care Showcase
• Access to digital enablers

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Primary care providers are supported to use digital health tools that improve safety and quality of care	189
LGBTIQA+ communities can access timely, culturally safe and appropriate primary health care services	82
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	82
People in the Adelaide PHN region have awareness of, and timely access to person centered models of comprehensive care across the care continuum	82
Support practitioners to improve communication and build relationships with other health care providers	177
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access timely, culturally safe and appropriate primary health care services	81
Families, children and young people can access timely early intervention, prevention and support services	81
Integration, coordination and partnerships between primary and acute care, supports continuity of care and improved health outcomes	81
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	81

Activity Demographics

Target Population Cohort

Vulnerable population groups

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

A literature review was conducted, with data insights gathered to identify service availability, use, access and unmet needs of the workforce. A questionnaire was designed to inform the community consultations via kitchen table discussions and engagements with seven peak bodies, including Allied Health Associations and Societies. Triangulation of these consultation insights from all stakeholders; service providers; community; peak bodies and broader PHN representatives were used to develop the needs statements. Identification of emerging themes and evidence review generated multiple need statements for the Clinical Council, Community Advisory Council, and General Practice Council to participate in a prioritisation of needs for the APHN region.
The summary of themes were Awareness, Access, Communication, and System and Infrastructure.
Opportunities identified include:
• Models of care for the prevention and management of chronic conditions that adequately fund activities to improve coordination and integration of MDT care, and access to MDT services required for improved health outcomes.
• Targeted MDT programs for consumers with the greatest need and socioeconomic disadvantage to achieve equitable health outcomes with limited resourcing.
• Include resourcing for workforce capacity building activities to upskill MDT providers to more effectively coordinate and integrate care and maximise the use of available infrastructure and resourcing.
• Models of care for the prevention and management of chronic conditions that adequately fund activities to improve workforce and consumer capacity.
• Targeted activities to improve health system literacy of vulnerable population groups, and the primary care providers supporting these population groups.
• Include adequate resourcing for workforce and consumer capacity building activities.
Co-design with Solo and small General Practice to
1. Identify needs and challenges
2. Facilitate communication

3. Enhance collaboration
4. Gather feedback
5. Improve patient care
6. Ensuring alignment
Building on the APHN Allied Health Needs Assessment, inform Allied Health Commissioning through consultation with Allied Health, GP advisory bodies.

Collaboration

Northern Adelaide Local Health Network - Northern Adelaide Wrap Around Care Pilot – Collaborative project with Northern Adelaide Local Health Network, General Practices and Allied Health Providers to deliver care coordination and tailored MDT care to those who are frequent presenters to NALHN ED.
Small and Solo General Practices – Central and Southern Region
Allied Health Providers – APHN region – identified by general practices involved in pilots to ensure continuity of care to consumers.

Activity Milestone Details/Duration

Activity Start Date

31/10/2024

Activity End Date

29/06/2028

Service Delivery Start Date

01/02/2024

Service Delivery End Date

30/06/2028

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Co-design or co-commissioning comments

Northern Adelaide Local Health Network - Northern Adelaide Wrap Around Care Pilot – Collaborative project with Northern Adelaide Local Health Network, General Practices and Allied Health Providers to deliver care coordination and tailored MDT care to those who are frequent presenters to NALHN ED.

Co-design with Solo and small General Practice in Central and Southern regions in 2024/25 and 2025/26 to
1. Identify needs and challenges
2. Facilitate communication
3. Enhance collaboration
4. Gather feedback
5. Improve patient care
6. Ensuring alignment

to develop models of care to support MDT care.

Will build on the APHN Allied Health Needs Assessment, inform Allied Health Commissioning through consultation with Allied Health and GP advisory bodies.

MyM - 202426 - A202426 –MyMedicare

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

MyM

Activity Number *

202426

Activity Title *

A202426 –MyMedicare

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

Provide information, resources and practical support to non-accredited practices by actively demonstrating the benefits of accreditation, guiding them through the RACGP 5th Standards (where applicable) and facilitating understanding of the RACGP 5th Standards, and to encourage uptake of accreditation and registration for MyMedicare.
The intended outcomes of this activity are to:
• Increase the number of general practices within APHN that are accredited,
• Improve the safety and quality in health care provided by general practice staff and practitioners,
• Improve access of general practices within APHN to Commonwealth funded programs such as MyMedicare,
• Support general practices to establish mechanisms for patients and families to provide input and feedback, such as establishing Community Advisory Committees.

Description of Activity *

• Identify non-accredited practices within the APHN region.
• Non-Accredited practices in the APHN region are offered structured support, including resources and practice support, to facilitate their progression toward accreditation in the NPGA scheme and to support their ability to register for Commonwealth funded programs such as MyMedicare.
• Practices are provided with comprehensive information outlining the benefits of accreditation to support informed decision

making.
• Practices are supported in identifying and understanding the additional opportunities available to them upon becoming accredited.
• Disseminate information on MyMedicare to practices and patients to enhance understanding, increase registration and encourage active participation in the scheme, including supporting patient registration with MyMedicare.

• Create resources and support mechanisms to assist general practices in achieving and maintaining accreditation throughout each accreditation cycle.
• Conduct market analysis to better understand the drivers influencing accreditation participation.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177

Activity Demographics

Target Population Cohort

Non-Accredited General Practices

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Engage in initial consultation with small and solo practices across the region – which represents the majority of non-accredited practices. Concurrently, the PHN will also conduct some market analysis to classify practice types within the region and identify the drivers influencing practice to participate in accreditation and MyMedicare. This analysis will align closely with other activities such as WIP-PS, ensuring strategic integration and informed decision making. Ongoing consultation with all practices as to the best means of communicating the benefit of accreditation and MyMedicare registration to supplement the current practice support model which supports this on a face to face and individual basis.

Collaboration

APHN will engage with the National PHN Collaborative – MyMedicare Implementation project to support APHN deliver an effective local response that aligns with the national MyMedicare roadmap.

Activity Milestone Details/Duration

Activity Start Date

30/06/2024

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Co-design or co-commissioning comments

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

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

1000

Activity Title *

CF1. Community and Provider Immunisation Engagement and Support

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Community and provider immunisation support is commissioned to one organisation which utilises specialist nurses to provide:
• Education and mentoring to build the capacity of primary care providers to deliver best practice vaccinations, especially for vulnerable population groups (Aboriginal and Torres Strait Islander and multicultural communities, children and older persons, those experiencing homelessness and medically at risk)
• Outreach vaccinations for vulnerable population groups to improve access and immunisation rates
• Overseas immunisation histories and catch-up schedules uploaded to the AIR to enable children to attend early childhood education and child care, and ensure migrant communities have the documentation required to commence workforce participation
• Information and counselling to improve immunisation health literacy and address vaccine hesitancy, especially among vulnerable communities
• Identification of barriers to vaccine uptake and vaccine hesitancy within the local region.

Description of Activity *

The commissioned Champion Nurse Immunisation Program (CNIP) engages specialist nurses to deliver:
• Immunisation program support, education and mentoring for primary care providers.
• Information and counselling for vulnerable community groups.

• Identification of barriers to vaccine uptake.
• Activities to address vaccine hesitancy.
• Promotion and advocacy for immunisation at local community events.
• Outreach vaccinations for vulnerable population groups including Aboriginal and Torres Strait Islander peoples, multicultural communities, children and older persons, those experiencing homelessness and medically at risk.
• Uploading overseas immunisation histories and catch-up schedules on the AIR.
With practice-based support available to providers and expert immunisation nurses accessible to communities, it is anticipated increased immunisation program awareness will lead to improved immunisation coverage with a focus on vulnerable population groups. The program will be evaluated to determine its success.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Identify and support the capacity and capability of the Primary Healthcare Workforce to work with cohorts of patients in need of equitable access to healthcare services	178
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	82
People in the Adelaide PHN region have awareness of, and timely access to person centered models of comprehensive care across the care continuum	82
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate workforce and primary health care services	90
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	177
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access timely, culturally safe and appropriate primary health care services	81
Families, children and young people can access timely early intervention, prevention and support services	81

Activity Demographics

Target Population Cohort

Immunisation providers, vulnerable community members and children not immunised in alignment with the National Immunisation Schedule.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

The Champion Nurse Immunisation Program will engage local Indigenous schools, children's centres and other community controlled organisations to provide information about the importance of immunisations for Aboriginal and Torres Strait Islander communities. They will offer support and training, where required and appropriate, for primary care providers supporting local Aboriginal and Torres Strait Islander communities.

