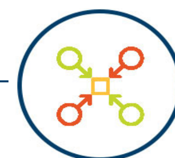
Our Activity Work Plan 2019 - 2021

phn COUNTRY SA

An Australian Government Initiative

Strategic Vision



The key objectives of Country SA PHN (CSAPHN) are:

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

PHNs must make informed choices about how best to use their resources to achieve these objectives. Together with the PHN Needs Assessment and the PHN Performance Framework, PHNs will outline activities and provide measurable performance indicators to the Australian Government and the Australian public with visibility as to the activities of each PHN.

Core Flexible Funding

Flexible funding is provided for CSAPHN to commission frontline services to Country South Australia (SA) through service providers based on the national health priorities identified by the Government and local health priorities identified in our Needs Assessment.

Mental Health – Early intervention & low intensity strategies

This activity will complement and integrate with primary mental health care funded programs and stepped care ideology while also focussing on early intervention strategies, low intensity approaches and holistic complementary services.

The activities will:

- Focus on wellness promotion and prevention by providing access to information, advice and self-help resources; and
- Increase early intervention through access to lower cost, evidence-based alternatives to face-to-face psychological therapy services.

Mental Health - Acute Transitions and Holistic Supports

Aligning with the objective of Improving coordination of care this activity will complement and integrate with primary mental health care funded programs and stepped care ideology while also supporting regional interfaces between inpatient and community mental health settings.

The activities will:

- Provide wrap-around holistic coordinated care for disadvantaged rural people with complex needs; and
- Bridge the gap between acute episode discharge and re-entry to primary mental health services and wrap around supports via coordinated care and appropriate clinical triage.

Aboriginal Health - Chronic Disease Program

Activities aim to:

- Increase access to culturally safe, comprehensive and coordinated care;
- Contribute to improved Aboriginal and Torres Strait Islander health outcomes;
- Increased capacity to Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMS) to provide quality services; and
- Enable best practice approach to the delivery of care.

The activity will:

- Provide support to rural and remote communities in delivering comprehensive and coordinated care to Aboriginal patients with chronic conditions;
- Provision of primary health care services to clients with a chronic and/or complex condition that aims to improve the health outcomes of the client and enables self-management of their condition;

- Provide primary health care services, include screening, early intervention, treatment and condition, and self-management; and
- Provide targeted health and lifestyle conditions that are to be prioritised include chronic condition care and management, and managing risk factors such as smoking, nutrition, alcohol and physical activity.

Aboriginal Health - Workforce Support and Capacity Building

Activities aim to:

- Increase the participation of Aboriginal primary health care providers in professional development, inclusive of Integrated Team Care service providers;
- Increase access to culturally safe, comprehensive and coordinated care;
- Enable ACCHOs and AMS achieve increased capacity to provide quality services; and
- Enable best practice approach to delivery of care.

Aboriginal Health Workforce grants activity will:

- Increase the Aboriginal health practitioner/worker workforce where issues have been identified in terms of availability (local people) and development of the workforce in particular areas where it has been identified in relation to chronic conditions.

Aboriginal Health - Ngangkari Traditional Healers

The activity aims to support Aboriginal and Torres Strait Islander understanding of health and the complex interplay between cultural, spiritual, physical, social and emotional health.

This is targeted at ACCHOs Services to provide Ngangkari Services as part of a holistic health framework. It supports the clinical activities undertaken and can serve to improve participation and engagement in lifestyle programs and education that need to be undertaken.

Aboriginal Health - Aboriginal Health Navigator Project (Discharge Care to Community)

The aim of the activity is to improve patient pathways of Aboriginal and Torres Strait Islander people in systematic discharge, referral and follow-up between hospital and primary health care services.

This Activity is designed to support patient self management through supported health system navigation. The activity seeks to develop a function that will lead the design and implementation of a Health System Navigation mechanism to support Aboriginal and Torres Strait Islander patients transitioning from tertiary to community-based healthcare.

The Health Navigator focusses on the health needs of the individual, supporting the patient’s identified health needs, and in particular, managing the transition of care through admission and discharge and between non-acute services in conjunction with the Integrated Team Care (ITC) Care Coordinators, where present.

