Adelaide PHN

Strategic Framework

Adelaide PHN is a membership based organisation, committed to genuine community involvement and input into improving the health outcomes of people living in metropolitan South Australia. Our Strategic Framework reflects our priority areas from the Commonwealth Government and our local priority populations. It is a truly collaborative and integrated Strategic Framework – endorsed by the Adelaide PHN Board.

The Adelaide PHN Strategic Framework provides the overarching strategic direction for our organisation and staff. It maps our activities against the Commonwealth Government Performance and Quality Framework and details the strategies and key result areas we see as critical to achieving our vision. Adelaide PHN conducts Needs Assessments every 3 years and undertakes annual Activity Work Planning to ensure that we understand and respond to the needs, issues and opportunities in our community. Adelaide PHN will provide annual reports on our performance against these indicators to the Commonwealth and our stakeholders.

Our Vision

A healthier Adelaide by 2030

Our Mission

We will;

Connect and facilitate a quality health system

Ensure that you are heard consulted and empowered

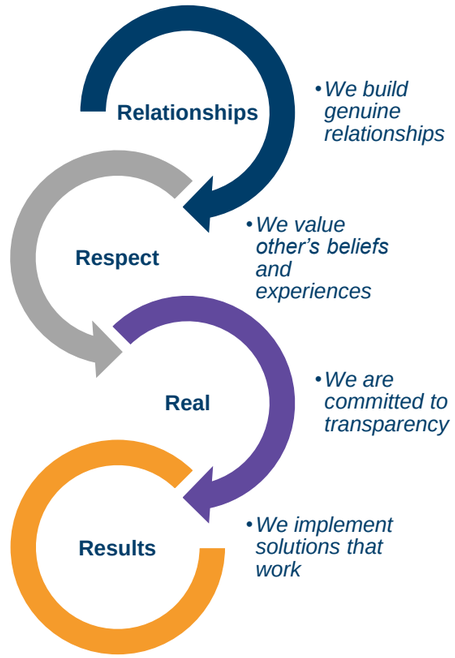
Work with you to improve your health outcomes

Improve your experience of the health system and your health outcomes

Ensure health providers work together

Respond to health needs of the most vulnerable in our community

Our Values



STRATEGIC PLAN SUMMARY

2020-2025

phn ADELAIDE
An Australian Government initiative

VISION

A HEALTHIER ADELAIDE BY 2030

NATIONAL PRIORITIES

Aboriginal Health

Work together to address health inequities for Aboriginal people and increase access to culturally appropriate services

Aged Care

Facilitate and establish person centres services that enable and empower older people with the involvement of their families and carers to live well and independently in our community

Mental Health and Alcohol and other Drugs

Build a person centred, collaborative and integrated primary mental health and alcohol and other drug system that improves access and outcomes and reduces inequity

Digital Health

Use technology to connect you to health

Population Health

Understand the health needs of our region and determine priorities

Workforce

Develop and sustain our primary health care workforce

LOCAL PRIORITY POPULATIONS

Children and Youth

Facilitate and establish accessible child and youth friendly services that enable and empower, with the involvement of families and carers

Culturally and Linguistically Diverse Communities

Address health inequities for the CALD community and increase access to culturally appropriate services

Disability

Advocate for appropriate and accessible primary health care services, that enable and empower people living with disability, with the involvement of their families and carers

Palliative Care

Collaborate to improve systems for timely access to integrated and appropriate end of life services and support

MISSION: WE WILL

Connect and facilitate a quality health system **right care, right place, right time, right provider**

Ensure that you are heard, consulted and empowered **engagement**

Work with you to improve your health outcomes **collaboration**

Improve your experience of the health system and your health outcomes | **person centred**

Ensure health providers work together | **integration**

Respond to health needs of the most vulnerable in our community | **priorities**

OUTCOMES

Less days lost as a result of pain in our community

Increased access to services for vulnerable communities

Increased use of digital health

Reduced potentially preventable hospitalisations

Better outcomes and experience in primary health care

More culturally appropriate services

More coordinated care

Increased rates of cancer screening and immunisation

Increased partnership and integration

Higher quality primary care (accreditation)