Coverage

Whole Region

Yes

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

Activity Consultation and Collaboration

Consultation

• This activity was established in consultation with immunisation service providers, including General Practice, Local Councils, Child and Family Health Service and Hospitals.
• Australian Immunisation Register (AIR) was consulted to identify low immunisation coverage regions across Metropolitan Adelaide. This then provided the priority localities for the Champion Nurse Immunisation Program. Ongoing review of immunisation coverage data informs delivery of the program.
• Ongoing consultation occurs with general practices and SA Health Immunisation Branch.

Collaboration

• Australian Immunisation Register (AIR) - to effectively manage the childhood immunisation data through (AIR) data cleansing activities to accurately reflect the current immunisation status of children.
• The provider commissioned to deliver the Champion Nurse Immunisation Program will collaborate with General Practices, Local Councils, early childhood and education settings, Child and Family Health Service, Aboriginal education settings and community controlled organisations, Migrant Health Service, and Non-Government Organisations supporting identified vulnerable community group in order to:
- provide immunisation program support and education to providers and information to the community.
- identify barriers to vaccine uptake and address vaccine hesitancy.
- promote and advocate for immunisation at local community events.
- deliver vaccinations for vulnerable population groups in outreach settings.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2026

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2026

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

No

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

No

Co-design or co-commissioning comments

na

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

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

5000

Activity Title *

CF5. Living Well with Persistent Pain Program

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The aim of the Living Well with Persistent Pain Program and Multicultural Wellbeing Program activity is to provide a multi-disciplinary, collaborative primary care-based persistent pain management network, which:
• Supports individuals to better understand and manage their condition, including multicultural and Aboriginal and Torres Strait Islander communities living with persistent pain.
• Delivers group education programs that support individuals with the knowledge to better understand their pain condition and equip them with the necessary tools to improve their quality of life;
• Develops resources to facilitate key information to be accessible across time to a broader audience.
• Is able to better understand and respond to the specific embodied pain needs of various cultural groups.
• Improves individual's ability to navigate the health system; and
• Minimises the burden of pain on individual consumers and the wider community.

Description of Activity *

Living Well with Persistent Pain (LWwPP) Program
The LWwPP program is based on evidence showing multidisciplinary biopsychosocial interventions, such as pain management programs are successful in assisting people to manage ongoing or persistent pain. Based on the successful PainWise® Turning Pain into Gain Program, this activity is a comprehensive pain management program.

Individuals are referred to the program by their GP for a 12-month intervention. The program provides access to:
• A group education program focused on understanding pain and strategies to support the management of chronic pain;
• One-on-one discussions with a clinician care coordinator to understand the participant's pain experience and how it affects them;
• A tailored plan of individual allied health services with a network of providers that have expertise in the management of persistent pain.
• Opportunity to trial group exercise therapy e.g. hydrotherapy.
Participants undergo an initial assessment with the program Care Coordinator and have a personalised care plan developed. Referral to a GP with a Special Interest in chronic pain is also available to develop care plans for more complex cases such as those where the referring GP is seeking a second opinion, and or support in medication changes or deprescribing or other complications. As people with persistent pain often require complex management plans, participants are supported to access up to five allied health appointments as part of their care plan (in addition to any allied health appointments under an Enhanced Primary Care plan from their regular GP).
Alongside this, participants attend a series of six group education sessions delivered by the multi-disciplinary team to learn to develop self-management skills which support their work with the GP and the allied health team. Through the delivery of the education sessions, the multi-disciplinary team also supports individuals to understand the roles and functions of clinicians that may be in their care team, assisting participants to develop an understanding of the components of the health system and how they work.
Two service providers are commissioned to deliver the program, each aligned with the relevant Local Health Network boundary.

Multicultural Wellbeing Program
While there are services within the community to assist people experiencing persistent pain these are not always accessible, or suitable for people from refugee or multicultural backgrounds due to language barriers, experiences of trauma, differing cultural backgrounds, low levels of health literacy, and reduced capacity to navigate the health system. Each cultural group has differences in the way that pain is understood, the meaning that is attributed to pain, cultural responses to pain, and types of exercise/movement that are considered more appropriate. In addition, the context in which pain is experienced and emotions associated influence the intensity of pain experienced. Consequently, effective approaches to pain must be grounded in bio-psychosocial and cultural frameworks.
The Multicultural Wellbeing Program (MWP) delivers a range of language specific group programs each year, providing culturally relevant information and activities to assist participants to better understand and manage their pain. Each program is supported by interpreters and codesigned with up to twenty participants. The programs are delivered over a ten-week period, following individual assessments with each participant. Weekly sessions consist of both gentle exercise and educational components with topics including:
• Understanding pain from biopsychosocial and a neuroscience perspective
• Understanding the difference between acute and chronic pain management
• Exploring the meanings attributed to pain from individuals and community perspectives
• Factors contributing to the experience of pain (lifestyle, sleep, stress, food, activity levels, thoughts/ feelings)
• Exploring healthy lifestyle and active management strategies that promote recovery
• The role of pacing and gentle movement/physical activity in chronic pain management
A group evaluation takes place at the end of the program, in addition to individual assessments of program outcomes, and referral to appropriate services for ongoing care.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	82
People in the Adelaide PHN region have awareness of, and timely access to person centered models of comprehensive care across the care continuum	82
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	177
Support practitioners to improve communication and build relationships with other health care providers	177
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access timely, culturally safe and appropriate primary health care services	81
Families, children and young people can access timely early intervention, prevention and support services	81
Integration, coordination and partnerships between primary and acute care, supports continuity of care and improved health outcomes	81
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	81

Activity Demographics

Target Population Cohort

People living with persistent pain

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

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

Activity Consultation and Collaboration

Consultation

Prior to the development of the program, consultations were undertaken with Royal Adelaide Hospital Pain Management Unit, Northern Adelaide Local Health Network, PainWise® Turning Pain into Gain Program operators, and identified general practice and allied health providers.
During the early stages of the program implementation, program leaders participated in the SA Health Transforming Health Chronic Pain Model of Care consultation process as part of both the Working Group and Steering Committee. This participation assisted to align the activity with the State model and ensure integration/prevent duplication across the sectors.
Adelaide PHN continues to work with the commissioned service providers to identify opportunities and develop the program further. Tertiary services are also engaged on an ongoing basis.
To support the MWP additional consultation with Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) was undertaken to develop an appropriate model of care to meet the unique needs of refugees and CALD community members experiencing chronic pain, Ongoing consultation occurs with commissioned service providers to identify further opportunities for program improvement. Tertiary services are also engaged on an ongoing basis.

Collaboration

Local Health Networks:
• Partnering to support integration of primary and acute chronic pain services and the identification of system wide quality improvement opportunities
• Referral pathways with the LHN chronic pain services
General Practices in target areas:
• Service delivery to support them to manage patients' persistent pain condition alongside any chronic condition(s)
Referral pathways to appropriate services including general practice, allied health, culturally appropriate mental health care,

migrant health and community development programs.
• Referral of appropriate consumers.
Allied health services, including pharmacies:
• Building capacity of these providers to support patients to manage their persistent pain.
Living Well with Persistent Pain programs:
• Identifying shared opportunities to minimise duplication.
Pain support groups:
• Referral pathways to provide ongoing support for consumers upon discharge from the program.
Academic Institutions:
Engagement with University of South Australia to explore research partnership opportunities.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2027

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

No

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

No

Co-design or co-commissioning comments

na

CF - 202205 - A202205 - Improving access for vulnerable populations

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

202205

Activity Title *

A202205 - Improving access for vulnerable populations

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

This activity aims to support the most vulnerable population groups in the Adelaide PHN region with the poorest health outcomes through the support for self-management of their health and health literacy to reduce the burden of long-term chronic conditions and improve people's quality of life of refugee, humanitarian entrant and newly arrived backgrounds by;
- Facilitating the coordination and integration of quality population health programs in the primary health care settings in partnership with the community organisations, NGOs, and SA Health
-

Description of Activity *

The outcome of the 2022-2023 community consultation and review of Adelaide PHN needs assessment (population health) identified that there was a continued need for activity to be focused on communities from refugee, humanitarian entrant and newly arrived backgrounds. These community members continue to experience challenges accessing appropriate primary health care services within the Adelaide PHN region.

The service model developed addresses access to appropriate primary health care for individuals from refugee, humanitarian entrant and newly arrived backgrounds through three streams.

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

Adelaide PHN will ensure the model is connected, integrated and promoted to community, service providers and the broader primary health care system.

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Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
LGBTIQA+ communities can access timely, culturally safe and appropriate primary health care services	82
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	82
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate workforce and primary health care services	90
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access timely, culturally safe and appropriate primary health care services	81
Families, children and young people can access timely early intervention, prevention and support services	81
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	81

Activity Demographics

Target Population Cohort

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

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

In 2022-2023, The Adelaide PHN updated the needs assessment for the population health. Health needs and service gaps for the vulnerable population were short-listed. Community and stakeholders were and will continue to be targeted for engagement and consultation and this is includes but was not limited to Adelaide PHN Community and Clinical Advisory Councils and a community-wide survey.