Population Health – Direct Clinical Service Delivery

The aim of this activity is to ensure rural and remote communities and individuals have better access to direct frontline services, targeted education and information on locally accessible services with regards to; chronic disease and risk factors, cancer and screening and medicine usage is well managed to reduce potentially preventable hospitalisations.

This is achieved by commissioning organisations that provide direct service delivery, promote health risk behaviour modification and provide education and information for population with, or at risk of, chronic disease.

- Non-dispensing pharmacist in general practice program. Currently services are in Far West, Barossa and South East regions. The services focus on appropriate use of medicines, improved medication adherence, reconciliation and review of electronic record accuracy to improve patient outcomes and to prevent medication related preventable hospitalisation.
- Community Paramedic Program. This activity provides supplementary resources in rural and remote communities which support and coordinate care options and linking vulnerable people with health care suited to their unique circumstances. Coverage is the Far West region, specifically in Ceduna, and in the Limestone Coast region.

- Skin cancer screening and awareness program. This activity provides direct frontline service delivery in rural and remote locations without a permanent GP, where the workforce is predominantly overseas trained and where GPs lack confidence in the core competencies required to undertake screening and excisions. Ongoing funding to this program will see it extend to other CSAPHN regions which include but are not limited to; Mid North, Flinders and Port Augusta and South East.
- Culturally and Linguistically Diverse Wellness and Health Literacy Program. This activity includes frontline service delivery in the form of general health checks, chronic disease risk assessments, immunisation, cancer screening and illness prevention and health literacy. Service delivery occurs in the Riverland, Murray Mallee and Limestone Coast regions.

Population Health – Chronic Condition Literacy and Self-Management

The aim of this activity is to ensure rural and remote communities and individuals have better access to targeted education and information on locally accessible services with regards to; chronic disease, risk factors and self-management strategies that contribute to reducing potentially preventable hospitalisations.

These activities include, but are not limited to:

- Heart Foundation – cardiovascular risk community awareness program.
- Diabetes SA – community self-management program
- Asthma Australia – human-centred asthma and chronic condition care program.
- Arthritis SA – living with chronic pain: techniques for coping program.
- Cancer Council SA – skin cancer prevention and early detection program.
- "Get screened and get on with living campaign" promoting uptake of breast, bowel and cervix screening in South Australia.

Population Health – Sexual Health

The aim of this activity is to ensure rural and remote communities and individuals have better access to direct frontline service delivery, targeted education and information on locally accessible services with regards to sexual health.

Activities will provide a sexual health screening and outreach service to improve access and community awareness raising of the importance of screening for good sexual health. Sexual health counselling and wellness for the LGBTQI population is included.

These activities include, but are not limited to:

- Sexual health screening program. This activity delivers the full scope of sexual and reproductive health screening, outreach to improve access to service and awareness raising activities for primary health care workers and communities. This service is available across the whole of CSAPHN region.
- Sexual health counselling and wellness program. This activity provides direct front line service delivery to vulnerable populations around; sexual health and safety, coping strategies and self-harm and suicide prevention. Service currently occurs in Adelaide Hills and Fleurieu region, but it is planned to extend this to other areas of need as identified.

Population Health – Illness Prevention Through Health Literacy, Promotion and Clinical Service

The aim of this activity is to ensure rural and remote communities and individuals have better access to direct frontline service delivery, targeted education and information on locally accessible services, resources and online supports with regards to; illness prevention, health literacy, health promotion and associated clinical services.

These activities include, but are not limited to chronic disease, screening, immunisation, supports to older persons and people vulnerable through homelessness and domestic violence.

Population Health - Immunisation

The aim of this activity is to ensure rural and remote communities and individuals have better access to direct frontline service delivery, targeted education and information on locally accessible services with regards to; the benefits of immunisation; reducing the incidence of vaccine preventable disease and reduce hospitalisations from vaccine preventable disease.

Activities include but are not limited to:

- Targeting geographic regions of low vaccination compliance with a focus on vulnerable populations.

