Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2019-2022:

Core Funding

GP Support Funding

This Core Activity Work Plan template has the following parts:

1. The Core Activity Work Plan for the financial years 2019-20, 2020-2021 and 2021-2022. Please complete the table of planned activities funded under the following:
    a) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
    b) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.
2. The Indicative Budget for the financial years 2019-20, 2020-21 and 2021-22. Please attach an excel spreadsheet using the template provided to submit indicative budgets for:
    c) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
    d) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.

Adelaide PHN

This Activity Work Plan has been endorsed by the CEO.

Submitted on 02 April 2019

Overview

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

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

This Activity Work Plan covers the period from 1 July 2019 to 30 June 2022.

1. Strategic Vision for Adelaide PHN (APHN)

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

APHN Vision (our aspirations for the future)
Connecting you to health

APHN Purpose (our reason for existence)
Facilitating a collaborative and responsive health care system for metropolitan Adelaide.

The key objectives of (Primary Health Networks) are to:
1. Increase the efficiency of Health Services for patients, particularly those at risk of poor health outcomes, and

2. Improve the coordination of care to ensure patients receive the right care, in the right place, at the right time.

Our strategic objectives are:

Strategy 1

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

Strategy 2

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

Strategy 3

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

Strategy 4

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

Strategy 5

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

Strategy 6

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

Contents

1. (a) Planned PHN activities for 2019-20, 2020-21 and 2021-22 – Core Flexible Funding Stream

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2022.

CF1. Champion Nurse Immunisation Program

Proposed Activities – CF1. Champion Nurse Immunisation Program	
ACTIVITY TITLE	***CF1. Champion Nurse Immunisation Program***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as CF1.1*
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Immunisation
Needs Assessment Priority	IH-GPH1. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non-Aboriginal and Torres Strait Islander children GPH1. The CALD community are disproportionally affected by Hepatitis B GPH3. Identified areas of the Adelaide PHN (APHN) region have childhood immunisation rates below the national average GPH22.Prevention and early intervention strategies for childhood and youth health conditions
Aim of Activity	The Champion Nurse Immunisation Program (CNIP) is one of five elements of the SA PHN Immunisation Hub program. The CNIP commissions specialist nurses to provide: • immunisation program support and education to providers to increase childhood immunisation rates especially for Aboriginal and Torres Strait Islander children, • support and information to the community, especially CALD communities and the impact of Hepatitis B , • identify barriers to vaccine uptake and vaccine hesitancy within the local region • endeavour to collaborate and integrate with SA Health in promoting and incentivising the uptake of Meningococcal B vaccines in the 12 months to 4-year age group.
Description of Activity	The currently commissioned Champion Nurse Immunisation Program (CNIP), will engage specialist nurses to provide: • immunisation program support and education to providers • support and information to the community

	• identify barriers to vaccine uptake • address vaccine hesitancy • promote and advocate for immunisation at local community events • address immunisation requirements for CALD and new emerging communities With practice-based support available to providers and expert immunisation nurses accessible to communities, it is anticipated increased immunisation program awareness will lead to improved immunisation coverage. The program will be evaluated to determine its success and there is possibility for its expansion into rural regions.
Target population cohort	Immunisation providers, community members and under-immunised children
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. The Champion Nurse Immunisation Project will engage local Indigenous schools to provide information about the importance of immunisations of Aboriginal and Torres Strait Islander children. They will offer support and training, where required and appropriate, to Aboriginal and Torres Strait Islander specific health services within primary health care.
Coverage	Entire APHN region
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 cross Metropolitan Adelaide. This then provided the priority localities for the Champion Nurse Immunisation Program. • The South Australian Immunisation Provider Network (IPN) are consulted at their regular meetings.
Collaboration	• Australian Immunisation Register (AIR) - to effectively manage the childhood immunisation data through (AIR) data cleaning activities to accurately reflect the current immunisation status of children. • The organisation commissioned to deliver the Champion Immunisation Nurse project – this co-designed activity will ensure all key elements of the Champion Immunisation Nurse project are undertaken in a timely manner and objectives met.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022

	Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF2. Adelaide Refugees and New Arrivals Project (ARANAP)

Proposed Activities – CF2. Adelaide Refugees and New Arrivals Program (ARANAP)	
ACTIVITY TITLE	***CF2. Adelaide Refugees and New Arrivals Program (ARANAP)***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Modified Activity *Previously referenced as CF2.1*
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Culturally & Linguistically Diverse Communities
Needs Assessment Priority	GPH2. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people. GPH14. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and specific health issues. GPH15. Lack of easily understood and accessible referral pathways across systems and settings. GPH17. Lack of community awareness about existing health care services for different population groups, consumers and providers. GPH19. Need to improve provision of education to consumers and professionals across the health sector to encourage the take up and application of preventative health measures. GPH20. Need to improve the aptitude/attitude and consistency of empathetic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. GPH23. Awareness and timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers. GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Aim of Activity	The aims of ARANAP model are: 1. Connect refugee and newly arrived people to relevant health care services (including other APHN commissioned services) and provide care coordination to have immediate clinical needs attended to and enable positive engagement with the health system. 2. Support refugee and newly arrived people, through a health literacy approach, to understand their health condition and the health system and to better self-manage their health.

	3. Support primary health care providers, including General Practice, to have increased capacity to deliver culturally safe and culturally appropriate services to refugee and newly arrived people.
Description of Activity	Refugee and newly arrived people have ongoing challenges in accessing appropriate primary health care services in the APHN region. The ARANAP model addresses access to appropriate primary health care for refugee and new arrival communities through three streams. 1. Supporting refugee and newly arrived people to access appropriate and timely health care services by: o Connecting individuals with primary health care services, o Refugee Health Nurses coordinating the care of program patients, o Refugee Health Nurses working with both the patients and primary health care clinicians to ensure all health care concerns are attended to (including receiving a GP conducted comprehensive first health assessment in Australia, to support Refugee Health Service demand management, if necessary). 2. Supporting refugee and new arrivals to understand their condition and the health system by: o Bilingual-Bicultural workers using a Conversational Health Literacy Assessment Tool (CHAT) developed by Deakin University to measure health literacy and track progress in a patient's ability to self-manage and to understand their health, o Patients 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 patient's health literacy assessment results across the program to inform topic areas for further education and support to small groups of patients and the wider refugee and new arrival communities in culturally safe and appropriate ways, including multiple formats and multiple languages. 3. Improving the capacity of mainstream primary health care services, including general practice to deliver culturally appropriate services to refugee and new arrival communities by: o Using a best practice framework to generate a gap analysis and deliver targeted support to primary health care providers to improve the appropriateness of care to refugee and newly arrived people, o Working with a focused number of practices to enable them to conduct first comprehensive health assessments for newly arrived people. ARANAP will also work towards improved system integration of primary health care services for refugees and newly arrived people including: o Identifying and promoting best practice approaches and/or pathways for refugees and new arrivals across the spectrum of health care providers

	○ Facilitating, supporting and advocating for collaboration, coordination and integration. The APHN will ensure all components of the model are connected, integrated and promoted to community, service providers and the broader primary health care system. Additionally, to ensure a multi-pronged approach, refugee and new arrival Communities considerations will also be supported and embedded in other activities such as immunisation, HealthPathways, commissioned services, education and training. The APHN strives to be culturally safe and culturally appropriate in all activities undertaken.
Target population cohort	Refugee and New Arrival Communities
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Entire APHN region with specific focus on areas of high refugee and new arrival settlement in the north, south and central West of our region
Consultation	ARANAP was developed through an extensive consultation and codesign process involving an environmental scan, sector consultation, request for proposal, co-design workshop with sector-wide participation. These activities were conducted from 2017 through 2018. Adelaide PHN has worked with the providers of the program to conduct minor redesign and strengthen the health literacy component of the program. Continued consultation will be undertaken through sector networking and the program's Steering Group.
Collaboration	• Collaborate with general practices in target areas to increase their knowledge and capacity to provide culturally appropriate services to refugee and new arrival communities. • Collaborate with Local Health Networks (LHNs) to coordinate and support referral pathways of identified population groups and or those with health condition(s) presenting at Emergency Departments and clinical handover (discharge summaries) after hospitalisation in target areas. • Collaborate with pharmacies and allied health services in target areas to support general practices and patients in managing health condition(s). • Collaborate with relevant NGOs to provide additional support, educational and or promotional services. • Network with appropriate agencies, organisations and community groups to support and guide the delivery of this activity • Collaborate with SA Health to ensure the sector is provided with information and resources to assist their work with refugees and new arrivals - as recommended by the Settlement Services Advisory Council for PHNs • Undertake effective needs analysis with refugee communities to ensure targeted support for new arrivals – as recommended by the Settlement Services Advisory Council for PHNs

Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF3. Adelaide Respiratory Health Project

Proposed Activities – CF3. Adelaide Respiratory Health Project	
ACTIVITY TITLE	***CF3. Adelaide Respiratory Health Project***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as CF3.1*
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Chronic Condition Management
Needs Assessment Priority	IH-GPH2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people. GPH4. Selected areas of the APHN region have high rates of smoking which correlates with areas of high prevalence of COPD. GPH11.Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis). GPH23. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers. GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Aim of Activity	1. Build the capacity of participating GPs and Pharmacies to deliver evidence based and best practice COPD and asthma care to the community; 2. To facilitate and increase collaboration and integration between the participating General Practices, Pharmacies and other relevant organisations e.g. referral paths including the Contractor and Sub-Contractors; 3. Develop resources to facilitate the successful replication of the project in additional settings.
Description of Activity	The Adelaide Respiratory Health Project (ARHP) will continue to support the development and/or delivery of solutions which aim to improve outcomes for people living with Chronic Obstructive Pulmonary Disease (COPD) and Asthma, build the capacity of service providers to deliver safe and effective care and demonstrate reductions in preventable hospitalisations for COPD and Asthma in the APHN region. The model focuses on interventions which support people living with COPD and/or Asthma across the continuum with a focus on vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, Palliative Care patients, people with multi-morbidities and people not able to access services due to frailty or disability.