Collaboration

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

Activity Milestone Details/Duration

Activity Start Date

30/06/2023

Activity End Date

29/06/2026

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2026

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Co-design or co-commissioning comments

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

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

202221

Activity Title *

A202221 - Integrated Care with Local Health Networks

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

System Integration

Aim of Activity *

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

Description of Activity *

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

These activities have been aligned to APHN's Integrated Care Framework dimension of integration:
Professional Integration activities:
• Provide education and networking opportunities that brings GPs and hospital consultants together and improves knowledge,
• General Practitioners will be engaged to support workforce activities that foster increased partnership approaches to care.
• Work collaboratively with GPs to facilitate better GP understanding of Local Health Network pathways.

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

issues.

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

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

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Integration between primary mental health services and alcohol and other drug treatment services to improve continuity of care and outcomes	135
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	189
People in the Adelaide PHN region have awareness of, and timely access to person centered models of comprehensive care across the care continuum	82
Support practitioners to improve communication and build relationships with other health care providers	177

Activity Demographics

Target Population Cohort

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

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

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

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

Collaboration

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

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

General Practitioners:
• Participate in facilitated workshops to identify system issues and potential quality improvement activities.
• Participate in education and networking sessions to improve clinical skills and knowledge, relationships and understanding of pathways.
2025 - Newly developed Collaboration Agreements have been signed with the LHNs, indicating a new level of maturity between the APHN and LHNs.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2027

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Co-design or co-commissioning comments

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

HSI - 202225 - A202225 - PHN Clinical Referral Pathways

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202225

Activity Title *

A202225 - PHN Clinical Referral Pathways

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

System Integration

Aim of Activity *

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

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

Description of Activity *

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

work with SA Health outpatient reform activities, including e-referral and Clinical Prioritisation Criteria (CPC) projects to enhance integration.
work with SA Health outpatient reform activities, including e-referral and Clinical Prioritisation Criteria (CPC) projects to enhance integration.
• Promotion of HealthPathways in South Australia to the health and aged care sectors.
Addressing the PHN objectives and priorities identified through the Needs Assessment, this activity looks to enhance consistent care and management of health conditions, increase awareness and utilisation of appropriate referral pathways and resources and improve the patient journey.

Priority clinical areas for 2025-2026 include but not limited to
Cancer Care
Cardiovascular Disease
Child & Youth Health
Endocrinology and Diabetes care (reviews)
Infectious Diseases
Rheumatology
Mental Health and Alcohol and other Drugs
Plastic Surgery (skin lesions)
Genetics
Gynaecology
Older Persons' health (includes dementia care)
Orthopaedic surgery and pain management
Vascular Surgery, Wound Care
Sexual Health
Veterans Health
Urgent Care Presentations
Family, Domestic and Sexual Violence
Vulnerable populations
including yet not limited to Culturally and Linguistically Diverse Health, Aboriginal and Torres Strait Islander Health, Intellectual disability health, rural health (CSAPHN partnership)

Further to the above clinical priorities, APHN commits to Aged Care and Dementia Support Referral Pathways
This activity involves:

- Identification of aged care and dementia clinical referral pathway priorities for care delivery in South Australia.
- Maintenance and enhancement of aged care and dementia clinical and referral pathways tailored to the local context.
- Consultation with local health professionals and relevant stakeholders to inform aged care and dementia support pathways development.
- Promotion of health professional use of aged care and dementia pathways within HealthPathways in South Australia.

Activities will assist health professionals to provide aged care and dementia advice, referrals and care to people through:

- Developing locally relevant aged care and dementia clinical and referral pathways in consultation with key stakeholders including (but not limited to) specialists, general practitioners, practice nurses, allied health professionals and aged care providers.
- Continuing to engage with Dementia Australia to facilitate nationally consistent dementia pathway development to support people living with mild cognitive impairment or dementia and their carers with diagnostic and post-diagnostic service and supports to enable early intervention and to live well in the community for longer.
- Monitoring, reviewing and improving existing aged care and dementia clinical and referral pathways.
- Embedding HPSA aged care and dementia care pathways in the care of people in APHN region through awareness and engagement with general practice, allied health and aged care service providers.
- Maintaining existing aged care and dementia care service information and expanding service mapping for public and private aged care, and aged care support services for country SA region.

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

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27: 2024 Update

Priorities

Priority	Page reference
Increased visibility of Adelaide PHN commissioned service providers and eligibility criteria to GPs, state, community services and to underserviced groups to enhance access	135
Integration between primary mental health services and alcohol and other drug treatment services to improve continuity of care and outcomes	135
Primary care providers are supported to use digital health tools that improve safety and quality of care	189
Primary health care providers are supported to adopt and fully implement digital health technologies	189
LGBTIQA+ communities can access safe, inclusive and appropriate suicide prevention and primary mental health care services	134
People in the Adelaide PHN region have awareness of, and timely access to person centered models of comprehensive care across the care continuum	82
AOD and related services are integrated, holistic and coordinated to improve continuity of care and experiences	158
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care	109
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate AOD treatment services	91
Families, children and young people can access timely early intervention, prevention and support services	81
Integration, coordination and partnerships between primary and acute care, supports continuity of care and improved health outcomes	81

People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	81

Activity Demographics

Target Population Cohort

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

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The HealthPathways process includes targeted consultation with State Health, Local Health Networks, General Practice, allied health professionals, consumer groups and relevant peak organisations. Consultation occurs with existing Adelaide PHN commissioned service providers and membership groups.
The HealthPathways SA Team and Steering Committee facilitates collaborative consultation mechanism with the activity partners and other stakeholders in the project.
Activities include but not limited to engagement and collaboration with Subject Matter Experts, peak bodies, clinical council and clinical networks, facilitation of Clinical Work Groups and ongoing feedback loops via the website.

Collaboration

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

Organisational Roles and Responsibilities:

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

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

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

Activity Milestone Details/Duration

Activity Start Date

30/06/2021

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

From 01/07/2019 to 30/06/2022 was funded under activity AH7 Health Pathways South Australia

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

Yes

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

Yes

Co-design or co-commissioning comments

CF - 202502 - A202502 – Swallowcliffe Children's Precinct

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

202502

Activity Title *

A202502 – Swallowcliffe Children's Precinct

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

To improve access and availability of primary care services within the Swallowcliffe area to improve health outcomes, literacy and quality of life of children and their families through a community-led, place-based approach.

Description of Activity *

Partnering with the Department of Premier and Cabinet, Adelaide PHN intends to engage a range of primary care providers to better understand the best practice approach to enhancing healthcare delivery for vulnerable communities, addressing health, development and wellbeing outcomes of children with complex needs, residing in low socioeconomic areas. Engagement and consultation with key primary care providers will allow great understanding and program model design, with the aim to fund a part-time GP and allied health to attend the Swallowcliffe Children's Precinct, to deliver primary care services, aligned to the communities' diverse needs.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	82
Families, children and young people can access timely early intervention, prevention and support services	81
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	81

Activity Demographics

Target Population Cohort

Children and families attending the Swallowcliffe precinct

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Playford	40202

Activity Consultation and Collaboration

Consultation

Extensive consultation with NALHN Child Development Unit (CDU)

Collaboration

Following the findings of the place-based lead, the SA Department of Premier and Cabinet,the initiative focuses on improving children's health, development, and well-being by partnering with local communities, governments, and businesses to design

tailored solutions. Key projects include the introduction of two Paediatric nurses from the Lyell McEwin Hospital, at Swallowcliffe Primary School two days a week and health checks at the Swallowcliffe preschool.

Activity Milestone Details/Duration

Activity Start Date

30/06/2025

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2025

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

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

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

Co-design or co-commissioning comments

CF-COVID-PCS - 3000 - COVID-19 Primary Care Support

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF-COVID-PCS

Activity Number *

3000

Activity Title *

COVID-19 Primary Care Support

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

This Activity will assist Adelaide PHN to monitor uptake of COVID-19 vaccinations, support primary care providers to participate in the National COVID-19 Vaccination Program (NCVP) and facilitate communications as required between the Department and primary care vaccination providers including, general practice, community pharmacies, disability support services and residential aged care homes (RACHs).