- Commissioning clinical activity via general practice to increase the uptake of Meningococcal B vaccine in the 0 – 4 year old cohort.
- Strategising in partnership with SA Health to respond to provider issues and emergency department presentations related to low or under immunised children. Supporting the skill base of immunisation providers with commissioned targeted vaccine education to support frontline service delivery.
- Providing information and resources that promote vaccine awareness, address vaccine hesitancy and information on access to services, including after hours service and home immunisation services.

Population Health – Integrating Primary Health Care Services (IPHCS)

The aim of this activity is to enable the building of a robust integrated primary health care system in country SA where access to frontline allied health, specialist nurse, chronic condition and other health support services are severely limited.

Through this activity, CSAPHN is endeavouring to improve access to frontline primary health services that are additional to general practice through the IPHCS program in locations with a population of 5,000 or less. These services, which mostly fall into allied health and specialist nurse roles, have a focus on improving health outcomes of country South Australians, particularly for those with chronic and complex conditions.

Key aspect of the program is that services:

- Address an identified need through a collaborative approach with general practice (inclusive of ACCHOs and Royal Flying Doctor Service), and the community;
- Are the result of a GP referral;
- Have a delivery approach that is person centred, evidence based and focuses on client education and activation along with enabling self-management;
- Are integrated with the health system including general practice, community health and other health care providers, both public and private;
- Support the continuity of care of the patient across the system;
- Ensures that general practice and health service providers are well informed;
- Work to agreed models of care and through local referral pathways;
- Upload health care 'event summaries' to My Health Record (where appropriate); and
- Participate in the use of a shared care platform under the Health Care Home reform.

Population Health – My Health Point of Care Innovative Technologies Trial (PoCiTT)

The aim of this project is to provide contemporary tools to rural and remote general practice (including ACCHOs) that will assist in early diagnosis and improved management of chronic conditions and better management of antibiotic prescribing through Point of Care Testing (PoCT) and Virtual Home monitoring.

CSAPHN commissioned PoCT and Virtual Home monitoring services to be provided in alignment with Health Care Home Trial with the project being further expanded to include 'My Health PoCiTT'.

The My Health PoCiTT service provides the following aspects:

- Access to PoCT and Home Monitoring resources;
- Upskilling of practice staff (including GPs) in the use of the PoCT and home monitoring technologies;
- Patient and practice user manuals;
- Phone help for both staff and patients;
- Alerts the practice where data identifies risk to the patient; and
- As needed, the service also connects the GP to a Medical Specialist (SA Health in-kind support) where assistance is needed in managing a condition that has been identified either through the PoCT or Home Monitoring devices.

Under this activity, practices will be supported to implement a business model that will enable them to continue to use PoCT and Home Monitoring as part of their overall model of care beyond this funding including aspects of required accreditation in line with the current Royal Australian College of General Practitioners (RACGP) accreditation standards.

Health Workforce – Primary Healthcare Wellness

This activity supports the existing primary health workforce, strengthens the viability of primary health care services and supports retention in rural and remote locations that are under-serviced.

Health workforce issues continue to be a recurring theme in stakeholder and community consultation. Activities are specifically related to workforce development and support to ensure retention of the existing workforce.

This activity provides specialised support for the health and wellbeing of rural and remote GPs, registrars and medical students. Activities include clinical services and medical interventions via direct service delivered either face to face or via telehealth consultations.

Digital Health - HealthPathways South Australia

HealthPathways is an online portal that provides general practitioners (GPs) and other health professionals with access to evidence-based assessment, management and localised referral resources for specific health conditions. GPs and other health professionals across the health sectors collaborate on the development and implementation of local pathways to ensure patients receive the right care in the right place at the right time.

CSAPHN in a collaborative partnership with SA Health and Adelaide PHN have implemented HealthPathways across South Australia, and involves:

- Identification of clinical priorities for delivery of care in South Australia;
- Development of clinical and referral pathways tailored to the local context; and
- Promotion of health professional use of HealthPathways in South Australia.

This activity looks to enhance consistent care and management of health conditions, increase awareness and utilisation of appropriate services and improve the patient journey through our local health system.