Our **Strategic Objectives** assist us to translate our vision into specific plans and activities

Strategy # 1
Have a sound understanding of the health and service needs of our communities

Strategy # 2
Develop, implement, review and improve system wide approaches and activities within our priority areas

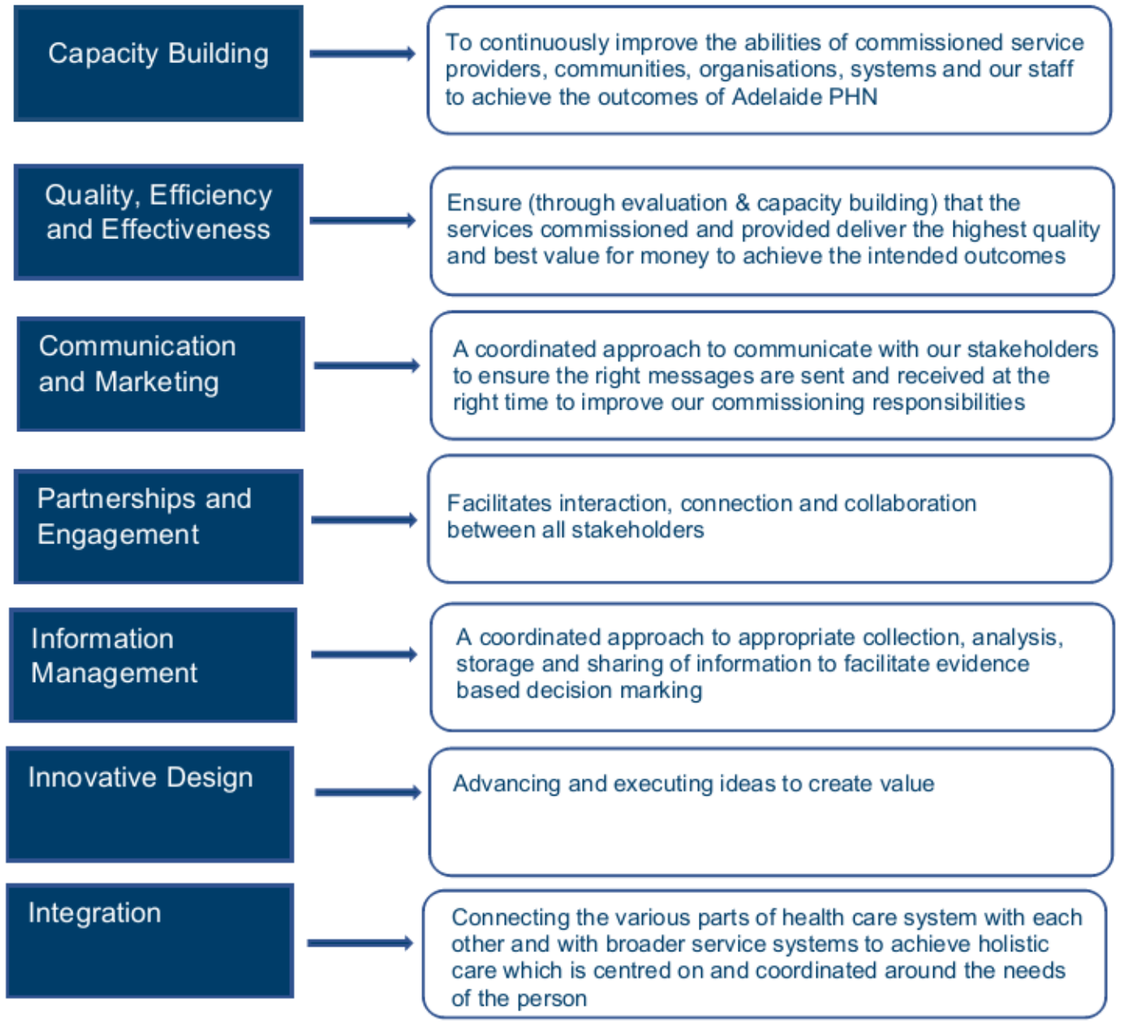
Strategy # 3
Support primary health care providers to deliver quality, efficient and effective services (right care, right place, and right time)