Description of Activity *

The activity aims to enable primary care provider awareness and participation in the NCVP.
This activity will fund employment of a position to work closely with primary healthcare providers, Residential Aged Care providers, key state health partners and stakeholders in the Adelaide PHN metropolitan region to:
- Monitor uptake of, and identify barriers to COVID-19 vaccinations in the APHN region
- Communicate with and support primary care vaccination providers to access relevant resources to support vaccination service delivery, including direction to the COVID-19 Vaccine Operations Centre where appropriate
- Lead engagement to assist in connecting RACHs and other at-risk populations with primary care immunisation providers for COVID-19 vaccinations
- Support RACHs to plan and deliver 6 monthly COVID-19 vaccination clinics, (where low levels of uptake are identified)
- As required, provide strategic advice/guidance to the Department on local issues/concerns

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177

Activity Demographics

Target Population Cohort

People living in RACHs and other community members located with the APHN region.
People working in Primary Care, Aged Care and Disability Support services.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation occurs with existing Adelaide PHN membership groups, and will include broad local consultation strategies with but not limited to general practice, RACHs, State Health, Local Health Networks, local primary care clinicians and community pharmacy along with relevant peak organisations including Ageing Australia.

Collaboration

APHN will engage with the Department Health, Disability and Ageing, and National Centre for Immunisation Research and Surveillance (NCIRS) to support APHN deliver an effective local response.

Activity Milestone Details/Duration

Activity Start Date

31/12/2024

Activity End Date

30/12/2026

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Co-design or co-commissioning comments

HSI - 3000 - HSI3. Digital Health Plan

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

3000

Activity Title *

HSI3. Digital Health Plan

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Digital Health

Other Program Key Priority Area Description

Aim of Activity *

The Digital Health Plan is an ambitious approach to digital health, designed to drive system-wide change through digital enablement towards a healthier Adelaide.

It envisions a digital primary health system that leverages data and technology to inform value-based care, securely share critical patient information for improved diagnosis and healthcare management, empower people to participate in their own health care, and facilitate insight-driven planning, resource allocation, and continuous quality improvement.

Description of Activity *

The Digital Health Plan is structured around five focus areas namely: Partnerships and Innovation; Workforce Capability; Digital Integration and Connectivity; Health Intelligence; and Data and Information Sharing.
The activities the Digital Health Plan will provide include:

Digital Health Capability and Readiness Initiative (DHCRI)
• The aim of the DHCRI is to gain a better understanding of the current digital capabilities of all general practices within our region. It stems from findings that primary health care service providers benefit from a more personalised support based on where they are in their digital health journey.

• Primary care providers will be surveyed and supported with tailored resources that guide them to address identified areas for improvement.
• Primary care providers will be offered digital health training and educational opportunities based on their identified needs.
• Providers will be invited to take advantage of exiting digital health solutions and programs offered by Adelaide PHN.
• Primary care providers will be provided with reporting on their digital health maturity, capability, and readiness for digital change.
• Closing the digital divide by identifying and inviting new health services to participate in suitable digital health pilot projects based on their level of digital maturity.

Digital Health Services
• Increase the use of digital technology in the health care setting such as telehealth, secure messaging delivery, data extraction tools and ongoing support with clinical applications and templates.
• Provide access and support for practices around the Primary Sense tool to help facilitate improved practice data quality, improve the completeness and quality of patient records to support clinical decision making and manage patient follow up, and provide a means to recall patients in a timely manner in an effort to minimise unwarranted variations of care and to provide appropriate care to patients.
• Provide training and support in the use of Primary Sense tool to facilitate identification of patients with high risk of developing preventable chronic conditions and to improve management of patients with chronic conditions.
• Increase the use of clinical audit tools in a health care setting to assist in analysis of patient cohorts to improve population health outcomes.
• Provide assistance and access to data extraction tools and importance of correct clinically coded records.
• Work with health care providers to increase their understanding and utilisation of secure messaging technologies to assist with timely and secure sharing of information between health care providers.
• Assist consumers and health care providers to have access to timely information and assist with coordination of health care services to ensure the best possible outcomes for the consumer.

My Health Record Support
• Continue to assist healthcare organisations to register and connect to the My Health Record
• Continue to support the adoption and usage of the My Health Record by General Practice, Allied Health, Pharmacy and Specialists to improve information sharing across healthcare providers.
• Continue to educate practice staff to understand the My Health Record and its benefits and to assist consumers on how to access their health care information through the My Health Record.
• Continue to support primary health care providers to actively view and upload clinical documents to patients with an active My Health Record
• Continue to encourage and support active viewing and cross viewing of documents within patients My Health Record.
• Continue to support primary health care providers not registered to participate in the My Health Record to register and actively participate.
• Continue to assist in providing information and support on security practices, policies and procedures required by healthcare organisation to participate in the My Health Record system.
• Continue to provide support and information on the requirements of general practice to participate in the Practice Incentives Program (PIP) eHealth Incentive.

Primary Sense Adoption
Adelaide PHN is committed to empowering general practices by granting them access to Primary Sense, an advanced population health management, clinical decision support and data extraction tool. Through this initiative, all qualifying general practices will have the opportunity to leverage the power of Primary Sense to enhance their operational efficiency and clinical decision-making. To ensure that no practice is left behind, the PHN will provide grants to cover the license fee for data extraction for practices whose existing software does not integrate with Primary Sense. This proactive approach ensures that all practices that chose to share their data with the PHN, regardless of their current software setup, can benefit from data analytics provided by Adelaide PHN. This initiative demonstrates the PHN's unwavering commitment to supporting general practices and promoting the use of cutting-edge technology for better healthcare delivery. Primary Sense The license allows the PHN to extract general practice data for practice analysis and aggregates general practice data for service planning, reporting and population health needs. Primary Sense aims to strengthen the capabilities of primary care providers and enhance patient care outcomes.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Primary care providers are supported to use digital health tools that improve safety and quality of care	189
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	189
Primary health care providers are supported to adopt and fully implement digital health technologies	189
Primary health care providers have access to resources and support to improve digital health literacy	189
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	81

Activity Demographics

Target Population Cohort

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

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

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

Activity Consultation and Collaboration

Consultation

Stakeholder engagement and consultation are currently ongoing with the following peak bodies;
• The Australian Digital Health Agency
• SA Health to support the increased usage of the My Health Record system across all SA Health sites.
• Outcome Services Survey - identify service and quality improvement gaps in PHN services and experience in interactions with other healthcare providers and local hospital services.
• APHN GP Survey – enable APHN to better support General Practice with respect to improving quality of care, practice accreditation improvement and uptake, meaningful use of digital health systems to streamline the flow of relevant patient information, develop health information management systems to inform quality improvement in healthcare and the collection and use of clinical data.
• Adelaide PHN Council Engagement and Feedback
• For Primary Sense, stakeholder engagement and consultation are also ongoing with the following: Adelaide PHN Clinical Council, General Practitioners in region, General Practice Managers, Practice Nurses, Country SA PHN and other PHNs using Primary Sense

Collaboration

• Digital Health Agency - to provide ongoing consultation with PHN staff to ensure consistent messaging across the PHN's, access to resources, data sources and a point of call to assist PHN's with addressment of issues, feedback and advice as needed.
• All Health Care Providers and peak organisations - to gather ongoing feedback, issues and what's working well and what's not, to inform where the PHN can support General Practice, Pharmacy, Specialists of all specialities, Allied Health Providers etc. located with the APHN region
• Peak organisations - to advise the APHN on how to best engage this cohort of health professionals also to advise on the barriers that effect access to Digital Health uptake for both the providers and consumers.

• Adelaide PHN will collaborate with WAPHA and other PHNs in installing and rolling out Primary Sense to eligible General Practices and will continue to work with WAPHA as part of the implementation.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2027

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Co-design or co-commissioning comments

na

HSI - 4000 - HSI4. System Integration and Stakeholder Engagement

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

4000

Activity Title *

HSI4. System Integration and Stakeholder Engagement

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

System Integration

Aim of Activity *

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

Description of Activity *

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

The Adelaide PHN Partnering Framework guides the development and implementation of agreed shared initiatives. The Framework aims to facilitate a connected, quality health system where health providers work together to improve people's experiences of the health system and their health outcomes.