	The results of this activity will continually aim to improve collaborative working across sectors (with particular focus on clinical handover and shared ways of working); Implementation of evidence best practice models that are practice and patient centred (such as Asthma/COPD action plans); increase the availability, efficiency and effectiveness of respiratory health care and increasing workforce capacity and capability.
Target population cohort	People living with COPD and/or Asthma across the care continuum with a focus on vulnerable population groups (particularly, Aboriginal and Torres Strait Islander people, Children and Youth, Palliative Care patients, people with multi-morbidities and people not able to access services due to frailty or disability).
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. The Adelaide Respiratory Health Project will engage the local Integrated Team Care [ITC] team to offer support and resources for patients with COPD or Asthma, whilst providing direct links to Asthma Australia programs, staff and resources.
Coverage	Preference will be given to services that support residents of the Local Government Areas of Playford, Salisbury, Port Adelaide/Enfield and Onkaparinga, but where deemed appropriate and a need is identified could be offered in other locations across the Adelaide PHN region
Consultation	Previous funding through the Australian National Health Prevention Agency (ANPHA) enabled an 18-month partnership project (2013/15) with Asthma SA, Lung Foundation Australia, the Pharmaceutical Society of Australia (SA/NT Branch), Drug and Alcohol Services SA [DASSA], Cancer Council (Quitline), Northern Region GP Council and the Northern Adelaide Local Health Network [NALHN] to focus on an integrated approach to respiratory health in northern Adelaide, raising community awareness of the relationship between smoking rates and respiratory conditions. Learnings from evaluation of stakeholder feedback from both projects highlighted the benefit of organisations working collaboratively in targeted populations and areas of need and this approach has informed the development of the service model for the ARHP. A workshop was undertaken with members from the steering group involved in previous projects to determine key learning and issues encountered. The findings from this workshop assisted in refining the scope of the project.
Collaboration	• Ongoing collaboration with Asthma SA will continue to raise community awareness and support primary health care practitioners (especially GPs and Pharmacists) with Asthma resources available to assist with management of the condition. • Ongoing collaboration with Lung Foundation Australia will continue support primary health care practitioners (especially GPs and Pharmacists) with COPD resources available to assist with management of the condition. • Ongoing collaboration with Pharmaceutical Society of Australia [SA/NT Branch] to support increased interventions and management at the pharmacy level to support smoking cessation and patient medication compliance.

	• Ongoing collaboration with Cancer Council [Quitline] to support the community and primary health care practitioners (especially GPs and Pharmacists) with the increasing referrals to Quitline and other smoking cessation resources and programs. • Continue to collaborate with Local Health Networks across metropolitan Adelaide to assist in consistent, improved clinical pathways for appropriate patient management of respiratory conditions. All relevant stakeholders will be invited to provide representation on the project working group, where appropriate.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2021 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2021 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF4. Care Connections Program

Proposed Activities – CF4. Care Connections Program	
ACTIVITY TITLE	***CF4. Care Connections Program***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as CF4.1*
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Coordinated chronic condition management
Needs Assessment Priority	GPH6. Selected APHN LGAs have higher rates of a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease, musculoskeletal) and multi-morbidities. GPH8. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services. GPH11.Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis) GPH12. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations. GPH14. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues. GPH18. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.
Aim of Activity	Care Connections is an opportunity for the Adelaide PHN to coordinate and integrate chronic condition management services for target patient cohorts to improve their health outcomes. Being the cornerstone of primary care the program also supports general practices. Care Connections uses the Patient Centred Medical Home Model to support transformation of primary health care in the Adelaide PHN region, focussing on areas with high prevalence of chronic conditions and multimorbidity. The aims are (to): 1. Improve chronic condition management in identified patient cohorts through implementation of elements of patient-centred medical home models; 2. Connect and integrate local level primary health care systems and providers in targeted areas of the Adelaide PHN region; 3. Implement quality improvement initiatives to support the Quadruple Aim of primary health care; and 4. Improve the quality use of medicines (QUM) in line with the National Strategy for Quality Use of Medicines.

Description of Activity	Care Connections is an initiative in response to the Primary Health Care Advisory Group Final Report: Better Outcomes for People with Chronic and Complex Conditions. The initiative has been designed to improve chronic condition management in primary care through supporting better coordination of care and integration across the health system. The main elements of Care Connections in 2019/22 will be: • *Integrated Care Hubs (ICH):* Existing and future ICHs are targeted general practices who are undertaking, or will undertake, activities designed to explore elements of the Person-Centred Medical Home (PCMH) model. Activities seek to improve chronic condition management, through leadership development, data-driven quality improvement, strengthening patient-clinician relationships, team-based care and participation in local medical neighbourhood initiatives. As practices move through the Care Connections program, they will: o Identify areas for improvement around chronic condition management within their practice and develop a plan for action. This action will be supported by activities described in GPS1 and HSI7. o Undertake to develop and implement mechanisms for supporting continuous quality improvement. This action will be supported by activities described in GPS1 and HSI4. o Identify patients who would benefit from a person-centred approach to the management of their chronic condition(s) or are at risk of unplanned hospital admissions. This process allows practices to go beyond traditional condition-specific interventions and address patient needs across the entire care spectrum (including preventive, chronic and acute) o Participate in (or co-design, where appropriate) PHN supported and/or commissioned evidence-based Improvement Activities which meet the specific needs of the identified patients and align with best-practice chronic condition management. These activities may include, for example: ▪ improved utilisation and scope of practice team members, both health professionals and administrative staff ▪ utilisation of shared care platforms, patient portals and assistive technology ▪ coordinated options for medicines review and management ▪ nurse-led clinics, group self-management and shared medical appointments ▪ frailty and falls management ▪ health and lifestyle coaching for patients ▪ improved access to specialised care Each of these Improvement Activities within the ICH will be direct patient service delivery, enhancing the practices' ability to provide comprehensive care for the identified patients.

	• *Local Medical Neighbourhood*: This activity seeks to strengthen and sustain relationships between and within ICHs and other key health providers. These relationships encourage collaboration and communication including the flow of information across and between clinicians and patients, to include specialists, hospitals, home health, long term care and other clinical providers.
	  ○ ICHs will be asked to identify potential partners for local medical neighbourhood activities from their referral lists
	  ○ Commissioned providers will upskill interested identified partners in the overarching PCMH-N (Neighbourhood) model and support them to build capacity for team-based care within their organisations. This action may be supported by activities described in HSI5 and HSI7
	  ○ Communities of practice, formed by the ICH with their local medical neighbourhood partners will review local population health issues, identify shared patients, and develop and deliver an integrated patient initiative supported by Adelaide PHN LMN grants. They may also identify and undertake shared training opportunities to support their chosen patient initiative. These patient initiatives should build on the activities the ICH has undertaken as part of their Improvement Plan & Activities and may include, for example:
	  ▪ co-location of staff or shared resourcing of co-located health practitioners
	  ▪ cross-professional group self-management and shared medical appointments
	  ▪ comprehensive shared care planning, supporting the uptake of MBS case conferencing items
	  ○ Local Medical Neighbourhood grants for local medical neighbourhood partners who are not aligned with an ICH to explore opportunities for direct patient PCMH-N activities in their region. This would be an expression of interest process which would target regions and populations that do not have an ICH to support them but may benefit from chronic condition management activities at a population level. This may include:
	  ▪ screening, assessment and referral initiatives
	  ▪ self-management support
	  ▪ health and lifestyle coaching

Target population cohort	People living with one or more chronic conditions, with a specific focus on older people, who would benefit from improved coordination of care and flexible care options
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No

	If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Public Health Information Development Unit (PHIDU) Population Health Areas (PHAs) (based on ABS Statistical Area Level 2): Davoren Park, Elizabeth East, Elizabeth/ Smithfield - Elizabeth North, Parafield/ Parafield Gardens/ Paralowie, Salisbury/ Salisbury North, Dry Creek - South/ Port Adelaide/ The Parks, Largs Bay - Semaphore/ North Haven, Christie Downs/ Hackham West - Huntfield Heights, Christies Beach/ Lonsdale, Morphett Vale - East/ Morphett Vale – West.
Consultation	Initial consultations were undertaken with APHN Clinical Councils for feedback to inform preliminary design. Further consultations were then conducted with general practices in the identified areas (see coverage for reference) to refine the activity model and ensure consistency with on-the-ground workforce concerns. The following groups have been and will continue to be consulted to further inform activities undertaken as part of Care Connections program design and development: • Primary health care workforce • Specific Local Health Networks (LHNs) to coordinate referral pathways of identified population groups and or those with health condition(s) presenting at Emergency and/or Outpatient Departments and discharge summaries (after hospitalisation) in target areas. • Pharmacies and allied health services in target areas to support general practices and patients in managing health condition(s). • Aboriginal Community Controlled Health Organisation(s) (ACCHO) to support culturally appropriate services for Aboriginal and Torres Strait Islander people. NGOs to provide additional support, educational and or health promotion services and activities.
Collaboration	Collaboration on this activity continues and is integral to the ongoing nature of ICH's, medical neighbourhood and well-coordinated and integrated primary health care. Collaboration continues with: • Local Health Networks • Allied health • Pharmacies • Community Health and social support providers These engagements continue to build, strengthen and sustain targeted relationships in the local geographic regions, to support the development of the Local Medical Neighbourhood. This work may include clarifying referral pathways, identifying capacity and capability issues, and supporting linkages between these organisations and the Integrated Care Hubs. The Care Connections project is complementary to the Health Care Home roll out and will enhance chronic disease care coordination with the targeting and provision of specific resources in areas of identified high need.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022

	If applicable, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☒ Open tender ☒ Expression of Interest (EOI) ☐ Other approach (please provide details) Mixed commissioning approach will allow each element of Care Connections to be procured as is appropriate to the design of each element. 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF5. Living Well with Persistent Pain Program