Strategy # 4
Ensure engagement and involvement of community members in development of health promotion, prevention, early intervention and empowerment

Strategy # 5
Commission services that are high quality, efficient, effective, integrated and innovative

Strategy # 6
Be an efficient and effective organisation

Our **Key Result Areas** assist us to group our critical activities and achieve our organisational goals



PHN National Priority Area Outcomes

PHN Program Objectives	Increase the efficiency and effectiveness of medical services, particularly for patients at risk of poor health outcomes. Improve coordination of care to ensure patients receive the right care, in the right place, at the right time.						
National Priority Areas	**Mental Health**	**Alcohol and Other Drugs**	**Aboriginal & Torres Strait Islander Health**	**Population Health**	**Aged Care**	**Workforce**	**Digital Health**
APHN Priority Area Statements ***We will…***	*Build a person-centred, collaborative and integrated primary mental health and alcohol and drug system that improves access and outcomes and reduces inequality*	*Build a person-centred, collaborative and integrated primary mental health and alcohol and drug system that improves access and outcomes and reduces inequality*	*Work together to address health inequities for Aboriginal people and increase access to culturally appropriate services*	*Understand the health needs if our region and determine priorities*	*Facilitate and establish person-centred services that enable and empower older people, with the involvement of the families and carers, to live well and independently in our community*	*Develop and sustain our primary health care workforce*	*Use technology to connect you to health*
Intermediate outcomes **(5 years)**	People in PHN region access mental health services appropriate to their individual needs (Improving Access) Health care providers in PHN region have an integrated approach to mental health care and suicide prevention (Coordinated Care) PHN commissioned mental health services improve outcomes for patients (Quality Care)	People in PHN region are able to access appropriate drug and alcohol treatment services (Improving Access) Health care providers in PHN region have an integrated approach to drug and alcohol treatment services (Coordinated Care)	PHNs address needs of Aboriginal and Torres Strait Islander people in their region (Addressing Needs) Local health care providers provide culturally appropriate services to Aboriginal and Torres Strait Islander people (Quality Care) Aboriginal and Torres Strait Islander identified health workforce capability and capacity matches needs of regions (Quality Care) Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care (Coordinated Care) Aboriginal and Torres Strait Islander people are able to access primary health care services as required (Improving Access)	Fewer preventable hospitalisations in PHN region for people with chronic and vaccine preventable diseases (Addressing Needs) PHNs support health care providers to address factors impacting population health (Quality Care)	Older people in the PHN region are supported to access primary health care services that meet their needs including self-care in the home (Improving Access) Fewer preventable hospitalisations in the PHN region for older people (Quality care) Local health and other care providers are supported to deliver coordinated, effective and appropriate care to older people in the PHN region (Quality care)	Local workforce has suitable cultural and clinical skills to address health needs of PHN region (Quality Care) PHNs support general practices and other health care providers to provide quality care to patients (Quality Care)	Health care providers are aware of digital health systems and technologies (Coordinated Care) PHNs support health care providers to use digital health systems to improve patient care and communication (Quality Care) General practices and other health care providers use data to improve care (Quality Care)
Long-term outcome(s) **(10 years)**	People in PHN region enjoy better mental health and social and emotional wellbeing	Decrease in harm to population in PHN region from drug and alcohol misuse	PHNs contribute to closing the gap and Aboriginal and Torres Strait Islander people experience improved emotional, social and physical wellbeing	Improved health outcomes for all population groups in the PHN region	Local health care system provides coordinated, quality care to older people Older people in the PHN region are supported to enjoy a greater quality of life	People are able to access a high quality, culturally safe and appropriately trained workforce	Digital health enables better coordinated care and better-informed treatment decisions