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

- Clinical Engagement including facilitating sessions that identify system issues and potential solution;
- Digital Health;
- Activities supported by the GP Integration Units and LHN Collaboration Agreements;

- Regional Mental Health and Suicide Prevention; and
- Application of or engagement with HealthPathways and SA Health Clinical Referral Pathways

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Primary care providers are supported to use digital health tools that improve safety and quality of care	189
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	189
Primary health care providers are supported to adopt and fully implement digital health technologies	189
Primary health care providers have access to resources and support to improve digital health literacy	189
People experiencing severe mental health conditions have access to appropriate supports, services and coordinated care	134
AOD and related services are integrated, holistic and coordinated to improve continuity of care and experiences	158
Support practitioners to improve communication and build relationships with other health care providers	177
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177
Integration, coordination and partnerships between primary and acute care, supports continuity of care and improved health outcomes	81

Activity Demographics

Target Population Cohort

Patients with chronic conditions who have frequent contact with hospital services

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

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

Activity Consultation and Collaboration

Consultation

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

Collaboration

The System Integration and Stakeholder Engagement Strategy is progressed separately within each Local Health Network and involves key senior executive representatives from APHN, the relevant Local Health Network to collaborate in the oversight and performance monitoring and evaluation functions. In addition, each partner contributes the following.
Adelaide PHN:
• Integration Coordinators provide Project Management oversight to each of the shared priority activities.
• Advisory Councils are regularly consulted with and actively contribute to our Annual Need Assessment process to support the Adelaide PHN to address barriers and foster local connectivity. And provide intelligence on local health conditions and trend, and assist in identifying opportunities to support access to a timely and responsive health system.
Local Health Network:
• Local Health Network staff facilitate collaboration with relevant departments and units within Local Health Network services as per each shared priority activity, and facilitate the identification of potential future activities.
LGAs and other stakeholders are engaged as relevant to deliver place-based approaches in line with APHN Strategic Plan.
2025 - Newly developed Collaboration Agreements have been signed with the LHNs, indicating a new level of maturity between the APHN and LHNs.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2027

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Co-design or co-commissioning comments

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

HSI - 6000 - HSI6. Supporting our diverse Workforce

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

6000

Activity Title *

HSI6. Supporting our diverse Workforce

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

The aim of this activity is to deliver a range of flexible, integrated workforce initiatives that meet the identified needs of our workforce, in line with national and local health priorities.

Description of Activity *

The Adelaide PHN will provide a range of flexible opportunities for primary care providers in our region to develop professional capabilities and undertake quality improvement to enhance their ability to work as part of an integrated primary health care system, to provide the right care at the right time and the right place.
Professional development, multi-disciplinary approaches to care, quality improvement actions and methods of disseminating best practice will focus on identified areas of need including consumer centred care, equitable access to services, and cultural safety for vulnerable and diverse consumers.
The intended outcomes are:
• Increased participation of primary health care providers in workforce professional development
• Adoption and effective use of best practice approaches to improve clinical outcomes and delivery of care
• High satisfaction by attendees of professional development services, with learning outcomes consistently met

Associated Activities:
GPS1; A202222

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Identify and support the capacity and capability of the Primary Healthcare Workforce to work with cohorts of patients in need of equitable access to healthcare services	178
Older people requiring community and residential aged care services are supported by a skilled, motivated, and empowered workforce	109
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate workforce and primary health care services	90
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	177
Support practitioners to improve communication and build relationships with other health care providers	177
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177
Integration, coordination and partnerships between primary and acute care, supports continuity of care and improved health outcomes	81

Activity Demographics

Target Population Cohort

All Primary Health Care practitioners/providers/professionals

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Elements of the continuing professional development schedule will incorporate sessions to support culturally appropriate services and care to Aboriginal and Torres Strait Islander consumers. Ensuring that primary health care providers are proficient in culturally safe practice will be embedded within this program.

Coverage

Whole Region

Yes

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

Activity Consultation and Collaboration

Consultation

Engagement with Adelaide PHN membership groups and provider networks is ongoing to ensure continuing professional development and capacity building activity:
• Meets workforce needs.
• Incorporates high-quality, evidence-based content and approaches.
• Supports the development of cross-sector, interdisciplinary partnerships among professionals through information sharing and networking opportunities.
• Supports the quality improvement of primary care services and the measurement of activity outcomes through feedback mechanisms including survey evaluations.

Collaboration

Collaboration activity occurs with the following stakeholder groups:
• Primary care provider networks of all disciplines, and professional organisations/peak bodies to ensure education content and mode of delivery meets discipline learning needs.
• Local Health Networks (LHNs) – to assist with the development of appropriate clinical pathways and referral management guidelines.
• Organisations working with Culturally and Linguistically Diverse communities such as Migrant Health Service – to assist in the provision of cultural safety, cultural competence education.
• Aboriginal Community Controlled Health Organisations, Aboriginal Health Council of SA and LHN Aboriginal primary care providers to support culturally appropriate services for Aboriginal and Torres Strait Islander people.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2027

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

No

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

No

Co-design or co-commissioning comments

HSI - 7000 - HSI Op1. Operational

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

7000

Activity Title *

HSI Op1. Operational

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

Health Systems Improvement - Operational Expenditure

Aim of Activity *

Health Systems Improvement - Operational Expenditure

Description of Activity *

Health Systems Improvement - Operational Expenditure

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Primary care providers are supported to use digital health tools that improve safety and quality of care	189
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	189
Primary health care providers are supported to adopt and fully implement digital health technologies	189
Primary health care providers have access to resources and support to improve digital health literacy	189
LGBTIQA+ communities can access timely, culturally safe and appropriate primary health care services	82
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	177
Support practitioners to improve communication and build relationships with other health care providers	177
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177
Integration, coordination and partnerships between primary and acute care, supports continuity of care and improved health outcomes	81

Activity Demographics

Target Population Cohort

Health Systems Improvement - Operational Expenditure

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Health Systems Improvement - Operational Expenditure

Collaboration

Health Systems Improvement - Operational Expenditure

Activity Milestone Details/Duration

Activity Start Date

30/06/2021

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Co-design or co-commissioning comments

Health Systems Improvement - Operational Expenditure

HSI - 202210 - A202210 - Dementia Consumer Pathway Resource

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202210

Activity Title *

A202210 - Dementia Consumer Pathway Resource

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

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

Description of Activity *

The Adelaide PHN has mapped, developed, reviewed and is now maintaining and enhancing a localised online consumer resource that support people living with dementia and their carers and families.

Country SA Primary Health Network (CSAPHN) in partnership with Adelaide Primary Health Network (APHN) have developed a consumer facing custom website to support older people, their carers and families to easily navigate, understand and make informed choices about dementia health and aged care services that may be of benefit to them.

The Adelaide PHN have tailored dementia support resources which detail the post-diagnostic care and psychosocial supports available for people living with dementia, and their carers and families, within their local area, including local, state and federal government, private sector, and non-government community-based support

The online consumer resources have been embedded into new and existing Dementia Pathways of care published on the HealthPathways South Australia (HPSA) online platform.
APHN will promote and increase the awareness, engagement with, and utilisation of dementia support pathways and the relevant consumer resources to local health care practitioners across the Metropolitan Adelaide region via existing HealthPathways mechanisms.
Other activities to enhance familiarity of the resources may include:
• upskilling GPs and other health professionals on their value and utilisation, including use and access of the associated pathways
• linkage to primary care providers via APHN Contracts and Capacity Building Coordinator – Primary Careand targeted Quality Improvement activities
• key communication and marketing strategies and collaboration with APHN commissioned service providers, key stakeholders and primary care sector.
• Continued Participation in national and regional roundtable and information sharing meetings with other PHNs, Dementia Australia and relevant consultants.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	189
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	82
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care	109
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	81

Activity Demographics

Target Population Cohort

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

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

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

Collaboration

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

Activity Milestone Details/Duration

Activity Start Date

31/12/2021

Activity End Date

29/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

Yes

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

No

Co-design or co-commissioning comments

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

HSI - 202211 - A202211 - Aged Care Clinical Referral Pathways

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202211

Activity Title *

A202211 - Aged Care Clinical Referral Pathways

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

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

Description of Activity *

Previously named A202211 – HealthPathways Aged Care

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

Broadly activities involve:
• creating, reviewing and enhancing aged care clinical, information and referral pathways on the HPSA platform.
• Identification of clinical priorities, service gaps and needs with the region associated to aged care, and older persons health and related areas.
• Supporting and promoting the use of aged care pathways to local health practitioners and increasing usage across the Aged Care sector.

HealthPathways for Aged Care
Aged care clinical referral pathways will continue to support health professionals to provide advice, referrals and connections for Older South Australians and their carer's into local health, support and aged care services. Pathway implementation will be based on the need of the South Australian community.
Adelaide PHN will work to increase the awareness, engagement, and utilisation of aged care pathways by local health care practitioners (including GPs, allied health, practice staff and Residential Aged Care Facility clinical staff) and engage local clinical practitioners, consumers and aged care stakeholders and experts in their development.
In accordance with the PHN aged care policy guidance provided by the Department, HPSA will:
• Develop and review aged care clinical and referral pathways relevant to the health needs of the PHN region - or as directed by the Department - for use by clinicians during consultation with patients, to support assessment and referral to local services and supports
• HealthPathways SA (HPSA) agrees to deliver the following initial pathways yet to be localised to the South Australian context:
• Carer Stress and Support (name changed to Carer health)
• Delirium
• Before Residential Aged Care (Entering a Residential Aged Care Facility)
• Weight and Nutrition Management in Older Persons
• Depression in Older Persons
• Fitness to drive
• Restrictive Practices - This pathway is no longer scheduled. Restrictive practices principles and guidance have been included within all relevant clinical pathways across the dementia and aged care pathways.