Proposed Activities – CF5. Living Well with Persistent Pain Program	
ACTIVITY TITLE	***CF5. Living Well with Persistent Pain Program***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Modified Activity *Previously referenced as CF5.1 and CF5.2*
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Chronic Condition Management
Needs Assessment Priority	GPH7. Services for people living with persistent pain are limited with long delays to access hospital-based services. GPH24. A coordinated approach to improve navigation and pathways for patients to better manage their conditions.
Aim of Activity	The aim of the activity is to provide a multi-disciplinary, collaborative primary care-based persistent pain management network, which: • supports individuals to better understand their condition; • equips them with the necessary tools to improve their quality of life; • improves individual's ability to navigate the health system; and • minimises the burden of pain on the individuals and the wider community.
Description of Activity	The Living Well with Persistent Pain (LWwPP) program is based on evidence showing multidisciplinary biopsychosocial interventions, such as pain management programs are successful in assisting people to manage ongoing or persistent pain. Based on the successful PainWise® Turning Pain into Gain Program, this activity is a comprehensive pain management program. Individuals are referred to the program by their GP for a 12-month intervention. In the program, they can access: • an education program focused on making changes to improve the patient's daily life; • one-on-one discussions about the patient's pain and how it affects them; • a tailored plan of allied health services. Participants undergo an initial assessment with the program Care Coordinator and have a personalised care plan developed. A GP with a Special Interest may also be available in the program to develop care plans for more complex cases such as those where the referring GP is seeking a second opinion, support in medication changes or deprescribing or other complications. As people with persistent pain often require complex management plans, participants are supported with access to 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 and develop self-management skills which support their work with the GP and the allied health team. The multi-disciplinary team, in the course of the education sessions 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. Three services will deliver the program, each aligned with the relevant Local Health Network boundary.
Target population cohort	People living with persistent pain
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Local Health Networks boundaries – Northern Adelaide Local Health Network, Central Adelaide Local Health Network and Southern Local Health Network
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. During the early stages of the program implementation, program leaders participated in the SA Health Transforming Health Chronic Pain Model of Care consultation process as part of both the Working Group and Steering Committee. This participation assisted to align the activity with the State model and ensure integration across the sectors. Adelaide PHN continues to work with the commissioned service provider to identify opportunities and develop the program further. Tertiary services are also engaged ongoingly.
Collaboration	Local Health Networks: • Partnering as a delivery partner • Referral of appropriate patients • Pathways with the new SALHN chronic pain program. General Practices in target areas: • Service delivery to support them to manage patients' persistent pain condition alongside any chronic condition(s) • Referral of appropriate patients. 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: Identifying shared opportunities and pathways for support post-program.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022

	If applicable, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☒ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF6. Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program

Proposed Activities – CF6. Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program	
ACTIVITY TITLE	***CF6. Aboriginal and Torres Strait Islander Cultural Learning and Capacity Building Program***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as CF6.1*
Program Key Priority Area	Choose from the following: Workforce If Other (please provide details): Aboriginal Health
Needs Assessment Priority	IH-GPH2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people. IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people. GPH20. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. GPH21. Minimise instances of poor quality and unwarranted variations of care and follow up.
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 and respectful services across the primary health care sector for improved patient experience. • Increase commissioned service providers and the primary health care services capacity in addressing local issues and supporting the health system better meet the needs of the Aboriginal and Torres Strait Islander patients participating in the project. • Increase mainstream primary health care provider knowledge and understanding of measures under the Indigenous Australian Health Program (IAHP) and improve access to primary health care for Aboriginal and Torres Strait Islander people. • Increase access to culturally safe services and appropriate chronic disease management programs for Aboriginal and Torres Strait Islander people
Description of Activity	This project will deliver: • Cultural learning (accredited training) to improve the capacity of mainstream primary health care providers and workforce to deliver

	safe, accessible and culturally responsive services for Aboriginal and Torres Strait Islander people. • Cultural learning (accredited training) to the primary health care workforce which will include Adelaide PHN commissioned service providers. • Capacity building workshops on the 6 Aboriginal Actions within the National Health and Safety Quality Standards for commissioned service providers • Fund an additional Health Project Officer Position within the Integrated Team Care (ITC) commissioned service provider to support capacity building with mainstream primary health care providers. • Support the delivery of best practice approaches to improve health outcomes and delivery of care to Aboriginal and Torres Strait Islander people. • Provide formal and informal information sessions for mainstream primary health care providers, including GPs, practice staff, allied health, specialists and pharmacies on the IAHP and associated incentives • Promote the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule (MBS) items, including Aboriginal and Torres Strait Islander Health Assessments and follow up items; • Support access to appropriate chronic disease management programs for Aboriginal and Torres Strait Islander people
Target population cohort	The target audience for the training will be Adelaide PHN commissioned service providers and the broader primary health care workforce. Focusing on mainstream service providers, such as general practitioners, practice managers and nursing staff, reception staff, allied health professionals, pharmacists and pharmacy assistants.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? YesIf yes, briefly describe how this activity will engage with the Indigenous sector The commissioned agency is an Aboriginal Organisation and will work in partnership with Adelaide PHN in collaboration with Aboriginal State peak bodies, consolidate and extend collaborative working relationships with Aboriginal Community Controlled Health Organisations, primary health and acute services, as well as primary and state based health and support agencies. 1. Both organisations will continue their collaborative work with SAMHRI's Aboriginal Research Unit (Wardliparingga) on the implementation of programs and initiatives for culturally appropriate best practice management of a range of chronic conditions for Aboriginal and Torres Strait Islander people.
Coverage	The training sessions will be delivered across the Northern, Western and Southern regions of metropolitan Adelaide.
Consultation	Consultations have occurred with the following stakeholders to help inform the development of this project: • Integrated Team Care Program workforce • The Adelaide PHN Aboriginal Consumer Advisory Council South Australian Health and Medical Research Institute – Warldaparingga Aboriginal Unit

	• Kaurna Elder Further 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 on this activity is evolving and it is expected that the APHN will engage with: • Aboriginal Community Controlled Health Organisations • Aboriginal Services within LHNs • Primary Health Care Providers • Integrated Team Care Program • South Australian Health and Medical Research Institute – Warldaparingga Aboriginal Unit • Rural Doctors Workforce Agency
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: June 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No

Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF7. Aboriginal Health and Youth Care Coordination Project

Proposed Activities – CF7. Aboriginal Health and Youth Care Coordination Project	
ACTIVITY TITLE	***CF7. Aboriginal Health and Youth Care Coordination Project***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as CF8.1*
Program Key Priority Area	Choose from the following: Aboriginal and Torres Strait Islander Health If Other (please provide details): Workforce
Needs Assessment Priority	IH-GPH2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non-Aboriginal and Torres Strait Islander people. IH-GPH3. Accessibility to primary health services for Aboriginal and Torres Strait Islander people. IH-GPH5. Awareness of timely access to appropriate services (including after-hours services) for Aboriginal and Torres Strait Islander people.
Aim of Activity	The aim of the Project includes: • providing access to a consistent and culturally sensitive, medically appropriate GP service to Aboriginal and Torres Strait Islander patients living in Southern Adelaide Local Health Network (SALHN) region participating in the project; • providing specialised GP services for other groups, specifically teenagers and adolescents patients living in the SALHN region participating in the project; and • improving patient outcomes by ensuring consistency and clinical compliance surrounding the management acute and chronic conditions of vulnerable communities in SALHN region.
Description of Activity	This project aims to address the significant shortage of appropriate general practice services for Aboriginal and Torres Strait Islander people in the south by supporting care the delivery primary health care services in the southern region of Adelaide. The project will provide a consistent GP service in the southern region which will improve patient outcomes by ensuring consistency and clinical compliance surrounding the management of Aboriginal people with mental health issues and acute and chronic conditions. Provide youth friendly medical services including treatment plans and promote general adolescent and mental health awareness and increase timely access to a GP. Whilst a few organisations exist in the Noarlunga precinct to support teenagers and adolescents (e.g. Headspace), the added support from a specialised GP

	service will assist with the timely identification and referral of patients that may benefit from timely access and support from GPs with experience and training in mental health. This project aims to address this gap in the south by implementing specific programs focussed on care coordination in Aboriginal Health and Youth Mental Health (to meet the needs of the vulnerable communities identified in the target areas. The project outcomes are: • Local culturally appropriate GP services are provided for Aboriginal and Torres Strait Islander people • Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care to support management of their chronic conditions to improve health outcomes • Aboriginal and Torres Strait Islander people can access primary health care services as required • Increased treatment plans and coordinated care for young people to improve health outcomes specifically in areas of sexual health, mental health, chronic disease prevention • Partnerships, integration and pathways are formalised with other local health care providers to ensure there is an integrated approach to the provision of care in the region.
Target population cohort	Aboriginal and Torres Strait Islander people and teenagers and adolescents
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. Partnership established and referral pathways developed between the provider and the Aboriginal Community Controlled organisation (Nunkuwarrin Yunti) that delivers Mental Health and AOD services in the South.
Coverage	Southern Adelaide LHN region
Consultation	Building on previous consultation undertaken for the pilot project with patients, LHN and health professionals involved in the (pilot) project, this project will continue to consult with the Aboriginal and Torres Strait Islander community, youth, schools and other primary health organisations (such as Aboriginal Family Clinic and Nunkuwarrin Yunti) in SALHN region.
Collaboration	• Aboriginal Family Clinics (Southern Adelaide Local Health Network) – Client sharing and integration of services. • GPEx – Providing placement and training for GP registrars • St. John's Ambulance – Providing GP and nursing support for community events, including Schoolies festival and the City to Bay • University of Adelaide – Medical Student placements • Seacliff Surf Lifesaving Club– Sponsor the club and provide education sessions to teenage members aged 13-18Headspace Centres
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019