PHN Program

PHN indicators	APHN activities	Intermediate outcomes (5 years)	Long term outcome (10 years)
P3 Rate of general practice accreditation	Capacity Building Primary Care Provider Support	PHNs support general practices and other health care providers to provide quality care to patients	PHNs support local primary health care services to be efficient and effective, meeting the needs of patients at risk of poor health outcomes
P4 Support provided to general practices and other health care providers	Primary care provider support (accreditation, data driven improvement PENCS, workforce development) Commissioning support activities to improve access to high quality care (access to Health pathways, clinical guidelines, client management platforms, quality use of medicines) Support for integration activities (Care Connections/Health Care Homes/GP liaison units)		
P5 Rate of regular uploads to My Health Record	Capacity Building Primary Care Provider Support		
To be developed: an indicator of use of Patient Reported Experience Measures in determining provision of quality care	TBD		
P1 PHN activities address prioritised needs	Iterative needs assessment, activity work planning, CSP workplans, performance monitoring and capacity building in line with national and local priorities and quality dimensions Data collection and review including membership processes and input Design based on need and local solutions	PHN activities and initiatives address local needs	
P2 Health system improvement and innovation	Design, co design and co funding with state health, LHNs, NGOs Capacity building, engagement and commissioning innovative primary care solutions that address identified need (Paediatric Partnerships, Priority Care Centres) Integration across primary and tertiary services (GP liaison units, HealthPathways)		
To be developed: an indicator of health literacy in each PHN region	TBD		
P6 Rate of general practices receiving payment for after hours services.	Capacity Building Primary Care Provider Support	People in the PHN region are able to access general practices and other services as appropriate PHNs support general practices and other health care providers to provide appropriate after hours access	
P7 Rate of GP style emergency department presentations	Design, co design and co funding with state health, LHNs, NGOs Capacity building, engagement and commissioning innovative hospital avoidance solutions that address identified need (Priority Care Centres) Integration across primary and tertiary services (GP liaison units/Health Pathways)		
P8 Measure of patient experience of access to GP	Design, co design and co funding with state health, LHNs, NGOs (PREMS) Capacity building, engagement and commissioning innovative hospital avoidance solutions that address identified need (Priority Care Centres) Integration across primary and tertiary services (GP liaison units/Health Pathways) Primary Care provider support to improve access (Care Connections/ Health Care Homes) Support health literacy and service navigation (After Hours Awareness Resource)		

PHN indicators	APHN activities	Intermediate outcomes (5 years)	Long term outcome (10 years)
P9 Rate of GP team care arrangements/ case conferences	Primary Care provider support (workforce development) to increase access to team based care Capacity Building, engagement, quality improvement and commissioning primary care services (Care Connections/Health Care Homes/Paediatric partnerships/Living with Persistent Pain) Partnership to improve integration between NGOs in chronic condition management (Chronic Conditions Collaborative)	People in the PHN region receive coordinated, culturally appropriate services from local health providers	
P10 Cross views of My Health Record (MHREP indicators 9-10)	Capacity Building Primary Care Provider Support		
P11 Rate of discharge summaries uploaded to My Health Record	Capacity Building Primary Care Provider Support Integration across primary and tertiary services (GP liaison units)		
To be developed: indicator on cultural appropriateness	TBD		
P12 Rate of potentially preventable hospitalisations	Design, co design and co funding with state health, LHNs, NGOs Capacity building, engagement and commissioning innovative hospital avoidance solutions that address identified need (Priority Care Centres) Integration across primary and tertiary services (GP liaison units/Health Pathways) Primary Care provider support to improve access (Care Connections/ Health Care Homes)	Patients in local region receive the right care in the right place at the right time	
P13 Numbers of health professionals available	Commissioning services based on established need and in areas of priority Clinical Intern and graduate programs to address workforce shortages Workforce development Capacity Building and primary health care provider support to increase patient centred medical home and medical neighbourhood Integration across primary and tertiary services (GP liaison units/Health Pathways) GP Survey		

Mental Health

Build a person-centred, collaborative and integrated primary mental health and alcohol and drug system that improves access and outcomes and reduces inequality