Based on local Health Professional consultation and requirements of pathways currently in development, HPSA also agrees to deliver (between July 2025 – June 2026) the following pathways yet to be localised to the South Australian context: - vision loss
- Balance and Strength Tests
- Veterans' health pathways

HealthPathways SA agrees to keep up-to-date the following clinical pathways that have already been localised to the South Australian context:
- Before Entering a Residential Aged Care Home (RACH)
- Carer Health
- Comprehensive Medical Assessment for Residential Aged Care Homes
- Falls Prevention ScreeningMedication Management Review
• Frail but Stable Older Persons
• Unexpected Deterioration in an Older Person
- Carer Stress and Support (name changed to Carer health)
- Delirium
- Weight and Nutrition Management in Older Persons
- Depression in Older Persons
- Fitness to drive

HealthPathways SA (HPSA) agrees to review referral, psychosocial support and resource pathways already localised, as they relate to the above clinical pathway. These include but not limited to:
• Aged Care Support
• Respite and Carer Supports
• Falls Risk Assessment

• Non-Acute Older Persons' Health Assessment / Advice
• Hospital avoidance services
• Chronic Disease Management Plan assessment and referrals
• Older Persons Mental Health Assessment /Advice
- Care Finders / Navigation services
- • Psychological therapy service for Older persons
• relevant allied health and community nursing pages

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

Consultation, engagement and communication will be a key activity. Both will take place according to the guiding principles set out in the HealthPathways SA Program Plan and associated Operational Plans.
Adelaide PHN will undertake engagement activities within the local region. HealthPathways SA will facilitate a Clinical Work Groups and planned consultation as required, with local service providers, primary care sector and consumer advocates to guide clinical and referral pathway development and enhancements.
The sharing of ideas, actions and outcomes with Country SA PHN and broader Australian PHN networks will be encouraged to maximise opportunities for greater engagement and impact.
APHN and CSAPHN will consider joint engagement strategies where identified as appropriate.
Whilst each PHN is responsible for dissemination of communication materials through their own processes and systems; strategies, mechanisms and messaging will be shared to ensure a level of consistency. Joint messaging may be considered on an as needs basis and agreed upon by both PHNs and any other relevant stakeholders involved at the time.

Associated activities of Aged Care Clinical Referral Pathways are:
• A202225 - PHN Clinical Referral Pathways
• A202302 - Dementia Support Pathways
• A202210 - Dementia Consumer Pathway Resource

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	189
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	82
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care	109
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	81

Activity Demographics

Target Population Cohort

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

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

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

Collaboration

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

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

program management.
Collaboration and engagement with regional and remote SA general practitioners in online consultation processes and pathway feedback.

Other keys stakeholders
• HealthPathways Community (Australasian network of HealthPathways jurisdictions)
• Streamliners Pty Limited
• Dementia Australia
• SA Health
• General Practice community
• Pharmacy and Allied health communities
• Residential Aged Care Facilities
• Domiciliary care providers
• In home care providers
• Council of the Ageing SA
• Veterans' health services
• Vulnerable population community organisations inc but not limited to
o Aboriginal community controlled aged care providers and elder support services
o Culturally and linguistically diverse specific aged care providers and support services
o LGBTQIA+ older persons support services
o Older persons mental health services

Activity Milestone Details/Duration

Activity Start Date

31/12/2021

Activity End Date

29/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No

Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

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

Yes

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

Yes

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

No

Co-design or co-commissioning comments

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

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

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202213

Activity Title *

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

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

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

Description of Activity *

The focus will be on improving the integration and coordination of health care for vulnerable populations, health of ageing Australians and building the multidisciplinary workforce capacity to maximise health care outcomes. The activity is informed by an evidence-based implementation of Australia's Primary Health Care 10 Year Plan 2022-2032 across the Adelaide metropolitan region and closely aligns with the Adelaide PHN Strategic Plan.
In addition, the activity facilitates evaluation of commissioning initiatives, guided by implementation and economic evaluation approaches including quality of life, experiences of health care for older people and other vulnerable populations, and experiences of primary care providers, to enable cost sustainability, scale up and evidence informed decision-making. By focussing on building research capacity and capability it supports the translation of research into routine practice and ultimately improves health outcomes for vulnerable people.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Identify and support the capacity and capability of the Primary Healthcare Workforce to work with cohorts of patients in need of equitable access to healthcare services	178
Older people living in the community and residential aged care are supported by timely, accessible, coordinated primary care services in and out of hours	109
Older people requiring community and residential aged care services are supported by a skilled, motivated, and empowered workforce	109
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care	109

Activity Demographics

Target Population Cohort

Older people

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation between partners has led to an agreed Strategic and Activity plan, reported quarterly. Consultation has occurred via work groups to establish industry priorities in aged and primary care, codesign of research evaluation approaches and implementation.

Collaboration

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

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

Activity Milestone Details/Duration

Activity Start Date

20/04/2022

Activity End Date

30/03/2028

Service Delivery Start Date

May 2022

Service Delivery End Date

May 2028

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

Yes

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

No

Co-design or co-commissioning comments

The 2 organisations co-designed this activity, which is iterative to meet the needs of both organisations.

HSI - 202219 - A202219 - Northern Health and Wellbeing Partnership

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202219

Activity Title *

A202219 - Northern Health and Wellbeing Partnership

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The Northern Adelaide Health and Wellbeing Partnership is centred on a common vision to improve health and wellbeing outcomes for Northern Adelaide. Eighteen founding partners (signatories to a memorandum of understanding in 2022), representing government agencies, local councils, universities, health, aged and community care providers and private investors, are driven by a shared belief in equity of access to quality healthcare, education and employment, and a recognition that when it comes to addressing complex health and social issues 'closer, we go further'. The Partnership seeks to identify and prioritise opportunities for collaboration and support the implementation of agreed deliverables.

Description of Activity *

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

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	82
Families, children and young people can access timely early intervention, prevention and support services	81
Integration, coordination and partnerships between primary and acute care, supports continuity of care and improved health outcomes	81
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	81

Activity Demographics

Target Population Cohort

People living in the northern region of Adelaide

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

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

Activity Consultation and Collaboration

Consultation

The APHN is a signatory to the Partnership MOU and hosts the funds (on behalf of the eighteen organisations that have financially contributed). This funding has been used to establish two dedicated roles which are also hosted by the APHN to support and lead the Partnership's activities. The Partnership Director commenced in April 2022 and Senior Project Officer commenced in July 2022.

The CEO of the PHN is the interim Chair of the Partnership's Executive Committee. This group has a focus in the strategic oversight and execution of the Partnership's workplan and deliverables – including development of a Health Precinct for Northern Adelaide; education and career pathways across the region in the health, disability and aged sector; supporting advocacy needs through a united Partnership voice, and; promoting collaborative research and investment opportunities.

Collaboration

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

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2027

Service Delivery Start Date

April 2022

Service Delivery End Date

June 2027

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

Yes

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

No

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

No

Co-design or co-commissioning comments

Partnership Agreement Strategic enablers – key deliverables A project plan outlining key priority areas, enablers and deliverables will be developed and progressed with input from all 18 Partners via small working groups, round tables and the partnership Executive Steering Committee, coordinated by the Director of the partnership. Further project plans will be informed by and build on progress of the previous plans and activity.

HSI - 202220 - A202220 - Partnership in Medical Internship Program

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202220

Activity Title *

A202220 - Partnership in Medical Internship Program

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aboriginal and Torres Strait Islander Health

Other Program Key Priority Area Description

Aim of Activity *

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

Description of Activity *

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

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

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

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Identify and support the capacity and capability of the Primary Healthcare Workforce to work with cohorts of patients in need of equitable access to healthcare services	178
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	177
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate workforce and primary health care services	90

Activity Demographics

Target Population Cohort

Trainee Medical Officers

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

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

Collaboration

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

Activity Milestone Details/Duration

Activity Start Date

31/07/2022

Activity End Date

29/06/2027

Service Delivery Start Date

January 2025

Service Delivery End Date

June 2027

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

Yes

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

No

Co-design or co-commissioning comments

Watto Purrunna Aboriginal Primary Health Service was incorporated into the Medical Internship Program within NALHN in early 2023. This was achieved through a co-funded Medical Education Program between Adelaide PHN and Watto Purrunna. 2024-25 will be the second year of the Internship program.
2025-26 will be the third year of the internship program and will see an increase in the number of Medical Officers rotating through the service from five (5) to ten (10), for an agreed ten (10) week placement in the 2025 calendar year.

HSI - 202222 - A202222 - Support to General Practices

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202222

Activity Title *

A202222 - Support to General Practices

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

Support primary health care providers to deliver quality, efficient and effective services (right care, right place, and right time time) by delivering high quality information, training and promote continuous quality improvement.
Support primary health care providers to increase understanding and/or utilisation of digital health systems, including how digital platforms can support patient care.