	Activity end date: 30/06/2020 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2020 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF8. Palliative Care Access to Medicines

Proposed Activities – CF8. Palliative Care Access to Medicines (PCAM)	
ACTIVITY TITLE	***CF8. Palliative Care Access to Medicines***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as CF9.1*
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Palliative Care
Needs Assessment Priority	GPH9. Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations. GPH12. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations. GPH23. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly Aboriginal and Torres Strait Islander people, children and youth, people with a disability, older people, palliative care patients and their carers.
Aim of Activity	This activity aims to: • Increase patient and carer access (within and after-hours) to palliative care to medicines (focussing on a previously developed Core Medicines List) through improved prescriber and community pharmacy integration across metropolitan Adelaide.
Description of Activity	South Australian research has shown that access, within and after-hours, to subcutaneous palliative care medicines from community pharmacies can be difficult, with pharmacists unable to anticipate which medicines to stock. This prompted the development of a Core Medicines List (CML) to improve community access to terminal phase medicines. The PCAM project has been designed to improve timely access to end-of-life medicines for people with life-limiting illnesses. Based around a list of medicines recommended by SA Health Specialist Palliative Care Services – the Core Medicines List (CML) – and anticipatory prescribing strategies, the PCAM project will: • Raise patient, carer and health professional awareness of the CML and anticipatory prescribing strategies; and • Identify and understand issues associated with patient and carer's access to CML • Identify and address barriers associated with the supply of CML. • medicines. The commissioned service provider will continue to work with the clinical community, particularly community pharmacies to: • Improve GP prescribing practices for palliative and end-of-life care and management, based on the CML and anticipatory prescribing strategies, through evidence-based educational approaches

	• Support community pharmacies to increase the routine stocking and replenishing the medicines on the CML; and utilising a consistent approach regarding problem-solving around issues of access to and supply of CML • Identify where shared patients may exist and improve communication practices between the involved general practitioners and pharmacies The commissioned service provider will also build on, support and implement strategies and targeted resources to raise awareness of the CML for end-of-life care in the community and anticipatory prescribing in end-of-life care in the community through a variety of activities, including linking with key stakeholders through a Project Steering Group. The PCAM PSG will provide guidance on project implementation; promote the CML and PCAM project widely to relevant networks; contribute knowledge and understanding of community-based end-of-life care; and foster alignment with other palliative care initiatives. Adelaide PHN Practice Facilitators will integrate with the project by working with General Practice to raise awareness of the Core Medicines List and advocate for GPs to prescribe from this list, linking practices with pharmacies that have agreed to stock the medicines.
Target population cohort	People with life-limiting conditions nearing the end of life
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Entire APHN region
Consultation	Consultation on this activity will continue through working party meetings attended by the following organisations: • Country SA Primary Health Network • GP Partners • Palliative Care SA • Pharmaceutical Society of Australia (SA Branch) • Pharmacy Guild of Australia (SA Branch) • Silverchain (RDNS) • SA Ambulance Services • Specialist Palliative Care Services Pharmacists (SALHN, CALHN, NALHN)
Collaboration	The successful service provider will collaborate with the APHN and the following organisations through a Project Steering Group to ensure system integration. They consist of but not limited to: • SA Health (Specialist Palliative Care Services) • GP Partners – locate GPs who participate in the Palliative Care Shared Care Program; linking with these GPs and existing resources; understanding GP issues • Palliative Care SA – Resources and links around advocacy • Pharmacy Guild of Australia (SA Branch) – engagement with pharmacies; understanding pharmacy issues

	• Aged and Community Services SA & NT and Leading Age Services Australia
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2020 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2020 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF9. Integrated Care with Northern Adelaide Local Health Network (ICwNALHN)

Proposed Activities – CF9. Integrated Care with Northern Adelaide Local Health Network (ICwNALHN)	
ACTIVITY TITLE	***CF9. Integrated Care with Northern Adelaide Local Health Network (ICwNALHN)***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity (New activity title) *Previously referenced as CF10.1.*
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Integrated Care
Needs Assessment Priority	GPH14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. GPH20. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. GPH21. Minimise instances of poor quality and unwarranted variations of care and follow up. GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Aim of Activity	This activity aims to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and the Lyell McEwin Hospital in the Northern Adelaide Local Health Network.
Description of Activity	The activity will work in the following domains to improve patient outcomes through a -strengthened acute-primary care interface in the Northern Adelaide Local Health Network (NALHN) region: Engagement and Relationship Building • Identifying and engaging general practices with patients in the cohort group Communication and Collaboration • Working between inpatient and outpatient services and general practice to ensure patient information is exchanged in a timely and appropriate manner as part of the clinical handover process Access and Navigation • Promoting and disseminating referral and management guidelines and resources as part of HealthPathways Capacity and Capability Building • Supporting general practice and hospital clinicians to enable improved management of the patient cohort in primary care through peer to peer mentoring and education Integration

	• Linking relevant hospital specialist areas, staff and resources and liaison services with general practice to support management of the patient cohort. The activity will be jointly funded by APHN and the Northern Adelaide Local Health Network (NALHN) and undertaken at the Lyell McEwin Hospital. The activity will employ a 0.6FTE General Practitioner and additional in-kind funding will be provided by the hospital to cover a 0.6FTE care coordinator, 0.8FTE administration and accommodation related expenses.
Target population cohort	The target population will be adults and/or children with chronic conditions who have frequent contact with hospital services.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Northern Adelaide Local Health Network region
Consultation	This activity has been established in consultation with general practitioners and clinicians and administrative staff from Lyell McEwin Hospital This activity is governed by a Steering Group, involving participants from APHN, Lyell McEwin Hospital to oversee the performance monitoring and evaluation functions..
Collaboration	This activity will be jointly implemented in collaboration with NALHN and will be undertaken at the Lyell McEwin Hospital. This activity will engage and collaborate with general practice and clinicians and administrative staff from the Lyell McEwin Hospital to improve communication and build sustainable working relationships to ensure systems and processes support the quality and timeliness of clinical handover and the coordination of care for patients across the hospital/community interface.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Partnership

	2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF10. Integrated Care with Southern Adelaide Local Health Network (ICwSALHN)

Proposed Activities – CF10. Integrated Care with Southern Adelaide Local Health Network (ICwSALHN)	
ACTIVITY TITLE	***CF10. Integrated Care with Southern Adelaide Local Health Network (ICwSALHN)***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity (New activity title) *Previously referenced as CF11.1.*
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Integrated Care
Needs Assessment Priority	GPH14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. GPH20. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. GPH21. Minimise instances of poor quality and unwarranted variations of care and follow up. GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Aim of Activity	This activity aims to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and the Flinders Medical Centre Hospital in the Southern Adelaide Local Health Network.
Description of Activity	The activity will work in the following domains to improve patient outcomes through a -strengthened acute-primary care interface in the Southern Adelaide Local Health Network (SALHN) region: Engagement and Relationship Building • Identifying and engaging general practices with patients in the cohort group Communication and Collaboration • Working between inpatient and outpatient services and general practice to ensure patient information is exchanged in a timely and appropriate manner as part of the clinical handover process Access and Navigation • Promoting and disseminating referral and management guidelines and resources as part of HealthPathways Capacity and Capability Building • Supporting general practice and hospital clinicians to enable improved management of the patient cohort in primary care through peer to peer mentoring and education Integration

	• Linking relevant hospital specialist areas, staff and resources and liaison services with general practice to support management of the patient cohort. The activity will be jointly funded by APHN and the Southern Adelaide Local Health Network (SALHN).
Target population cohort	The target population will be adults and/or children with chronic conditions who have frequent contact with hospital services.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Southern Adelaide Local Health Network region
Consultation	This activity is being established in consultation with general practitioners and clinicians and administrative staff from Flinders Medical Centre .
Collaboration	This activity will be jointly implemented in collaboration with SALHN and will be undertaken at the Flinders Medical Centre.. This activity will engage and collaborate with general practice and clinicians and administrative staff from the Flinders Medical Centre to improve communication and build sustainable working relationships to ensure systems and processes support the quality and timeliness of clinical handover and the coordination of care for patients across the hospital/community interface.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Partnership 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process?

	Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF11. Integrated Care with Central Adelaide Local Health Network (ICwCALHN)

Proposed Activities – CF11. Integrated Care with Central Adelaide Local Health Network (ICwCALHN)	
ACTIVITY TITLE	***CF11. Integrated Care with Central Adelaide Local Health Network (ICwCALHN)***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Modified Activity *Previously referenced as CF12.1*
Program Key Priority Area	Choose from the following: Population Health If Other (please provide details): Integrated Care
Needs Assessment Priority	GPH14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. GPH20. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. GPH21. Minimise instances of poor quality and unwarranted variations of care and follow up. GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
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 Royal Adelaide Hospital in the Central Adelaide Local Health Network.
Description of Activity	The activity will work in the following domains to improve patient outcomes through a -strengthened acute-primary care interface in the Central Adelaide Local Health Network (CALHN) region: Engagement and Relationship Building • Identifying and engaging general practices with patients in the cohort group Communication and Collaboration • Working between inpatient and outpatient services and general practice to ensure patient information is exchanged in a timely and appropriate manner as part of the clinical handover process Access and Navigation • Promoting and disseminating referral and management guidelines and resources as part of HealthPathways Capacity and Capability Building • Supporting general practice and hospital clinicians to enable improved management of the patient cohort in primary care through peer to peer mentoring and education Integration Linking relevant hospital specialist areas, staff and resources and liaison services with general practice to support management of the patient cohort.

