Our Activity Work Plan 2021 - 2023

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.

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

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 and 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;
- Increase 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;
- Provide 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 number of Aboriginal and Torres Strait Islander people in the health workforce;
- 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 Traineeship Grant activity will:

- Support to Aboriginal promary health care providers inclusive of Integrated Team Care providers to increase the capacity of the health workforce via recruitment of an Aboriginal trainee.

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.

Creating Healthy Neighbourhoods

This activity will encompass a range of initiatives that support appropriate access to health and related services, targeted support, education and information.

Healthy Neighbourhood Illness Prevention, activities under this initiative are designed to empower and provide information and resources to support decision making and access to appropriate frontline health services.

This may be achieved by but not limited to:

- Activities directed to the specific needs of our vulnerable populations (including but not limited to, people with a disability, people made vulnerable through homelessness and / or domestic violence, new arrivals having experienced trauma) and are at risk of ill health including chronic and complex conditions.
- Screening initiatives for priority populations that include but are not limited to; Culturally and Linguistically Diverse Populations, LGBTIQ+ populations and TransMen.

- Country SA skin cancer screening and awareness program to access skin checks and improve health literacy in locations where there is limited to or no access to this medical service, and in rural and remote locations without a permanent GP, and where the medical workforce lacks the capability to perform screening and procedures.
- Cancer screening promotion – Get Screened and Get on With Living and other promotions for regular access to cancer screening including but not limited to bowel, breast, cervical and skin, in accordance with Australian national population-based screening activities and PHN performance indicators.

Immunisation and Vaccinations

The aim of this activity is to contribute to herd immunity in the community along with reducing risk of contracting a vaccine preventable condition, this activity contributes to the headline indicator of improving immunisation rates and includes but is not limited to:

- Targeting geographic regions of low vaccination compliance with a focus on vulnerable populations and including uptake of Meningococcal B vaccine in the zero to four year-old cohort
- Supporting the skill base of immunisation providers with commissioned targeted vaccine education to support frontline service delivery of immunisations; promoting of vaccine awareness; and addressing vaccine hesitancy.
- Promoting, supporting, and monitoring of vaccinations that impact the health of communities and individuals including Human Papillomavirus (HPV); whooping cough (pertussis) for pregnant women; and influenza; shingles (herpes zoster) for people over 60.

Living Well with Chronic Conditions

Activities and initiatives under 'Living Well with Chronic Conditions' aim to:

- support patients as they experience the onset of chronic conditions whether childhood asthma, arthritis or other long term health conditions; and
- contribute to lessening the deterioration of patient's health and wellbeing and reduce their likelihood of becoming a potentially preventable hospitalisations statistic.

Managing Chronic Conditions

These initiatives will provide a range of frontline health services supported by digital and other enablers to achieve better health outcomes and include but are not limited to:

- up-to-date, evidence based health information at point of diagnosis in primary care and through ongoing coordinated team care;
- multi-faceted approach to healthy lifestyles and other risk behaviours through both direct personal intervention and accompanying virtual service such as outreach telemedicine and shared medical appointments; and
- supporting personalised care including but not limited to Point of Care Testing and Virtual Home Monitoring devices. This includes access to Medical Specialist advice for GPs and others in the care team.

Integrating Primary Health Care

In country communities of South Australia, access to primary health care such as allied health and other associated services that support better health outcomes for people with chronic conditions, continue to be limited.

Through this activity, patients will be able to access an appropriate level of integrated and capable primary care services that supports them to be active in self-management.

Health Workforce – Primary Healthcare Wellness

The aim of this activity is to enable access to primary health care that supports the resilience and wellbeing of GPs.

Primary Healthcare Wellness is specifically related to workforce resilience development and support to ensure retention of the existing medical workforce. This activity includes but is not limited to:

- Specialised support for the health and wellbeing of rural and remote GPs, registrars, and medical students. This includes provision of 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 has 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.

Ageing Well in Place

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:

- In association with the activity below (Integrated Care at Home), 'Avenues to Ageing' provides a range of supports that include, facilitated planning for future health and personal care through an Advance Care Directive along with providing one on one support to understand and navigate the My Aged Care gateway.
- Integrated care at home sets out to ensure that in their place of residence (whether at home in the community or at home in their residential aged care setting), they have adequate supports that recognise and can respond to their health needs including halting or reversal of deterioration.

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

This activity will improve integration between the Mental Health and Drug and 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 and alcohol through education;
- Support the development of drug and alcohol data to support evidence-based treatment national policy and service delivery; and
- Support service linkages between drug and alcohol treatment services and mental health services, as well as with social, educational and vocational long-term support services.

Surge Capacity and Workforce Support

This activity will support infection control training to the primary care, aged care and broader health care workforce sectors.

This will include dissemination and direct delivery (online if appropriate) of training materials, development of training plans for the sector in their areas. This activity will also support coordination activities to identify options to address workforce shortages in their regions including distribution of Personal Protective Equipment (PPE).