Description of Activity *

This activity has six elements:
• Accreditation support – Support General Practices to either become an accredited practice and/or maintain current accreditation status by providing relevant information and access to supporting resources. The activity will be delivered by utilising workshops, face to face support and any other mechanism in which supports the practice to fulfil accreditation requirements. Where appropriate support will be given to assist with Gap Analysis.

• Improving Patient Care through effective utilisation of clinical software – utilising clinical software and digital platforms to improve patient care and communication. The activity will be delivered by encouraging health care providers to take up digital platforms such as data extraction tools, Health Pathways, Clinical Templates, Shared Care Planning platforms, secure messaging, My Health Record and clinical information systems to assist with streamlining, timely access to information and appropriate

clinical pathways. Assisting providers to use digital technologies that enhance current workflows and identify areas for population health improvements. Advise on how implementing digital systems will improve access to information. Support and guide where appropriate decision making and provide relevant training, policy and procedures templates.

• General Practice participation in Quality Improvement (QI) activities (including the QI PIP and Patient experience) – work with and support general practices to understand the importance of quality improvement and implement quality improvement activities that support the provision of high-quality care to patients and encourage innovation. Assist general practice to understand the importance of the patient experience and gauging patient satisfaction in services and in turn support QI activities that improve the patient experience. The activity will be delivered by utilising and providing access to relevant information and resources, provide face to face visits, support where appropriate tools that assist in gauging patient experience and satisfaction via feedback mechanism. Provide general practice with QI support by assisting the practice to understand the demographics of the patient population. Provide information and support on the QI PIP including but not limited to, providing information, data extraction tools and training to identify patients that meet the criteria of the 10 key Improvement measure areas of the QI PIP.

• Innovative Solutions through effective use of health information management systems – support health care providers to provide better care for patients and help achieve health equity through the effective use of health information systems such as Shared Care Platforms, My Health Record, Secure messaging, HealthPathways SA and other systems that may be identified to support the relevant outcomes. Support clinical coding in recording of patient data to improve healthcare delivery to allow for analysis and interrogation of information which will assist in informing current and future activities to provide quality improvement in health and patient care. The activity will be delivered by assisting providers to understand the importance of clinical coding either by providing information or face to face support, the providers will also be assisted to understand and perform data cleaning within the clinical information system and provide training, resources and materials that support this.

• Partnership and Engagement with Primary Health Care Providers – Partner and engage with providers to improve the person's experience of primary health care by developing the capacity of providers, supporting quality improvement and integration of primary and acute care. The Activity will be delivered by providing primary health care providers with relevant information in relation to health reform and change, regular communication via APHN newsletter, education, engagement and networking events including quality improvement, digital health, chronic disease management, immunisation, screening, and other relevant topics as identified through needs assessment and/or surveys of General Practice.

• Increase referral pathways for patients by utilising appropriate digital health system – encourage and support health care providers to utilise digital platforms that support the sharing of information, pathways to support clinical decision making for patients and systems that support the sharing of information between clinical providers, acute sector and clinical handover. The activity will be delivered by encouraging health care providers to understand secure messaging and where appropriate provide support to understand, implement and use secure messaging. Encourage health care providers to actively utilise HealthPathways SA to support clinical decision making. Support healthcare providers participating in the My Health Record system to understand and develop relevant e-Referral for patients. Provide information on digital initiatives, changes and improvements via APHN newsletters and direct correspondence with healthcare providers. This activity will also support the engagement of GPs in the development of statewide clinical prioritisation criteria.

Previously undertaken under activity GPS1.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Primary care providers are supported to use digital health tools that improve safety and quality of care	189
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	189
Primary health care providers are supported to adopt and fully implement digital health technologies	189
Primary health care providers have access to resources and support to improve digital health literacy	189
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	177
Support practitioners to improve communication and build relationships with other health care providers	177
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177

Activity Demographics

Target Population Cohort

General practitioners in APHN region

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Engagement with various health care providers such as General Practice, Allied Health, Pharmacy; APHN membership groups. Collect feedback from survey of primary health care providers both from internal GP Census and external outcomes services survey. Utilise 'kitchen table' methodology to gain insights from primary care providers, community and other health care professionals to assist in guiding activities relevant to the providers and support better health outcomes for the community.

Collaboration

To ensure high-quality, evidence based continuing professional development and capacity building methods are used in delivering this activity, the activity will collaborate with:

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

Activity Milestone Details/Duration

Activity Start Date

30/06/2021

Activity End Date

29/06/2026

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No

Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

No

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

No

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

No

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

No

Co-design or co-commissioning comments

CF - 202226 - A202226 - Paediatric Partnership Program

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

202226

Activity Title *

A202226 - Paediatric Partnership Program

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The Program contributes to the provision of quality, timely and responsive paediatric services, and care coordination supports for children and young people aged 0-8 years requiring a developmental assessment, across metropolitan Adelaide.
The aims of the Project are:
1. A reduction in wait times for children requiring the Global Developmental Delay, Psych-Educational or Autism Spectrum Disorder Diagnostic Assessments with improved access to diagnosis, treatment and ongoing care.
2. Improved communication, collaboration and integration between public and private sectors offering Autism Spectrum Disorder Diagnostic or Global Development Delay Assessments.
3. Improved access to National Disability Insurance Scheme and related allied health services,
4. Improve access to quality, timely and responsive care for children and young people aged 0 -8 years; and
5. Improve patient and family/carer health care experiences.

Description of Activity *

The Paediatric Partnership program establishes a private referral pathway for public patients within NALHN and WCHN CDU to improve access for children 0-12 requiring a Global Developmental Delay, Psych-Educational or Autism Spectrum Disorder Diagnostic Assessment (Developmental assessments).

Referring partners, NALHN and WCHN can redirect most children under 8 that are currently on their waiting list. Redirections are coordinated by the referring partners and managed by Adelaide Paediatrics.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Families, children and young people can access timely early intervention, prevention and support services	81
Integration, coordination and partnerships between primary and acute care, supports continuity of care and improved health outcomes	81

Activity Demographics

Target Population Cohort

Children aged 0-12 years of age currently on the referring partners CDU waiting list for a developmental assessment.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

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

Activity Consultation and Collaboration

Consultation

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

Collaboration

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

Activity Milestone Details/Duration

Activity Start Date

30/06/2023

Activity End Date

29/06/2026

Service Delivery Start Date

July 2023

Service Delivery End Date

June 2026

Other Relevant Milestones

N/A

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

Yes

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

No

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

No

Co-design or co-commissioning comments

n/a

HSI - 202303 - A202303 - Supporting integration to improve Aboriginal and Torres Strait Islander health outcomes

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202303

Activity Title *

A202303 - Supporting integration to improve Aboriginal and Torres Strait Islander health outcomes

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aboriginal and Torres Strait Islander Health

Other Program Key Priority Area Description

Aim of Activity *

The project aims are:
• Improve the level of Aboriginal and Torres Strait Islander cultural awareness and competency to contribute to increased culturally appropriate, safe services across the primary health care sector for improved patient experience.
• Increase primary health care services capacity in addressing identified local issues and supporting the health system to better meet the needs of Aboriginal and Torres Strait Islander people and communities

Description of Activity *

This project will:
- Develop and strengthen partnerships to improve the capacity of Aboriginal Community Controlled Organisations (ACCO), education sector and the broader primary health care workforce.
- Support mainstream primary health care providers and workforce to deliver safe, accessible and culturally responsive services for Aboriginal and Torres Strait Islander people.
- Support best practice approaches to improve health outcomes and delivery of care to Aboriginal and Torres Strait Islander people.
- Promote the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule (MBS) items, including Aboriginal and Torres Strait Islander Health Assessments and follow up items.

-Codesign and capacity building within the ACCO/ACCHO sector to support transition of ITC in 25/26 in line with Closing the Gap principles.
The Aboriginal Health Project Officer activity includes:
- promote the ITC program for Aboriginal and Torres Strait Islander people with chronic diseases
- provide Aboriginal Community Controlled organisations contacts to stakeholders when they are seeking advice on Aboriginal people and how to engage with them
- Work alongside and provide guidance for internal staff members
- promote existing services e.g. Sonder programs and ITC, allied health, IAR-DST for Mental Healthcare, Bookabee's training, and UCC's.
- deliver 715 health checks for Aboriginal people and NALHN GPIU, CALHN Catchment Urgent and After Hours Care Options and SALHN urgent and after hours care options- provide posters.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	177
Aboriginal and Torres Strait Island people can access trans-generational trauma and grief counselling services and narrative therapies for suicide prevention and mental health	90
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate services for chronic conditions management and early interventions	90
Aboriginal and Torres Strait Islander people can access culturally safe information and access to Breast, Cervix and Bowel cancer screening services	91

Activity Demographics

Target Population Cohort

The target audience will be Aboriginal Community Controlled Organisations (ACCO), education sector and the broader primary health care workforce.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Adelaide PHN will work in partnership to consolidate and extend collaborative working relationships with ACCOs, education sector and the broader primary health care workforce.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultations and codesign will take place with the following stakeholders to help inform the development and ongoing review of this project:
- The Adelaide PHN Aboriginal Community Advisory Council
- Integrated Team Care Program workforce
- ACCOs and ACCHO
- Education sector

Consultation will be conducted with primary health care workforce and community members to explore how the Adelaide PHN can further support cultural learning and capacity building for the primary health care workforce.