PHN indicators	APHN activities	Intermediate outcomes (5 years)	Long term outcome (10 years)
MH1 Rate of regional population receiving PHN commissioned low intensity psychological interventions	CRU assessment and referral Referrer education and support (Workforce development) Commissioning additional LI services Capacity Building support to service providers re appropriate clinical pathways Redesign low intensity services and guidelines Partner with other mental health services to ensure step up step down pathways are enacted Ensure digital services are part of service offerings e.g. Head to Health	People in PHN region access mental health services appropriate to their individual needs	People in PHN region enjoy better mental health and social and emotional wellbeing
MH2 Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals	Commissioning a range of psychological therapies services for vulnerable populations Capacity building and design for quality, efficiency and effectiveness Ensure access for target populations Partner for appropriate demand and referral management Improving wait list management by providers		
MH3 Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness	Commissioning care coordination services Development of appropriate step up step down and escalation pathways into and out of PMHCS Integration with state mental health services and psychosocial programs Design care packages and increase access to physical health monitoring		
MH4 Formalised partnerships with other regional service providers to support integrated regional planning and service delivery	Co design, co fund, commissioning activities as per the plan Partner with LHNs to deliver integration activities Capacity build CSPs (workforce development) to engage with LHNs and other services to improve quality, efficiency and effectiveness Improve pathways and access between primary and tertiary mental health services	Health care providers in PHN region have an integrated approach to mental health care and suicide prevention	
MH5 Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within 7 days of referral	Capacity Building Suicide Prevention Services to collect and record data accurately and consistently and monitor quality efficiency and effectiveness Monitor access to timely services Co-Commission the way back and other clinical and non clinical services Partner with the Office for the Chief Psychiatrist to implement Towards Zero Suicide Integrate primary and tertiary services Capacity Build providers to use consistent tools and language with State MH Services		
MH6 Outcomes Readiness - Completion rates for clinical outcome measures	Capacity building to implement review and improve clinical outcome measure data collection processes Assist primary care providers and commissioned services with tools to ensure high quality efficient and effective data management Commission relevant software solutions/IT equipment Utilise benchmarks for clinical outcomes amongst providers	PHN commissioned mental health services improve outcomes for patients	

Aboriginal and Torres Strait Islander Health

Work together to address health inequities for Aboriginal people and increase access to culturally appropriate services

PHN indicators	APHN activities	Intermediate outcomes (5 years)	Long term outcome (10 years)
IH1 Numbers of ITC services delivered by PHN	Commissioning and Capacity Building for ITC Service Provider Primary Care Provider support via pathways, referral, access Partnering with South Australian Health and Medical Research Institute (SAHMRI), Aboriginal Medical Services (AMS), Aboriginal Community Controlled Health Organisation (ACCHO)	PHNs address needs of Aboriginal and Torres Strait Islander people in their region	PHNs contribute to closing the gap and Aboriginal and Torres Strait Islander people experience improved emotional, social and physical wellbeing
IH2 Types of organisations delivering ITC services	Partnering with SAHMRI, AMS, ACCHO Indigenous Health Program Officer (IHPO) activities Primary Care Provider support via pathways, referral, access Commissioning		
IH3 Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people	Capacity Building with AOD Commissioned Service Providers (Reconciliation Action Plan, workforce development) Commissioning (cultural safety) and Aboriginal specific services (ACCHO) Primary Care Provider support via pathways, referral, access Partnering with Drug and Alcohol Services SA (DASSA) and ACCHO	Local health care providers provide culturally appropriate services to Aboriginal and Torres Strait Islander people	
IH4 Proportion of PHN commissioned mental health services delivered to the regional Aboriginal and Torres Strait Islander population that were culturally appropriate	Capacity Building with MH Commissioned Service Providers (RAP, workforce development) Commissioning (cultural safety) and Aboriginal specific services (ACCHO) Primary Care Provider support via pathways, referral, access Partnering with MHS and ACCHO (deliverable in Regional MH Plan)		
IH5 ITC improves the cultural competency of mainstream primary health care services	Capacity Building with primary care providers (RAP, workforce development) Commissioning (cultural safety) and Aboriginal specific services (Winmante) Primary Care Provider support via pathways, referral, access Partnering with Aboriginal Health Council SA (AHCSA) and ACCHO IHPO activities		
To be developed: indicator on patient experience of cultural appropriateness	TBD		
IH6 PHN provides support for Aboriginal and Torres Strait Islander identified health workforce	Capacity Building with CTG/ITC (workforce development) Workforce strategy/plan Commissioning training/education/support Partnership with ACCHO, AMS, AHCSA and SAHMRI	Aboriginal and Torres Strait Islander identified health workforce capability and capacity matches needs of regions	