Digital Health – Health Connections

This activity aims to facilitate supported access to a consistent suite of digital tools and capabilities for healthcare providers and patients in the CSAPHN region to improve coordination, access, continuity and quality of care.

Health Connections is an activity name under which digital capabilities are being made available to health providers and patients in the CSAPHN region.

This activity covers three current initiatives:

- Health Connections - Video
  Addressing equity in access to health professionals in rural and remote regions, the ongoing development and growth of a network of health providers connected to a shared Cisco unified communication infrastructure that enables innovative service delivery models and improved collaboration and coordination between health providers and patients.

- Health Connections - Community
  A Community engagement platform deployed to support a variety of communities of practice across the country SA region including Health Care Homes and other health interest conversations, Health Connections – Community also provides a platform for community engagement to facilitate community input to the Community Advisory Committees and regional needs assessment processes.

- Health Connections – Care Planning
  Addressing system integration in a digitally challenged health environment, this online shared care planning platform enables the GP, patient and other health providers, involved in a patient's care, to access and contribute to a living shared care plan.

Aged Care – Direct Clinical Service Delivery

The aim of this activity is to ensure rural and remote communities and individuals have better access to direct frontline service delivery, targeted education and information on locally accessible services with regards to; life limiting illness, and end of life care. There is also a focus on imbedding pharmacy into the multi-disciplinary team supporting residents of Residential Aged Care Facilities (RACF)s.

Activities include, but are not limited to:

- Palliative Care program, this activity provides direct frontline services including psychological interventions and palliative care support, to people experiencing a life limiting illness. This program is delivered in the Barossa / Gawler region.
- Non-dispensing pharmacist in residential aged care facility program. This activity will address; medication misadventure, over-reliance on opioids, antibiotic overuse and deprescribing.

Aged Care – Illness Prevention Through Health Literacy

The aim of this activity is to ensure rural and remote communities and individuals have better access to direct frontline service delivery, targeted education and information on locally accessible services with regards to; my aged care support and active ageing.

Activities include, but are not limited to:

- My Aged Care Support Program. This activity uses community-based peer champions to provide one on one support to understand and navigate the My Aged Care gateway. Ageing people, their families and carers, are educated to be informed consumers and advocates for their health. This program is currently delivered in the Yorke Peninsula, Mid-North, Murray Mallee and Fleurieu regions with plans to extend to two other sites in the 2020.
- Frailty and Falls Prevention Program. This activity provides self-management and condition literacy programs with a focus on the importance of being active through life.

Alcohol & Other Drugs - Co Morbid Drug & Alcohol Support Services

This activity will improve integration between the Mental Health and Drug & Alcohol Services while also meeting the unique support and coordination needs of rural and remote communities.

Activities will:

- Support prevention and early intervention activities and treatment services;
- Promote evidence-based information about drug & alcohol through education;
- Support the development of drug & alcohol data to support evidence-based treatment national policy and service delivery; and
- Support service linkages between drug & alcohol treatment services and mental health services, as well as with social, educational and vocational long-term support services.

Health Systems Improvement

Health Systems Improvement Funding is provided to enable CSAPHN to undertake a broad range of activities to assist in the integration and coordination of health services in country SA, through population health planning, system integration, stakeholder engagement and support to general practice.

Health Systems Improvement activities will also support CSAPHN in its commissioning of health services in its country SA, through the monitoring and evaluation of all commissioned services.

Population Health Planning

The aim of this activity is to enable understanding of the country SA population, including social determinants, health and wellbeing, risk factors and service gaps in order to support activities that improve the health outcomes of that population.

The main activities include:

- data analysis, population health monitoring, analysis of health needs and services gaps, preparing and updating needs assessments;
- support for the multi-organisation Joint Needs Assessment Advisory Group (JNAAG); and
- regional profiles and other regionally mapped services and population health data for publication and use by a range of organisations and communities.

Stakeholder Engagement

This activity aims to engage key stakeholders across country SA to both understand the health needs of the population and provide support with integration of care.