Collaboration

Collaboration and consultation with the Aboriginal Community via the metropolitan ACCHO, ACCOs, and appropriate community forums to assist in the development of culturally appropriate services for Aboriginal and Torres Strait Islander people.

Activity Milestone Details/Duration

Activity Start Date

30/06/2023

Activity End Date

29/06/2026

Service Delivery Start Date

01/07/2023

Service Delivery End Date

30/06/2026

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Co-design or co-commissioning comments

Work in progress as the activity develops and partnerships are formed.

HSI - 202503 - A202503 – Data Governance

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202503

Activity Title *

A202503 – Data Governance

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

Data Governance

Aim of Activity *

To improve data governance and information security at Adelaide PHN.

Description of Activity *

Adelaide PHN engaged an external service provider in May 2024 to undertake an extensive review of our Cyber Security posture and resourcing. This review considered internal resourcing, existing software and hardware assets, and considered information security management systems (ISMS) as part of the review. Noting that Adelaide PHN is working towards attaining ISO27001 accreditation by 30/06/2025. The deliverables from this review included ~80 recommendations, and a detailed project plan. Adelaide PHN adopted the recommendations within the review and engaged a provider to assist internal resources to deliver the cyber security improvements, and to modernise systems and hardware where required. The initial project to uplift our cyber security position and address vulnerabilities and is due for completion before 30/05/2025.
Adelaide PHN intends to continue contributing to the Primary Health Insights (PHI) national data sharing initiative and will build towards moving all data assets from legacy systems into the Cloud. The PHI environment is a shared Microsoft Azure resource, facilitated by WAPHA, and is available to many PHNs across Australia.
Running parallel to the Security Uplift Project, Adelaide PHN commenced additional project tasks within the “Pathway to PHI” project to migrate program data, and dashboard and reporting functions from legacy on-premises systems to specific locations in PHI’s shared Microsoft Azure space. Following through on our commitment to utilise the features within PHI. The relocation of

these functions has enabled data to be stored consistently and securely within the Azure cloud and has also reduced system complexity. The new architecture has simplified the process for internal and external resources to consume program related data.
This Pathway to PHI project is expected to be ongoing and running alongside the development, implementation and review of identified security controls identified in our ISO27001 gap analysis in preparation for ISO27001 accreditation as we plan to leverage modern technologies and ensure that the data being consumed maintains its confidentiality, integrity and availability (CIA).
In late 2024 Adelaide PHN commenced a software development project to build a tool (code named Gary) to automate the process of validating Alcohol and Other Drug (AOD) program data. This function was previously done manually and had consumed significant internal resource. Gary has since been expanded to inject more programs, and there are plans to continue developing Gary's capability to not only ingest and validate data, but to also deposit the new clean data into the Data Warehouse, enabling a quicker transition from CSP submission to having visibility on PowerBI dashboards enabling better performance oversight.
Over the next 12 months, Adelaide PHN will move more data processing and development functions into the cloud, taking advantage of the Microsoft Azure native resources. By leveraging these development tools, we will be improving data management and wrangling processes without compromising security. Validated data will be stored in the cloud, and will remain in the cloud throughout development, maintenance, or visualisation processes. This approach requires additional investment in technical skills within the Adelaide PHN technical and data teams and will require more compute costs within the cloud. By using the cloud-based compute power within Azure, the PHI monthly costs will increase slightly, however this change in process will reduce the risk of data leakage and improve data governance.
Adelaide PHN is working towards more data and reporting functions being actioned within the Microsoft Azure environment during 2025/2026.
To support the ISO27001 accreditation project, Adelaide PHN has engaged the services of a dedicated project manager. This project is being managed internally, utilising internal resources for a lot of the policy / process development work, and an external provider will be complementing internal resources to ensure technical controls are implemented as per the standard requirements.
Adelaide PHN will be reviewing and consolidating systems and applications to reduce duplicative functions and ensure that each system is catalogued and administered appropriately with data governance and risk being a focus. There are also important systems that reside on local servers that will be migrated to cloud / SaaS applications to reduce the maintenance and administrative burden.
The internal Data Governance integrated steering group has oversight of these projects, to ensure that governance, risk, and security is always maintained.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Primary health care providers have access to resources and support to improve digital health literacy	189

Activity Demographics

Target Population Cohort

Commissioned Service Providers and Contract and Capacity Building Coordinators

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The activities include input from external contractors to ensure best practice methodologies are implemented, and to ensure that governance, risk, and security are maintained.

Collaboration

Adelaide PHN has worked with Primary Health Insights (PHI), WAPHA, Went West PHN, North Brisbane PHN, Comunet (MSP), and internal stakeholders to ensure that the above data and systems projects are delivered successfully without exposing Adelaide PHN to additional risk.

Activity Milestone Details/Duration

Activity Start Date

30/06/2025

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Co-design or co-commissioning comments

HSI - 202515 - A202515 – Emergency Preparedness and Coordination

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

202515

Activity Title *

A202515 – Emergency Preparedness and Coordination

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Management of health emergencies is coordinated between state and territory health authorities, Local Hospital Networks and, to varying degrees, primary care providers. In response to the Royal Commission into Natural Disaster Arrangements (Recommendation15.2) identified greater inclusion of primary healthcare providers in disaster management, including: representation on relevant disaster committees and plans and providing training, education and other supports.
Adelaide PHN will support building capacity to manage emergency preparedness, planning and coordination functions across primary care in our local region.

Description of Activity *

Adelaide PHN will support building capacity to manage emergency preparedness, planning and coordination functions across primary care in accordance with the Department of Health, Disability and Ageing (DHDA) Emergency Preparedness Policy Guidelines (to be provided mid 2025) including:
• Prepare and maintain emergency preparedness protocols.
• Update protocols annually in line with Emergency Preparedness Policy Guidelines.
• Engage regularly with local and district stakeholders relating to emergency preparedness, planning, response, and recovery.
• Integrate and coordinate health services in your local region to prepare for the event of a natural and/or health emergency situation.

This will be achieved through:
1. Engagement with Government of SA Department of Premier and Cabinet, Department of Health and Wellbeing - SA Health Disaster Management Branch, Local Health Networks and councils across metro Adelaide.
2. Identification of opportunities for PHN and primary care to participate in disaster planning processes at the local region and state levels, as appropriate and facilitate responsive emergency preparedness protocols.
3. Facilitating primary healthcare providers to undertake a formal role in regional and/or state disaster planning and response to natural disasters through enabling arrangements for participation in emergency response and disaster planning processes.

Needs Assessment Priorities *

Needs Assessment

Adelaide PHN Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape	177
Support practitioners to improve communication and build relationships with other health care providers	177
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care	177

Activity Demographics

Target Population Cohort

The target population will be primary care providers, with a focus on general practice.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The Adelaide PHN continue to identify and work with stakeholders to build local partnerships and solutions to strengthen continuity of care. Local stakeholders include but not limited to GPs, general practice, allied health, nursing, Local Health Networks, SA Health and South Australian Government.
Internal consultation with Adelaide PHN Advisory Councils (Clinical Council, Community Advisory Council, Aboriginal Community Advisory Council, GP Council). External consultations with consumers as required facilitated by Adelaide PHN kitchen table discussions and more broadly with subject matter experts across the primary care sector, tertiary sector and aged care sector.

Collaboration

Continue to work in partnership with Local Health Networks through formalised partnerships.
Continue to actively seek opportunities across PHN network to work together to maximise development of systems, tools, training, communication that facilitate local adaption.

Activity Milestone Details/Duration

Activity Start Date

30/06/2025

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Co-design or co-commissioning comments

CG - 202504 - O202504 – Corporate Governance

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CG

Activity Number *

202504

Activity Title *

O202504 – Corporate Governance

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Other Program Key Priority Area Description

Aim of Activity *

Description of Activity *

Needs Assessment Priorities *

Needs Assessment

Priorities

Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region

Activity Consultation and Collaboration

Consultation

Collaboration

Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Co-design or co-commissioning comments