PHN indicators	APHN activities	Intermediate outcomes (5 years)	Long term outcome (10 years)
IH7 ITC processes support Aboriginal and Torres Strait Islander people enrolled in the program to access coordinated care	Capacity Building with CTG/ITC (workforce development) Commissioning culturally appropriate services Primary care provider support via pathways referral and access Partnership with ACCHO, AMS, AHCSA and SAHMRI IHPO activities	Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care	
P9 Rate of GP team care arrangements/ case conferences	Capacity Building with CTG/ITC (workforce development) Commissioning culturally appropriate services Primary care provider support via pathways referral and access Partnership with ACCHO, AMS, AHCSA and SAHMRI IHPO activities		
P12 Rate of potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people	Capacity Building with primary care providers (workforce development) Commissioning (cultural safety) Primary Care Provider support via pathways, referral, access IHPO activities Partnership with ACCHO, AMS, AHCSA and SAHMRI		
IH8 Rate of Aboriginal and Torres Strait Islander population receiving specific health assessments	Capacity Building with primary care providers (workforce development) Commissioning (cultural safety) Primary Care Provider support via pathways, referral, access IHPO activities Partnership with ACCHO, AMS, AHCSA and SAHMRI	Aboriginal and Torres Strait Islander people are able to access primary health care services as required	

Alcohol and Other Drugs (AOD)

Build a person-centred, collaborative and integrated primary mental health and alcohol and drug system that improves access and outcomes and reduces inequality

PHN indicators	APHN activities	Intermediate Outcomes (5 years)	Long term outcome (10 years)
AOD1 Rate of drug and alcohol commissioned providers actively delivering services (bi-monthly AOD reporting)	Commissioning high quality treatment services Capacity building CSPs and the workforce Partnerships with AOD sector and with state based services (DASSA)	People in PHN region are able to access appropriate drug and alcohol treatment services	Decrease in harm to population in PHN region from drug and alcohol misuse
AOD2 Partnerships established with local key stakeholders for drug and alcohol treatment services	Commissioning high quality treatment services Capacity building CSPs and the workforce Partnerships with AOD sector and with state based services (DASSA) Memorandum of Administrative Administration (MoAA) between APHN, DASSA and CSA PHN outlines key areas of collaboration related to the planning, commissioning and evaluation of alcohol and other drug treatment and intervention services across the state.	Health care providers in PHN region have an integrated approach to drug and alcohol treatment services	

Population Health

Understand the health needs of our region and determine priorities

PHN indicators	APHN activities	Intermediate Outcomes (5 years)	Long term outcome (10 years)
P12 Rate of potentially preventable hospitalisations - for specific chronic diseases	Design, co design and co funding with state health, LHNs, NGOs Capacity building, engagement and commissioning innovative hospital avoidance solutions that address identified need (Priority Care Centres) Integration across primary and tertiary services (GP liaison units/Health Pathways) Primary Care provider support to improve access (Care Connections/ Health Care Homes)	Fewer preventable hospitalisations in PHN region for people with chronic and vaccine preventable diseases	Improved health outcomes for all population groups in the PHN region
PH1 Rate of children fully immunised at 5 years	Commission Champion Nurse program in areas of low uptake to immunise, workforce development, quality improvement Partner with SA Health and Country SA PHN on increasing uptake in populations and for diseases of concern (flu, Men B) Health Promotion Campaign and opportunistic vaccination (Expos, CALD and Aboriginal community events) Capacity Building via education and primary care provider support AIR data cleaning	PHNs support health care providers to address factors impacting population health	
PH2 Cancer screening rates for cervical, bowel and breast cancer	Partner with Cancer Council and Country SA PHN on screening campaign Commission Cancer Screening activities for target populations Primary Care Provider support and Capacity Building		
P4 Support provided to general practices and other health care providers – population health	Care Connections Integration across primary and tertiary services (GP liaison units)		