This activity is at the core of CSAPHN's work and includes but is not limited to:

- Stakeholder engagement with upwards of 5,000 health and associated services across the CSAPHN region;
- Strategic engagement with SA Health and the 6 Rural Local Health Networks regarding local and regional population health planning, workforce and system improvement;
- Key partnerships with peak health organisations with a focus on collaborative approaches for system integration;
- Support clinical councils and community advisory committees;

- Enabling local engagement and advocacy between stakeholders in order to explore solutions at the point of care;
- Engage stakeholders in targeted consultation and collaboration that contribute to CSAPHN's Needs Assessment;
- Support to integrate commissioned services into the core business of appropriate stakeholders; and
- Providing contract management, monitoring and evaluation.

System Integration

This activity aims to enable productive and targeted engagement to progress the system integration agenda across the country SA, State and National space, enabling improvements in care and the health outcomes of our population.

This activity supports the health system to work in a more coordinated way, developing and maintaining informal and formal partnerships including:

- Key engagement with SA Health and the 6 Rural Local Health Networks regarding strategic and local population planning and leverage for system improvement;
- Key partnerships relating to peak bodies and national agencies re collaborative approach to chronic co-morbidities and screening initiatives;
- Stakeholder engagement with upwards of 5,000 health and associated services sites across the region; and
- Progressing partnerships relating to digital health solutions to enable uploading of coordinated care and other activity across disconnected systems for country patients and services.

Health Referral Pathways and Care Coordination

The aim of this activity is to provide the underpinning support, including targeted stakeholder engagement that will enable improvements in patient care and navigation across primary, secondary and acute care.

This activity supports the:

- development of mechanisms to improve coordination of care for patients; and
- development, delivery and maintenance of health pathways, including localisation of integrated care service pathways.

Commissioning Support

The aim of this activity is to develop, administer and manage policies, processes and systems that advance best practice commissioning of health services for CSAPHN in line with departmental guidance.

Commissioning support ensures that CSAPHN staff have the knowledge, skills and tools to assist them to secure efficiency, value for money and probity in a planned approach across the Commissioning Cycle. Key factors of the activity support CSAPHN in:

- Maintaining of commissioning cycle including developing strategic partnerships, procurement, monitoring and evaluation;
- Advance service integration and co-design opportunities through strategic stakeholder engagement and partnerships;
- Driving evolution of market approaches over time;
- Systematic approach to procurement, tendering and preparation of contracts and other activities aligned to the commissioning cycle including
- Developing and managing necessary systems and processes such as compliance, risk management and management of contract registers; and
- Coordination of the CSAPHN Board's Independent Commissioning Committee to ensure best fit / best value service provision.

Practice Support

This activity provides support to general practice both in business capacity and population health support. It encourages continuous improvement and quality care, enhanced capacity, sustainability, improved access, better coordination and health outcomes for patients. This support is delivered via a targeted program that includes practice visits, remote support, webinars, assistance with resources and education.

This activity includes but is not limited to:

- Implement digital health changes for the meaningful use of the My Health Record and enabling technologies.
- Increase general practice capacity and sustainability through increased appropriate use of MBS and incentive payments;
- Support care planning and the Medical Home model changes;

- Promote engagement and participation in Practice Incentives Program (PIP) and the PIP Quality Improvement (QI) incentive;
- Support practice managers, practice nurses and general practice staff with continuous quality improvement and 5th Standards Accreditation;
- Support change management and implementation of the MBS review and other future changes;
- Improve data quality and use of clinical information systems;
- Support the uptake of systems such as HealthPathways and online care planning to improve coordination of care and integration with specialist and allied health;
- Provide clinical care updates, current preventative health information and other resources;
- Facilitate the delivery of primary health network communities of practice for mangers, nurses and staff;
- Facilitate the delivery of continuing professional development to general practice inclusive of; culturally appropriate training and culturally and linguistically diverse wellness;
- Support to integrate commissioned services, both clinical and self-management, into the general practice multi-disciplinary team;
- Promote mental wellness awareness for GPs and the general practice community; and
- Engage general practice in targeted consultation and collaboration that contribute to CSAPHN's Needs Assessment.