Target population cohort	The target population will be adults with chronic conditions who have frequent contact with hospital services.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Central Adelaide Local Health Network region
Consultation	This activity is being established in consultation with general practitioners and clinicians and administrative staff from Royal Adelaide Hospital.
Collaboration	This activity will be established in consultation with general practitioners and clinicians and administrative staff from Royal Adelaide Hospital This activity will be governed by a Steering Group, involving participants from APHN, Royal Adelaide Hospital to oversee the performance monitoring and evaluation functions.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Partnership 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? No

Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF12. Aboriginal and Torres Strait Islander Community Peer Support for Cancer Screening

Proposed Activities – CF12. Aboriginal and Torres Strait Islander Community Peer Support for Cancer Screening	
ACTIVITY TITLE	*CF12. Aboriginal and Torres Strait Islander Community Peer Support for Cancer Screening*
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity Previously referenced as HSI2.1
Program Key Priority Area	Choose from the following: Aboriginal and Torres Strait Islander Health If Other (please provide details): Population Health
Needs Assessment Priority	IH-GPH3. Accessibility to and appropriateness of primary health care services, particularly for Aboriginal and Torres Strait Islander people. IH-GPH4. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people.
Aim of Activity	This project aims to increase participation in breast, bowel and well women's screening for Aboriginal and Torres Strait Islander people living in metropolitan Adelaide, through community peer support approaches.
Description of Activity	Through community peer support approaches the project which will: • Develop and implement activities to increase Aboriginal and Torres Strait Islander people's awareness and understanding of cancer prevention and improve cancer screening health literacy • Work collaboratively with cancer screening services to increase accessibility for Aboriginal and Torres Strait Islander people in culturally appropriate ways • Promote coordinated and consistent approaches to cancer screening pathways for Aboriginal and Torres Strait Islander people The project will enable the service provider to engage Aboriginal peer workers as "peer ambassadors" to deliver culturally appropriate messages and information (yarning circles) about cancer screening and advocate with primary health care services for improved, culturally appropriate approaches to promoting and providing cancer screening. The project will comprise activities which assist with the implementation of recommendations from both the National Aboriginal and Torres Strait Islander Cancer Framework and the South Australian Aboriginal Cancer Control Plan regarding screening and early detection of cancer in Aboriginal and Torres Strait Islander people. The desired outcome of this project is to reduce the impact of cancer in Aboriginal communities, by empowering Aboriginal people to improve their cancer screening literacy and support their decisions and actions in relation to cancer screening.

	The intended outcomes of the Aboriginal Cancer Screening Project are: • Aboriginal people have improved health literacy for cancer screening including changing attitudes toward participating in screening (e.g. intention to be screened and actual screening), increased knowledge of causes and risk / protective and wellbeing factors, the benefits and importance of screening and where and how to access services; • Cancer screening service providers have increased confidence and ability to deliver culturally sensitive and appropriate services to Aboriginal People; • A coordinated and consistent cancer screening message is provided to Aboriginal people.
Target population cohort	Aboriginal and Torres Strait Islander population
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. Collaboration and support initiatives between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors. Key Stakeholders will be engaged to promote the Yarning Circles within their service region. Stakeholders include: • SAHMRI – Aboriginal Chronic Disease Consortium, Cancer Leadership Group • LHNs • Nunkuwarrin Yunti • Aboriginal Health Council of South Australia
Coverage	The Local Government Areas (LGAs) of Adelaide, Playford, Salisbury, Port Adelaide Enfield, West Torrens and Onkaparinga.
Consultation	During the beginning stage of the activity, Adelaide PHN consulted with the Aboriginal HPG in the scoping and design stage of the activity. We will now ensure we include the Aboriginal Community Council (newly established) in feedback and ongoing improvement for these activities. Adelaide PHN provides ongoing updates on activity to the Adelaide PHN Consumer Advisory Council. The provider will continue to consult with local Elders on the program activity and provide feedback to the Aboriginal Advisory Group of the Aboriginal Chronic Disease Consortium (South Australian Medical Research Institute) and the Integrated Team Care Workforce (Sonder).
Collaboration	One of the key desired outcomes of this program will be to promote coordinated and consistent approaches to cancer screening pathways for Aboriginal people in the Adelaide PHN region. To support this, the Adelaide PHN will facilitate bi-monthly meetings with the project's service provider and other key stakeholders to build relationships, address barriers and enablers and seek collaborative solutions to a coordinated approach to cancer screening for Aboriginal people. There is also scope to encourage collaboration through the coordination and integration the cancer screening peer ambassador workforce with the Closing the Gap Integrated Team Care teams, once established – enhancing the Closing

	the Gap's programs ability to access culturally appropriate supports to address the cancer screening requirements of its clients, and increasing the reach of the peer ambassadors into the community.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2020 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2020 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF13. Mental Health Clinical Internship (MHCI) Program

Proposed Activities – CF13. Mental Health Clinical Internship (MHCI) Program	
ACTIVITY TITLE	*CF13. Mental Health Clinical Internship (MHCI) Program*
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity Previously referenced as CF7.1
Program Key Priority Area	Choose from the following: Workforce If Other (please provide details): Mental Health
Needs Assessment Priority	GPH15. Lack of easily understood and accessible referral pathways across systems and settings. GPH16. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. GPH20. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. IH-PMH6. Greater prevalence of intentional self-harm and suicide in selected areas and specific population groups across the region including Aboriginal and Torres Strait Islander people. PMH2. Provision of psychological services comparatively low in areas of highest need.
Aim of Activity	The MHCI Program aims to support post graduate students from the disciplines of psychology, occupational therapy, social work and/or mental health nursing develop the specific clinical skills required to effectively deliver mental health services within a stepped care model. The Program will contribute to the development of the mental health workforce through the provision of internships: • that provide structured career pathways within built-in support, supervision and continuing professional development; and • are consistent with recognised standards for mental health clinicians and associated competencies.
Description of Activity	This activity addresses workforce capacity and skills development in clinical therapeutic intervention in mental health to address workforce shortages, particularly in relation to experienced Mental Health Clinicians capable of working with hard to reach populations. The Core Flex needs assessment refers to the Mental Health aspects of Primary Care and chronic conditions throughout the report, as well as the needs related to specific population groups. This is an area of need and is also identified in our Mental Health & Suicide Prevention Need Assessment. The MHCI Program will continue to be offered as a targeted 2-year program in regions with high need and offered to post graduate students to develop their

	skills and expertise in clinical practice. Upon completion of the program the Intern will have fulfilled the requirements for application for registration as an accredited Clinical Mental Health Social Worker, or in the case of other disciplines, two years post graduate clinical experience. The program will consist of: • Professional Development • Community Development, Education and Engagement • Observing Direct Clinical Practice • Co-facilitation of Clinical Practice • Supervised Practice • Clinical Supervision. The MHCI Program offers the duel benefit of supporting increased levels of service provision for hard to reach populations in areas of high need in the Adelaide metropolitan region and contributing to the development of overall workforce capacity, responsiveness and availability.
Target population cohort	Post-graduate students looking to develop their skills in clinical practice and can work towards credentialing suitable for delivering clinical mental health services.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	APHN region and targeted to areas of need
Consultation	The MHCI program has been informed by workforce requirements in the Adelaide PHN region (particularly with hard-to-reach populations) and community/stakeholder consultation.
Collaboration	The program model has been shared across other identified regions and providers to build provider capacity to offer these positions within their provider workforce. The Adelaide PHN, Sonder (formerly the Northern Health Network)and SA Health Mental Health community teams are keen to provide an opportunity for the MHCI positions to spend some time working with and alongside State Community Mental Health teams to further the integration and collaboration of both State and primary care service delivery. Further Sonder is supporting the other large PMHCS provider in the Adelaide region, Links to Wellbeing, to sustain the MHCI program in the Southern and Centre East region.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022

	Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF14. Aboriginal Peer Worker Support

Proposed Activities – CF14. Aboriginal Peer Worker Support	
ACTIVITY TITLE	***CF14. Aboriginal Peer Worker Support***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. New Activity If activity is existing or modified, provide the relevant reference/s from previous Activity Work Plan/s where possible.
Program Key Priority Area	Choose from the following: Workforce If Other (please provide details): Aboriginal and Torres Strait Islander Health
Needs Assessment Priority	IH-GPH2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people. IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people. IH-PMH6. Greater prevalence of intentional self-harm and suicide in selected areas and specific population groups across the region including Aboriginal and Torres Strait Islander people.
Aim of Activity	Describe what this activity will aim to achieve, and how it will address the identified need (300 word limit). • The activity aims to improve mental health outcomes by reducing barriers and facilitating early access to services for identified Aboriginal youth participating the project. • The activity also aims to meet the holistic (primary health care) needs of Aboriginal and Torres Strait Islander young people. • Increase cultural capacity and cultural safety of Adelaide headspace centres • Develop an Aboriginal and Torres Strait Islander Peer Support workforce
Description of Activity	Describe the activity, including what work will be undertaken, and how the activity and/or services will be delivered. The activity will focus on increasing access for Aboriginal and Torres Strait young people to headspace centres across the Adelaide Metropolitan region. The activity will also engage a cultural advisor to build cultural capacity of Adelaide metropolitan headspace centres and provide support to individual workers through cultural supervision.