COVID-19 Primary Care Support

This activity will assist PHNs to provide support for Australia's COVID-19 Vaccine and Treatment Strategy (Strategy) to the primary, aged care and disability sectors.

- provide guidance and expert advice to all types of health care providers.
- coordinate vaccine rollout within Residential Aged Care Facilities (RACFs) and disability accommodation facilities, including local service integration and communication, liaison with key delivery.
- coordinate the delivery of vaccination services to RACFs.
- support vaccine delivery sites in their establishment and operation.
- support vaccine delivery to be integrated within local health pathways to assist with the coordination of local COVID-19 primary care responses.
- support vaccine delivery with supply of PPE and consumables where vaccinating general practices and Aboriginal Community Controlled Health Services (ACCHS) are unable to source.
- support Allied Health Services in RACFs through the rollout of the COVID Allied Health Package - GP Education.

Community Paramedicine and Nurse Practitioner Care Model

This activity will encompass a range of initiatives that support appropriate access to health and related services, targeted support, education and information.

This activity is commissioned in part to, and conducted in partnership with, SA Ambulance Service (SAAS) and is known as the "Community Paramedic and Nurse Practitioner Program".

Activities include but are not limited to:

- Trial and evaluate a Community Paramedic/ Nurse Practitioner model in the remote south east and the remote west coast of the state, and other locations as identified.
- Recruit, train and support appropriately trained Community Paramedics and qualified advanced scope of practice or Nurse Practitioners (NP) to work in targeted regions.
- Engage with local General Practice / Aboriginal Community Controlled Health Services (ACCHS), other service providers and the local community to identify service gaps and plan appropriate service provision.
- Identify and support at risk patients to receive time appropriate care through the community paramedicine and nurse practitioner models.
- SAAS in-reach into aged care hospital avoidance activities through underspends.

- Work with Aboriginal and Torres Strait Islander people and their communities to improve timely access to health care when and where needed.
- Consider and plan for ongoing sustainability of this activity after the conclusion of the funding period.
- Scoping of this care model in other areas of need, and in particular using an advanced scope or nurse practitioner workforce is continuing.

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 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 six regional 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;
- Supporting clinical councils and community advisory committees;
- Enabling local engagement and advocacy between stakeholders in order to explore solutions at the point of care;
- Engaging stakeholders in targeted consultation and collaboration that contribute to CSAPHN's Needs Assessment;
- Supporting 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 six regional 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;

- Progressing partnerships relating to digital health solutions to enable uploading of coordinated care and other activity across disconnected systems for country patients and services; and
- Supporting primary care providers to access LGBTIQA+ upskilling through underspends.

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
- 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;
- 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.

General 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:

- Implementing digital health changes for the meaningful use of the My Health Record and enabling technologies;
- Increasing general practice capacity and sustainability through increased appropriate use of MBS and incentive payments;
- Supporting care planning and the Medical Home model changes;
- Promoting engagement and participation in Practice Incentives Program (PIP) and the PIP Quality Improvement (QI) incentive;
- Supporting practice managers, practice nurses and general practice staff with continuous quality improvement and 5th Standards Accreditation;
- Supporting change management and implementation of the MBS review and other future changes;
- Improving data quality and use of clinical information systems; and
- Supporting the uptake of systems such as HealthPathways and online care planning to improve coordination of care and integration with specialist and allied health;
- Providing clinical care updates, current preventative health information and other resources;
- Facilitating the delivery of primary health network communities of practice for mangers, nurses and staff;
- Facilitating the delivery of continuing professional development to general practice inclusive of; culturally appropriate training and culturally and linguistically diverse wellness;

- Supporting to integrate commissioned services, both clinical and self-management, into the general practice multi-disciplinary team;
- Promoting mental wellness awareness for GPs and the general practice community; and
- Engaging 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 improves the health and well-being of local communities.

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

Research, Evaluation and Advisory

The aim of this activity is to enable connection to evidence, support evaluation and investigate or initiate innovation and to provide a range of supporting mechanisms to commissioned providers.

Activities will:

- support development of cutting edge commissioning of services that integrate across the system and funding streams.
- support capacity building and sharing of ideas and best practice between commissioned service providers, along with connection to research institutions.
- develop a reporting portal specifically related to this program IPHCS through underspends.

PHN Pilots and Targeted Programs

COVID Allied Health Package and GP Education support

The aim of this activity is to support the delivery of information to key providers regarding new MBS items that assist in managing the health of people living in residential aged care facilities.

The activity will deliver an education package to GPs and other primary care providers, including practice nurses, regarding:

- the importance of providing allied health services to people with dementia and other residents with complex medical needs in Residential Aged Care Facilities (RACF); and
- the new temporary MBS allied health and mental health items for residents of aged care facilities, and how they can be used to support the residents. It is expected that a minimum of three education sessions are conducted.