Workforce Development and Capacity Building

This activity is aimed at supporting the existing primary health workforce, building local service capacity, stimulating market development, strengthening the viability of primary health care practices and supporting recruitment strategies.

This activity is at the core of CSAPHN's work, and includes but is not limited to:

- Promote mental wellness awareness for GPs and the general practice community;
- Foster collaboration across multi-disciplinary teams;
- Support targeted education, information and resources addressing clinical care and preventative health;
- Encourage investigation of new service delivery options and use of digital technologies;
- Support recruitment and retention strategies co-designed with primary health care and local communities;
- Facilitate the delivery of primary health network communities of practice for managers, nurses and staff; and
- Support uptake of commissioned services by the primacy health care workforce.

Community Advisory Committee - Local Health Cluster (LHC) Small Grants

The aim of the Local Health Clusters (LHC) Small Grants activity is to enable localised health promotion in rural and regional SA that improve the health and well-being of local communities.

LHC Small Grants will be co-designed between the LHCs and CSAPHN and will:

- Implement localised activity that addresses or go towards addressing the more granular local health needs as identified within communities, through community input;
- Engage in health promotion activities that align with, and may supplement, other CSAPHN health promotion strategies.; and
- Contributes to local small-scale solutions that work towards addressing community identified issues.

Workforce Recruitment and Retention

This activity supports the existing primary health workforce, builds local service capacity, stimulates market development, strengthens the viability of primary health care services and supports recruitment and retention in rural and remote locations that are under-serviced.

These activities include, but are not limited to:

- Education Services Program. This targeted education activity is designed to foster collaboration across multi-disciplinary teams, allow providers to investigate new service delivery options and imbed the use of HealthPathways and digital health in clinical practice.

- Clinical Services Program. This activity supports the primary health care workforce to deliver front line services to diabetic patients at any point on the care continuum as well as patients requiring advanced burns and wound management.
- Primary Health Care Nurse Transition to Practice Program. This activity will focus on the recruitment and retention of primary health care nurses by supporting their clinical skills and providing mentoring to aid transition into a general practice setting.
- Practice Review Program. This activity will focus on new technologies and systems, addressing practice issues, reviewing working culture and establishing action plans for practice improvement for recruitment and retention purposes.

Evaluation, Advisory and Support to Integrating Primary Health Care Services (IPHCS)

The aim of the IPHCS activity is to enable the building of a robust integrated primary health care system in country SA where access to frontline allied health, specialist nurse, chronic condition and other health support services are severely limited.

The aim of this activity is to provide evidence that the program is meeting expected outcomes even though multiple models of delivery are being used.

It also aims to provide a range of supporting mechanisms to providers.

- Integrating Primary Health Care Services (IPHCS) Evaluation and Advisory Process - an evaluation and advisory process has been put in place to support the commissioned providers and local communities receiving IPHCS to ensure that services are being established that are appropriate to address the local need.
- Supporting integration of IPHCS Patient Information Systems, Shared Care Platform and linkage to My Health Record IPHCS clients.

General Practice Support

General Practice Support program provides support to general practice both in business capacity and population health support. It encourages continuous improvement and quality care, enhanced capacity, sustainability, improved access, better coordination and health outcomes for patients.

This support is delivered via a targeted program that includes practice visits, remote support, webinars, assistance with resources and education.

This activity includes but is not limited to:

- Implement digital health changes for the meaningful use of the My Health Record and enabling technologies;
- Increase general practice capacity and sustainability through increased appropriate use of MBS and Incentive payments;
- Promote engagement and participation in Practice Incentives Program (PIP) and the PIP Quality Improvement (QI) incentive;
- Support practice managers, practice nurses and general practice staff with continuous quality improvement and 5th Standards Accreditation;
- Support care planning and the Medical Home model changes;
- Support change management and implementation of the MBS review and other future changes;
- Improve data quality and use of clinical information systems;
- Support the uptake of systems such as HealthPathways and online care planning to improve coordination of care and integration with specialist and allied health; and
- Provide clinical care updates, current preventative health information and other resources.