	The activity will employ Aboriginal and Torres Strait Islander Peer Workers in each of the headspace centres across the Adelaide region. These positions will be young Aboriginal and Torres Strait Islander persons with a lived experience of mental health or family history of mental health issues Support will be provided to the Aboriginal and Torres Strait Islander peer support workers to obtain accredited training in peer support work. Each of the positions will have joint projects on increasing access and meet regularly as a network to provide support and integration activities.
Target population cohort	Aboriginal and Torres Strait Islander people and teenagers and adolescents
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. Engagement between the headspace and the Aboriginal and Torres Strait Islander health sectors. This will be facilitated in part by the Cultural advisor and each of the headspace centres. Key Stakeholders will be engaged to co-design promote culturally appropriate headspace activities. These include; Aboriginal Health Council of South Australia Nunkuwarrin Yunti South Australian Health Medical Research Institute Nunga Tag Aboriginal Health Services, funded through SA health
Coverage	APHN region and targeted to areas of need
Consultation	Provide details of stakeholder engagement and consultation activities to support this activity. In addition to targeted stakeholders, the Adelaide PHN Aboriginal Advisory Council will play a key role in the consultation process in any co-design of this activity.
Collaboration	List and describe the role of each stakeholder that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services. Collaboration on this activity is evolving and may involve the following stakeholders; Aboriginal Community Controlled Health Organisations Aboriginal Services within LHNs Primary Health Care Providers Integrated Team Care Program Child and Adolescent mental health Community mental health

	Taoundi College Aboriginal Youth Care Coordination Project Drug and Alcohol services GP services Employment services Education providers
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

CF15. Domestic and Family Violence Support for Aboriginal Families

Proposed Activities – CF15. Domestic and Family Violence Support for Aboriginal Families	
ACTIVITY TITLE	***CF15. Domestic and Family Violence***
Existing, Modified, or New Activity	New Activity If activity is existing or modified, provide the relevant reference/s from previous Activity Work Plan/s where possible.
Program Key Priority Area	Choose from the following: Aboriginal and Torres Strait Islander Health If Other (please provide details): Population Health
Needs Assessment Priority	IH-GPH2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people. IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people. IH-GPH4. Awareness of timely access to appropriate services (including after-hours services) for Aboriginal and Torres Strait Islander people. IH-PMH6. Greater prevalence of intentional self-harm and suicide in selected areas and specific population groups across the region including Aboriginal and Torres Strait Islander people. IHAOD7. Increase access to and availability of culturally appropriate AOD treatment services particularly alcohol and illicit drugs for Aboriginal and Torres Strait Islander people.
Aim of Activity	This activity aims to reduce violence and its impacts in Aboriginal and Torres Strait Islander families, by: • increasing access to appropriate early intervention programs and primary health care services to better support Aboriginal families experiencing domestic and family violence (DFV); • strengthening relationships between primary care services and DFV specialist services to improve service integration and develop effective care pathways using a co-design process; • providing extended wrap around services to Aboriginal families experiencing family violence; and • providing access to informed and active participation of individuals and family in interventions.
	This new activity will increase access to appropriate early intervention programs and primary health care services to better support Aboriginal families experiencing domestic and family violence (DFV). This activity will work with perpetrators targeting those with addictions and mental health issues. Working both clinically and culturally supporting

Description of Activity	addiction prevention and referring clients to other trusted specialised services as needed. The roles in project will provide strengths-based health services and real time referrals as needed. Each role will support family members to access culturally appropriate services. The activity will also involve specific workforce support and capacity building to provide counselling support and increase access to services across the Adelaide metro region.
Target population cohort	Aboriginal and Torres Strait Islander population
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. The provider is the leading Aboriginal organisation that aims to reduce violence and its impacts in Aboriginal and Torres Strait Islander families, Key Aboriginal Stakeholder organisations will be engaged to support wrap around supports for families in need. These include; • Nunkuwarrin Yunti • Aboriginal Health Services, funded through SA health • Aboriginal Legal Rights Movement • Integrated Team Care Program • Aboriginal Sobriety Group
Coverage	APHN region and targeted to areas of need
Consultation	In addition to the Adelaide PHN Aboriginal Advisory Group, this project will consult with the Aboriginal and Torres Strait Islander community and other primary health organisations (such as Aboriginal Family Clinic and Nunkuwarrin Yunti) including the Aboriginal and Torres Strait ISLNDER Suicide Prevention Advisory Group.
Collaboration	List and describe the role of each stakeholder that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services. There will be several stakeholder partnerships. These include: • Adelaide PHN Commissioned Service providers • Adelaide PHN Aboriginal Advisory Council • Local GP services • Department of Child Protection • Aboriginal Legal Rights Movement • Anglicare • Uniting Communities • SA Housing • Aboriginal Sobriety Group • Aboriginal Prisoners Offender Service • Nunkuwarrin Yunti

Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2021 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2021 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No 1b. If yes, provide a description of the proposed decommissioning process and any potential implications.

HSI1. South Australia (SA) Immunisation Hub

Proposed Activities – HSI1. South Australia (SA) Immunisation Hub	
ACTIVITY TITLE	***HSI1. South Australia (SA) Immunisation Hub***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as HSI1.1*
Needs Assessment Priority	IH-GPH1. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non-Aboriginal and Torres Strait Islander children. GPH1. The CALD community are disproportionally affected by Hepatitis B GPH3. Identified areas of the Adelaide PHN (APHN) region have childhood immunisation rates below the national average GPH22. Prevention and early intervention strategies for childhood and youth health conditions
Aim of Activity	Provide a service across South Australia which will reduce the incidence of vaccine preventable disease in children, reduce the incidence and severity of influenza/pneumonia in adults and reduce hospitalisations from vaccine preventable disease. The Hub targets geographic regions of low vaccination compliance with a focus on Aboriginal and Torres Strait Islander communities, Culturally and Linguistically Diverse communities and low-income groups.
Description of Activity	The Adelaide and Country SA PHNs have jointly implemented the SA PHN Immunisation Hub, a multi-faceted approach to bridge gaps in immunisation service provision, support the skill base of immunisation providers, improve accessibility to after-hours immunisation services and promote the need for a well immunised community. The Hub engages with SA Health to monitor Aboriginal childhood immunisation rates and with immunisation providers to ensure communities are assisted to overcome barriers leading to under-immunisation. The objectives are: 1. Bridge gaps in immunisation service provision and increase uptake of immunisation for targeted population groups 2. Support the skill base of immunisation providers to provide safe, accessible and high-quality local immunisation initiatives through education, training and targeted practice support. 3. Improve accessibility to after-hours services and home immunisation services for disadvantaged groups 4. Raise awareness of the need for a well immunised community, augment the voice of immunisation supporters and increase community confidence in vaccines and the childhood, adolescent and adult immunisation programs There five domains or activity elements of the SA PHN Immunisation Hub are: 1. Australian Immunisation Register (AIR) Data Cleansing (2016/17-current) 2. Champion Immunisation Nurse Program (CNIP) (2017/18 -current) (see CF1) 3. Service Delivery (Ongoing since 2015/16) 4. Stakeholder Engagement (Ongoing since 2015/16)

	5. Provider Support (Ongoing since 2015/16)
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity. *CF1. Champion Nurse Immunisation Program*
Target population cohort	All children overdue for immunisation and all individuals (specifically those with medical risk factors) who risk significant illness from vaccine preventable disease
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. Champion Immunisation Nurse Program (CNIP) nurses will continue to engage with Aboriginal community organisation to advocate for immunisation. They will continue to attend community events such as CTG Day and NAIDOC week activities. The Immunisation Hub will continue to engage with the SA Health Immunisation Section who actively monitors Aboriginal Childhood immunisation coverage. The Hub will implement/assist with targeted activities as identified by SA Health. The Immunisation Hub will continue to produce Aboriginal Childhood Schedule fridge magnets for parents as a reminder of when immunisations are due.
Coverage	Entire APHN and CSAPHN regions
Consultation	• Australian Immunisation Register (AIR) data for Aboriginal and Torres Strait Islander children under 7 years of age is actively monitored and cleaned by the SA Health Immunisation Section. The Hub will continue to engage regularly with SA Health to develop strategies to respond to identified data and/or provider issues. • The Hub will continue to engage and consult with key stakeholders including: the Local Government Association, SA Health, Country Health SA, State Department of Education and Child Development (DECD), (State) Migrant Health Service, (State) Child and Family Health Service (CaFHS), Aboriginal Health Council SA, Hepatitis SA, General Practitioners and Local Councils in targeted areas of both APHN and Country SA PHN regions to enable sharing of information, resources and innovative ideas across the State. • The Hub is represented on the Hepatitis Action Plan Implementation Group – Hep B, to work with key stakeholders to ensure appropriate information is communicated and appropriate resources developed and to develop strategies to improve awareness of hepatitis B treatment and pathways. • The activity continues to engage and consult with the 480 members of the South Australian Immunisation Provider Network (IPN) by providing secretarial support to enable facilitation of meetings with stakeholders and relevant partners.
Collaboration	• Australian Immunisation Register (AIR) - to effectively manage the childhood immunisation data through (AIR) data cleaning activities to accurately reflect the current immunisation status of children.

	• The organisation (HAIMS) commissioned to deliver the Champion Immunisation Nurse Immunisation Program will continue to ensure all key elements of the Champion Immunisation Nurse Program are undertaken in a timely manner and with objectives met. • Immunisation service providers, including General Practice, Aboriginal Health Organisations, Local Councils, Child and Family Health Services and Hospitals – this activity will collaborate and support providers through providing clinical advice, face to face education and information through newsletter articles and the Immunisation Provider Network. • Country SA PHN (CSAPHN) – a partner in the SA PHN Immunisation Hub. CSAPHN will continue to support delivery of provider education, AIR data cleaning activities, community engagement activities to increase awareness of the immunisation program and networking with key stakeholders to ensure there remains a united focus on immunisation across the state. • SA Health Immunisation Section – the Hub will continue to regularly engage with the Immunisation Section to ensure consistent messaging, monitoring of Aboriginal children immunisation data and ensure providers receive appropriate support. • SA Health – this activity will continue to require hospital presentation and admission data for vaccine preventable diseases to be articulated to the APHN. Analysing this data will enable targeted activities with providers and communities. This activity will collaborate with specific Local Health Networks (LHNs) to investigate opportunities for the identification of children and adults in target groups in areas with low immunisation rates who present to Emergency Departments or on discharge summaries (after hospitalisation) as under-immunised. • Country Health SA – will continue to assist the Hub to recognise service delivery gaps and requests for support in rural SA. This group enlists representation from General Practice, Aboriginal Health, Department of Education and Child Development, Migrant Health, SA Health, Country Health SA and the Women's and Children's Hospital and focusses on ensuring a cross sector approach to increasing immunisation rates and decreasing vaccine preventable disease. • Hepatitis SA – the Hub will continue to collaborate to ensure Hepatitis B disease rates reduce and the community receives appropriate advice, resources, treatment and support through education session and support for commissioned service providers and attendance at community events such as World Hepatitis Day. Migrant Health – along with the Hub, this collaboration will ensure CALD and emerging communities are aware of immunisation recommendations and services. Local Government Association – collaboration continues with Local Councils delivering immunisation programs including the School Immunisation Program (SIP). Most SIP providers are members of the Immunisation Provider Network (IPN).
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022