Aged Care

Facilitate and establish person-centred services that enable and empower older people, with the involvement of the families and carers, to live well and independently in our community

PHN indicators	APHN activities	Intermediate outcomes (5 years)	Long term outcome (10 years)
AC1 Rate of MBS services provided by primary care providers in residential aged care facilities	Commissioning access to enhanced primary care for RACF (Dandelion, Assess Treat Stay) Capacity Building (RACF and primary care providers- workforce development) Greater Choice- work on ELC and 7 step pathways Partnership and Integration with LHNs	Older people in the PHN region are supported to access primary health care services that meet their needs including self-care in the home	Local health care system provides coordinated, quality care to older people Older people in the PHN region are supported to enjoy a greater quality of life
AC2 Rate of people aged 75 and over with a GP health assessment	Commissioning (Frailty- pre frailty workshops/data based improvement) Capacity Building with primary care providers (workforce development) Partnership and Integration with LHNs (communities of practice and specialist services) Primary Care Provider support via pathways, referral, access		
P12 Rate of potentially preventable hospitalisations - for older people	Commissioning (Frailty- pre frailty workshops/data based improvement) Capacity Building with primary care providers (workforce development) Partnership and Integration with LHNs (communities of practice and specialist services) Primary Care Provider support via pathways, referral, access	Local health and other care providers are supported to deliver coordinated, effective and appropriate care to older people in the PHN region	
P4 Support provided to general practices and other health care providers – aged care	Commissioning (Frailty- pre frailty workshops/data based improvement) Capacity Building with primary care providers (workforce development) Partnership and Integration with LHNs (communities of practice and specialist services) Primary Care Provider support via pathways, referral, access	Fewer preventable hospitalisations in the PHN region for older people	

Workforce

Develop and sustain our primary health care workforce

PHN indicators	APHN activities	Intermediate outcomes (5 years)	Long term outcome (10 years)
W1 Rate of drug and alcohol treatment service providers with suitable accreditation	All current CSPs are compliant with the minimum Accreditation Standards. AOD Project Schedules from 1 July 2020 will include explicit obligations for accreditation requirements – compliance with the *National Quality Framework for Drug and Alcohol Treatment Services* 2018		
W2 PHN support for drug and alcohol commissioned health professionals	Dedicated CPD Education & Training (quarantined % of all CPD events) Partnership with UoA (DASSA-WHO Collaborating Centre) to provide training and support in use of ASSIST / Brief Intervention Collaboration with DASSA to promote and support uptake of the Drug and Alcohol Clinical Advisory Service (DACAS), Collaboration with SA Health [via DASSA] re: implantation of the Take-Home Naloxone Trial Collaboration with RACGP to support regional implementation of the *Alcohol and other drugs GP education program* incl. post-training support and utilisation of PHN Practice Support Grant (TBC) Collaboration with AHCSA to synergise and optimise AOD sector capacity / Workforce development and training strategies (Playford, Port Adelaide, Onkaparinga)		
W3 PHN Commissioning Framework	Continue to maintain and enhance Adelaide PHN's Board Endorsed Commissioning Framework and associated policies, procedures, templates and guidance materials. Ensure commissioning activities are managed through robust but flexible contractual arrangements, internal governance structures, quality improvement, compliance monitoring and evaluation. Continue to maintain and enhance external communication mechanisms that support extensive communication, consultation and co-design activity with key stakeholders and enables the commissioning of culturally appropriate, sensitive and safe services that meet the needs of people from diverse backgrounds, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and people who identify with LGBTIQ communities	Local workforce has suitable cultural and clinical skills to address health needs of PHN region	People are able to access a high quality, culturally safe and appropriately trained workforce
IH3 Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people	Commission services in alignment with the Aboriginal and Torres Strait Islander Health Performance Framework and the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-26. Capacity building to incorporate culturally-specific and valid tools and measures - Indigenous Risk Impact Screen (IRIS), modified Growth and Empowerment Measure (GEM), Adapted Patient Health Questionnaire 9 (aPHQ-9). Commission 'Cultural Learning for Primary Health Care Providers'. Aligns with the cultural awareness criteria set by the RACGP National Faculty of Aboriginal and Torres Strait Islander Health and incorporated PIP Indigenous Health Incentive and strategies for compliance with the six domains of the NSQHS 'Quality Health Service Standards for Aboriginal and Torres Strait Islander Health.		