	If applicable, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Partnership 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No

HSI2. Get Screened and Get on with Living Campaign

Proposed Activities – HSI2. Get Screened and Get on with Living Campaign	
ACTIVITY TITLE	*HSI2. Get Screened and Get on with Living Campaign*
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity Previously referenced in GPS1.1.
Needs Assessment Priority	IH-GPH3. Accessibility to and appropriateness of primary health care services, particularly for Aboriginal and Torres Strait Islander people. IH-GPH4. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people. GPH2. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, LGBTIQ and older people. GPH13. Early screening of selected cancers (cervix, bowel, breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy.
Aim of Activity	Short term: • Increase awareness of the benefits of breast, bowel and cervical screening to the target population groups in South Australia • Support primary health care services, including general practice, in their role to encourage the population to screen for cancer • Enable sharing of resources and collaborative cancer screening promotion where the local primary health care system shares the same objective of increasing participation in cancer screening Long Term: • A health service system that works together to increase participation in breast, bowel and cervical screening in South Australia, and therefore increase the proportion of cancer detected at an early stage • Develop and implement a tailored extension of campaign with the health service sector representative of a priority population – either Aboriginal and Torres Strait Islander or Culturally and Linguistically Diverse communities
Description of Activity	*'Get Screened and Get on with Living'* was a new collaborative approach to promoting cancer screening in SA, piloted in 2018-19. This activity was designed and funded between **Adelaide PHN, Country SA PHN, Cancer Council SA and SA Health**, to promote the three national cancer screening programs – breast, bowel, cervix in a combined message. The campaign aims to convince SA men and women that they need to get screened because knowing they are cancer free gives them peace of mind to enjoy life. It also sends a further positive message in that if cancer is detected, the sooner it is identified the greater the chances of successful treatment.

	The campaign's tag line is "Get Screened and Get on with Living" and the call to action is for South Australians to talk to their GP about cancer screening, along with searching cancer screening online. This is matched with boosted responses in google. The campaign's "home" is a landing page on Cancer Council SA's website which features all campaign material available for free download and links to further information on the cancer screening programs. Campaign material includes digital video, online programmatic advertising collateral, newspaper and radio advertising as well as general practice information kits. Between October 2018 and March 2019, funding was provided for a pilot by the project partners to test the feasibility of the campaign and measure the success of this new approach. Interim program evaluation has indicated that the campaign has been received positively by local health care professionals, who have appreciated the efficiency of a coordinated approach from the services involved in the partnership. The campaign has also been received well by the public, with video completion and click through engagement via online advertising all performing above industry benchmarks. Further data in relation to participation rates for each cancer screening program in SA has been requested and will be available to the PHNs later in the year. In the 2019-2020, it is proposed that the current campaign be extended. This includes distributing general practice information kits, digital video playing on catch up TV, online programmatic advertising, paid social media, radio and print newspaper. Project partners will be approached to continue coordinating and co-funding the campaign, and additionally, Cancer Council SA will be approached to continue their in-kind contribution of managing oversight of the media campaign and evaluation plan. SA Health will be approached to continue their support in evaluation of campaign strategies.
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity.
Target population cohort	• Women aged 50-74 – eligible for breast screening in the Adelaide PHN region • Women aged 25-74 eligible for cervical screening in the Adelaide PHN region • People aged 50-74 who are eligible for the National Bowel Cancer Screening program in the Adelaide PHN region
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. While the current campaign is not indigenous specific, poster resources do feature people from different cultural backgrounds. To reflect an inclusive approach. Funding allocation for 2020-21 is planned to be used for a targeted version of the campaign towards a priority population within the above age/sex cohorts, either Culturally and Linguistically Diverse populations or Aboriginal and Torres Strait Islander population. This decision will be made in consultation with project partners and additionally based on potential to integrate with relevant existing activities. The local Aboriginal Community Controlled Health Organisation sector, SA Health Aboriginal Health Services, Cancer Council SA

	Aboriginal Programs, Adelaide PHN Aboriginal Community Advisory Council and the SAHMRI SA Aboriginal Chronic Condition Consortium Cancer Leadership Group and associated community reference group would be key stakeholders consulted within this approach.
Coverage	South Australia wide
Consultation	The collaborative approach of this project has meant that key cancer screening health services in SA have been involved in the design, implementation and evaluation of the feasibility of this campaign. Individual General Practice and General Practice Peak Body feedback was sought prior to the launch of the campaign, in relation to how we can support practices with a potential increase in cancer screening related enquiries and how we could collaborate with Peak Bodies to support the campaign awareness with primary care. A general practice information kit was developed in response to this to raise awareness of the campaign and enable general practice to participate in the campaign. Consultation with the public in relation to awareness and behavioural response to the pilot campaign is being undertaken in March 2019 through an in-kind contribution from SA Health, who has included questions specifically about the campaign in the 2019 Public Health Survey. This is an 'omnibus-type' service available to government and non-government organisations to obtain data on a range of population health and wellbeing issues within South Australia.
Collaboration	The project is supported through an integrated approach in the local cancer screening sector, co-funded by the 4 project partners (Adelaide PHN, Country SA PHN, Cancer Council SA and SA Health) and has supported by a Memorandum of Understanding. This MoU aligns the shared strategic objectives each organisation has in relation to promoting cancer screening in SA and aligns with the SA State-wide Cancer Control Plan. It also allows for coordinated support around cancer screening promotion for general practice in SA. Ongoing activity in the campaign will be supported by regular meetings and communication between all project partners.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2021 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2021 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known (2020-21 targeted version of campaign) ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender

	☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Partnership approach 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes

HSI3. HealthPathways South Australia

Proposed Activities – HSI3. HealthPathways South Australia	
ACTIVITY TITLE	***HSI. HealthPathways South Australia***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as HSI3.1*
Needs Assessment Priority	GPH15. Lack of easily understood and accessible referral pathways across systems and settings. GPH16. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. GPH21. Minimise instances of poor quality and unwarranted variations of care and follow-up.
Aim of Activity	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	The primary health care system in South Australia currently has few agreed models of care and clinical referral pathways at a whole of State, Adelaide PHN region, regionally or locally. The lack of system integration and agreed referral pathways has resulted in inconsistencies in patient care. 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. This activity is a collaborative partnership between APHN and CSAPHN alongside SA Health to implement 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 • Promotion of health professional use of HealthPathways in South Australia Addressing the PHN objectives and priorities identified through the Needs Assessment, this activity looks to enhance consistent care and management of health conditions, increase awareness and utilisation of appropriate services and improve the patient journey through our local health system.
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity.
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.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. HPSA engages with subject matter experts in Aboriginal Health as well as AHCSA, Wardliparingga Aboriginal Research Unit and the SA Aboriginal Chronic Disease Consortium.
Coverage	This activity is a state-wide rollout, covering all of South Australia.
Consultation	Consultation occurs with existing Adelaide PHN commissioned service providers and membership groups. The HealthPathways process also includes targeted consultation with but not limited to State Health, Local Health Networks, General Practices, allied health professionals, consumer groups and relevant peak organisations. The Clinical Leadership Group 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.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Partnership 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?

	Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes

HSI4. Digital Health Support

Proposed Activities – HSI4. Digital Health Support	
ACTIVITY TITLE	***HSI4. Digital Health Support***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as HSI5.1*
Needs Assessment Priority	GPH14. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. GPH21. Minimise instances of poor quality and unwarranted variations of care and follow up. GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Aim of Activity	The Digital Health project aims to engage with health care providers from all sectors across APHN region to promote and facilitate the use of the My Health Record and appropriate digital health technologies in an effort to increase the communication and collaboration between service providers, improve clinical hand over, help identify and support improvements in the quality of healthcare and patient follow up and increase timely access to consumer health information.
Description of Activity	The Digital Health activity will provide the following: **Digital Health** • Increase the use of digital technology in the health care setting such as secure messaging delivery, data extraction tools and ongoing support with clinical applications and templates. • Provide access and support for practices around the PenCS Clinical Audit tool to help facilitate improved practice data quality, 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 PenCS Clinical Audit tool to facilitate identification of patients with high risk of developing preventable chronic conditions and to improve management of patients with a chronic condition/s. • 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 utilisations 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**

	• 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.
Associated Flexible Activity/ies:	GPS1. General Practice Support
Target population cohort	All health care providers and health care provider organisations working across all sectors of health care.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Entire APHN region
Consultation	Stakeholder engagement and consultation are currently ongoing with the following peak bodies; • The Australian Digital Health Agency • SA Health to support the implementation 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. • Membership Feedback • Pen Computing Systems – implementation, roll out and ongoing support of the PenCS clinical audit tool to General Practices across the APHN region.

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.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Partnership and direct PHN engagement with primary and allied health care providers 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No

HSI5. Integrated Care Strategy

Proposed Activities – HSI5. Integrated Care Strategy	
ACTIVITY TITLE	***HSI5. Integrated Care Strategy***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Modified Activity *Previously referenced as HSI6.1*
Needs Assessment Priority	GPH9. Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations. GPH11. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis). GPH15. Lack of easily understood and accessible referral pathways across systems and settings. GPH16. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Aim of Activity	Building on existing engagement and collaboration the Integrated Care Strategy aims to develop and implement an integrated and coordinated strategy with SA Health, the LHNs and General Practice that supports disparate systems working together to enable people to access the right care, in the right place, at the right time to improve their overall health and wellbeing.

Description of Activity	While discussions are currently underway with SA Health and the LHNs including some targeted activity the aim of the Integrated Care Strategy is to formalise agreed actions on shared priorities including but not limited to:
	• Winter Wellness activities such as:
	  ○ Building on APHN's and other providers immunisation activity for influenza
	  ○ Supporting community wide messaging about ways to keep well during winter to help people better understand how to maintain health and wellbeing and options for care during winter months and beyond.
	• Potentially preventable hospitalisations
	• Appropriate alternatives to emergency department for presentations that can be managed in primary care
	• Referral pathways between tertiary mental health services and commissioned primary mental health care services
	• Clinical handover
	• Data sharing and analysis to improve understanding of service utilisation and pathways across the primary and acute sectors that support evidence informed service delivery
	• Shared planning and strategic governance that supports health system improvements for integrated care.

Associated Flexible Activity/ies:	CF4. Care Connections Program, HSI3. HealthPathways SA and HSI4. Digital Health Support
Target population cohort	People living in the APHN region who access primary care or hospital services, with a focus on chronic conditions and multi morbidities and those particularly those at risk of potentially preventable hospitalisations.
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Entire APHN region
Consultation	Provide details of stakeholder engagement and consultation activities to support this activity. Multiple consultations are planned and underway to ensure that relevant groups are involved in co-design of this concept. APHN and SA Health have a series of consultation sessions planned with General Practice in April/May 2019. This activity is informed by ongoing regular consultation through both the existing Adelaide PHN membership and partnership mechanisms and through those of SA Health and the Local Health Networks. Further consultation will be undertaken with identified groups as the co-design process identifies it is required.
Collaboration	List and describe the role of each stakeholder that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services. State health including LHNs as key partners in the development and delivery of the strategy.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Partnership

	2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? No

HSI6. South Australia PHNs Conference

Proposed Activities – HSI6. South Australia PHNs Conference	
ACTIVITY TITLE	***HSI6. South Australia PHNs Conference***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Existing Activity *Previously referenced as HSI7.1*
Needs Assessment Priority	GPH2. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, LGBTIQ and older people. GPH14. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues. GPH19. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures. GPH24. A coordinated approach to improve navigation and pathways for patients to manage their conditions. GPS1. Increase awareness and uptake of digital health systems and benefits for patients PSM3. Increase awareness and promotion of psychosocial support services for people with severe mental health conditions and their carers. PMH7. Increase awareness of appropriate mental health services to health professionals and community and carers through the provision of information and resources. AOD3. Increase integration between AOD and Primary Mental Health (PMH) service providers to improve health outcomes. IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people
Aim of Activity	The key aim of the activity is to engage Primary Health Care Professionals (General Practitioners and Practice Teams, Allied Health Professionals, Pharmacy, Mental Health Professionals and SA Health staff etc.) to facilitate innovative conversations around different models of care, integrated teams and referral pathways.
Description of Activity	The APHN in conjunction with Country SAPHN will run the (third) South Australian Primary Health Care Conference for all Primary Health Care Professionals with a focus on multidisciplinary teams, chronic disease and integrated care. Future conferences will endeavour to build on established relationships and connections, whilst further developing collaborative approaches to care using innovative approaches where possible. Conferences are scheduled bi-annually – the first one was in 2017, second in 2019.
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity.
Target population cohort	Primary Health Care Professionals (General Practitioners and Practice Teams, Allied Health Professionals, Pharmacy, Mental Health Professionals and SA Health staff etc.)
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?

	No If yes, briefly describe how this activity will engage with the Indigenous sector.
Coverage	Entire APHN and Country SA PHN regions
Consultation	Provide details of stakeholder engagement and consultation activities to support this activity. Extensive consultation with memberships groups, key stakeholders – across sectors and community, and other primary health care providers, as well as feedback from previous conferences will inform the direction and focus of future conferences.
Collaboration	This activity will collaborate with: • General Practitioners, Practice Teams, Allied Health Professionals and other Primary Health Care Professionals to provide targeted education and facilitation of collaboration, integration and partnerships adopting innovative approaches where possible. • Royal Australian College of General Practitioners (RACGP) to facilitate/approve accredited education for General Practitioners attending the conference • SA Health and other APHN partners to sponsor, exhibit of present at the conference demonstrating effective engagement. • APHN commissioned service providers will be encouraged toto promote their programs and services to primary health care professionals by participating in the conference as keynote speakers, presenters or exhibitors.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2020 Activity end date: 30/06/2021 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2020 Service delivery end date: April 2021 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes

	3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes

HSI7. Supporting our diverse Workforce

Proposed Activities – HSI7 Supporting our diverse Workforce	
ACTIVITY TITLE	***HSI7. Supporting our diverse Workforce***
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Modified Activity *Previously referenced as HSI8.1 and HSI4.1*
Needs Assessment Priority	GPH12. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations. GPH 17. Lack of community awareness about existing health care services for different population groups, consumers and providers. GPH 19. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures. GPH20. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. GPH21. Minimise instances of poor quality and unwarranted variations of care and follow up. GPH 24. A coordinated approach to improve navigation and pathways for patients to manage their conditions PMH7. Increase awareness of appropriate mental health to health professionals and community and carers through the provision of information and resources. AOD2. Build the capacity of health professionals through the provision of information, education and resources to support health professionals in the management of drug and alcohol dependence and related morbidities. PSM3. Increase the health workforce capacity to provide appropriate care to people with severe mental health conditions. IH-GPH3. Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.
Aim of Activity	The aim of this activity is to design and deliver a range of integrated workforce initiatives that meet the specific and identified needs of our workforce, in line with national and local health priorities, and addressing skill gaps, professional development and continuous quality improvement.
Description of Activity	The APHN will provide a range of professional development activities and quality improvement supports for primary health care providers to enhance their ability to work as part of a primary health care system to provide the right care in the right time and the right place. Professional development, networking and quality improvement actions and methods of disseminating best practice will focus on identified areas of need including empathic system and service level responses to health care consumers/patients, culturally diverse consumers, and quality use of medicines. A dedicated focus on increasing the health literacy knowledge of those working in Primary Health Care will be supported by providing staff and organisations with a) strategies and tools to improve client/patient understanding of written and spoken health information and b) identify

	opportunities to embed health literacy strategies into systems, operations and planning. Aspects of this activity will be integrated in the General Practice support activities. 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 in professional development service delivery with learning outcomes consistently met Sharing of best practice business skills and leadership development
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity.
Target population cohort	All Primary Health Care practitioners/providers/professionals
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes If yes, briefly describe how this activity will engage with the Indigenous sector. Elements of the continuing professional development schedule will incorporate sessions to support culturally appropriate services and care to Aboriginal and Torres Strait Islander clients/patients. Ensuring that primary health care providers are proficient in culturally safe practice will be embedded within this program.
Coverage	Entire APHN region
Consultation	Engagement with various Medical, Pharmacy, Allied Health Professional Associations/Peak Bodies; Feedback via previous continuing professional development service delivery providers; APHN membership groups. Collect Learning Needs Assessment survey of primary health care providers.
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: • Professional organisations representing general practice, GPs and other allied health – to ensure the mode of delivery and topic content is relevant to various disciplines • Local Health Networks (LHNs) – to assist with the development of appropriate clinical pathways and referral management guidelines • Drug and Therapeutic Information Service (DATIS) – to assist with the latest updates on medication management for chronic conditions • General Practices – for feedback on most relevant topics for professional development • Pharmacies and Allied Health providers for feedback on most relevant topics for professional development • Organisations working with Culturally and linguistically diverse communities such as Migrant Health Service – to assist in the provision of resources and delivery of culturally appropriate sessions such as cultural safety, cultural competence

	• Development of partnerships with health professional, allied health, pharmacy, dental, medical organisations and collaborative work including information sharing and networking. • Collaboration and consultation with the Aboriginal Community via the metropolitan ACCHO, Aboriginal Health Councils of SA and appropriate community forums to assist in the development of continuing professional development to support culturally appropriate services for Aboriginal and Torres Strait Islander people.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☒ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No

– General Practice Support funding

GPS1. Primary Health Care Provider Support

Proposed Activities – GPS1. Primary Health Care Provider Support	
ACTIVITY TITLE	*GPS1. Primary Health Care Provider Support*
Existing, Modified, or New Activity	Indicate if this is an existing activity, modified activity, or a new activity. Modified Activity *Previously referenced as GPS1.1*
Needs Assessment Priority	GPS1. Increase awareness and uptake of digital health systems and the benefits for patients. GPS2. Targeted support to increase awareness and utilisation of HealthPathways SA and specific pathways for patients. GPS3. Promote and targeted support to adopt best practice in utilisation of clinical software's to improve patient care and quality improvement activities.
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 promoting accreditation 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 area's 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

	gaging 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 gaging 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, recourse and materials that support this. • Partnership and Engagement with Primary Health Care Providers – Partner and engage with providers to improve the persons 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 eRefferal for patients. Provide information on digital initiatives, changes and improvements via APHN newsletters and direct correspondence with healthcare providers.
Associated Flexible Activity/ies:	Where applicable, provide the Activity Number/s for any associated flexible functions associated with, or directly supported by, this Activity. CF4, CF8, CF12, CF13, CF14, CF15, HS14, HS15, HS13, HS17

Target population cohort	All primary health care providers in APHN region
Indigenous specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? Yes The activity will support the sector by engaging and supporting health care providers to provide culturally appropriate care to Aboriginal people within the APHN region. Supporting health care providers with understanding the need to have culturally appropriate services, utilise clinical templates that have been developed specifically for Aboriginal people such has 715 health checks and support General Practice to identify Aboriginal patients within their practice that require follow up and encourage health checks to be regularly performed.
Coverage	Entire APHN region
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.
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	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI)

	☒ Other approach (please provide details) Partnership and direct PHN engagement with primary health care providers 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No