PHN indicators	APHN activities	Intermediate outcomes (5 years)	Long term outcome (10 years)
	Minimum data set submissions capture Indigenous access rates with baseline and benchmarked targets for each financial year reported on quarterly / half-yearly, as per contractual reporting obligations.		
IH4 Rate of PHN commissioned mental health services for the Aboriginal and Torres Strait Islander people that are culturally appropriate	Capacity Building with MH CSPs (RAP, workforce development) Commissioning (cultural safety) and Aboriginal specific services (ACCHO) Primary Care Provider support via pathways, referral, access Partnering with MHS and ACCHO (deliverable in Regional MH Plan)		
IH5 ITC improves the cultural competency of mainstream primary health care services	Capacity Building with primary care providers (RAP, workforce development) Commissioning (cultural safety) and Aboriginal specific services (Winmante) Primary Care Provider support via pathways, referral, access Partnering with AHCSA and ACCHO IHPO activities		
P4 Support provided to general practices and other health care providers - workforce	Capacity Building Primary Care Provider Support		
To be developed: indicator on patient experience of cultural appropriateness	TBD		
P3 Rate of general practice accreditation	Capacity Building Primary Care Provider Support	PHNs support general practices and other health care providers to provide quality care to patients	
P4 Support provided to general practices and other health care providers	Primary care provider support (Care Connections/Health Care Homes) Integration across primary and tertiary services (GP liaison units)		
P5 Rate of regular uploads to My Health Record			

Digital Health

Use technology to connect you to health

PHN indicators	APHN activities	Intermediate outcomes (5 years)	Long term outcome (10 years)
DH3 Rate of accredited general practices sharing data with PHN	Capacity Building with primary care providers (workforce development) Primary Care Provider support via pathways, referral, access Procure PenCS for general practice and contribute to NDSAS for data collection.	General practices and other health care providers use data to improve care	Digital health enables better coordinated care and better informed treatment decisions
DH2 Rate of health care providers using specific digital health systems	Capacity Building with primary care providers (workforce development) Primary Care Provider support via pathways, referral, access to secure messaging, shared care platforms (Inca, Mastercare) Engage with the DHA and Primary Health Care Providers.	PHNs support health care providers to use digital health systems to improve patient care and communication	
P4 Support provided to general practices and other health care providers – digital health	Capacity Building with primary care providers (workforce development) Primary Care Provider support via pathways, referral, access to secure messaging, shared care platforms (Inca, Mastercare) Engage with the DHA and Primary Health Care Providers.		
P5 Rate of regular uploads to My Health Record	Capacity Building with primary care providers (workforce development) including supported use in co commissioned GP Liaison Units in LHNs Primary Care Provider support via pathways, referral, access Engage with the DHA and Primary Health Care Providers.		
P10 Cross views of My Health Record	Capacity Building with primary care providers (workforce development) Primary Care Provider support via pathways, referral, access Engage with the DHA and Primary Health Care Providers.		
DH1 Rate of health care providers informed about My Health Record (MHREP indicators 1-4)	Capacity Building with primary care providers (workforce development) Primary Care Provider support via pathways, referral, access Engage with the DHA and Primary Health Care Providers.	Health care providers are aware of digital health systems and technologies	