Our Activity Plan 2018-19

phn COUNTRY SA
An Australian Government Initiative

Strategic Vision

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.**

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

Activity planning

The Country SA PHN (CSAPHN) Needs Assessment will identify local priorities, which will in turn guide the activities nominated for action in the 2018-19 Annual Plan.

Updated in April 2018, this Activity Work Plan covers the period from 1 July 2018 to 30 June 2019.

Primary Health Networks Flexible, Operational and After Hours Funding

Health Workforce – development and support

This activity is aimed at supporting the existing primary health workforce, building local service capacity, stimulating market development, strengthening the viability of primary health care practices and supporting recruitment strategies, especially in rural and remote locations that are underserviced.

This activity includes:

- A commissioned comprehensive education services program designed for all of the primary health care workforce across the entirety of rural and remote South Australia via face-to-face and webinar modality that supports clinical service delivery.
- Commissioned specialised support for the health and wellbeing of GPs, registrars and medical students. This includes clinical services and medical interventions.
- Commissioned specialised support for allied health practitioners for clinical learning and mentoring that supports clinical service delivery.
- Commissioned practical triage training, inclusive of primary health staff, aged care staff and non-clinical staff to support avoidable hospitalisation.
- Commissioned education and partnership with the diabetes sector targeted at the primary health care workforce to support them with clinical service delivery in caring for diabetic patients at any point on the care continuum.
- Event management support to deliver primary health care practice network activities.
- Sponsorship to provide support for the rural and remote workforce access to advanced upskilling and to support activities in one of the six key priority area domains.

Supporting care in the community for older people and palliative patients

The overarching aim is to partner with organisations that promote behaviour modification and community education with a focus on work in the ageing space. It ensures that communities have access to programs and information locally.

This activity addresses the PHN objectives as well as the key priority area of Aged Care and include:

- Commissioned palliative care support. This commissioned service is part of a legacy contract to provide psychological interventions and palliative care support in the Barossa/Gawler region of CSAPHN. The program enhances patient and family capacity for management and choice of treatment for disease symptoms and end of life interventions.

- Commissioned telephone and face-to-face support to understand and navigate the My Aged Care gateway will be provided to rural communities. Information sessions to consumers and service providers include: understanding the aged care system; and My Aged Care gateway. Local aged care providers and options will be planned and delivered in partnership with local key stakeholders.
- Commissioned support to improve awareness and understanding of the importance of being active throughout life, with a focus on frailty and falls prevention will be provided to rural communities.

Improving wrap-around care in country

The aim of these activities is to ensure general practice, allied health and pharmacy achieve increased capacity to provide quality service and quality patient outcomes.

Under this activity, CSAPHN proposes to commission a "Pharmacist in General Practice Program". This will enable a trial of a pharmacist in general practices to improve access to service for people living in rural and remote areas of country South Australia.

The aim of the program is to integrate a non-dispensing pharmacist into the multidisciplinary team in general practice to improve quality use of medicines, medication review, adherence, reconciliation and accuracy of electronic records to enhance health outcomes for patients.

Illness prevention through health literacy and promotion

The aim of this activity is to ensure communities and individuals have better access to targeted disease education and information on locally accessible services.

- Commission an increase in the number of primary health care nurses from rural South Australia participating in the Nurse Ambassador program. A focus is on embedding the use of the Australian cardiovascular risk tool (AR).
- Commission clinical services related to health checks and skin cancer screening for the farming community.
- Commission activity related to health checks and increasing the health literacy level of Culturally and Linguistically Diverse (CALD) communities in the Riverland, Murray Mallee and South East regions of South Australia. Service delivery will be clinical, including immunisation, cancer screening and chronic disease risk assessments as well as delivering illness prevention and health literacy activities to reduce avoidable hospitalisation.
- Commission activity related to appropriate clinical service provision to the LGBTQI community in rural and remote South Australia. Illness prevention is supported through inclusive practice, appropriate terminology, understanding of health issues, standards, referral pathways and acceptance of sexual and gender diversity.
- Commission small grant opportunities for activities that encourage community-based health promotion that promote illness prevention and increase health literacy.

Immunisation in country

This activity aims to improve rates of immunisation across country South Australia.

A joint funding project by CSAPHN and APHN is directed to the Immunisation Hub in a state-wide approach to the headline indicator of improving immunisation rates. This ensures a unified, ongoing immunisation focus across the State.

Immunisation Hub staff undertake activities to raise immunisation rates via the following:

- Targeting geographic regions of low vaccination compliance with a focus on Aboriginal and Torres Strait Islander people, CALD communities and low-income groups.
- Supporting the skill base of immunisation providers through education and training.
- Improving accessibility to after-hours services and home immunisation services.

HealthPathways

This activity aims to address the key PHN objective of improving coordination of care, through the development and statewide implementation of the HealthPathways online portal to support the consistent management of health conditions and improve the patient journey through our local health system.

The activity will involve:

- 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.

Integrated primary health care in areas of limited access

The aim of this activity is to enable the building of a robust integrated primary health care system in country South Australia, where access to allied health and specialist nurse services are severely limited. Improve access to primary health services that are additional to General Practice through the Integrating Primary Health Care Services (IPHCS) program in locations of 5,000 or less.

Key aspects of the program are that services:

- Address an identified need through a collaborative approach with general practice (inclusive of ACCHOs and RFDS), and the community.

- Are the result of a GP referral (unless otherwise specified).
- Are person centred, evidence based and focuses on client education and activation along with enabling self-management.
- Are integrated with the health system including other health care providers, both public and private.
- Support continuity of care.
- Work to agreed models of care and through local referral pathways.
- Upload health care 'event summaries' to My Health Record.
- Participate in the use of a shared care platform under the Health Care Home reform.

Health Connections platform

Health Connections is an activity name under which digital capabilities are being made available to health providers and patients in the CSAPHN region. This activity aims to facilitate health care provider and patient access to digital tools and capabilities that improve coordination, access, continuity and quality of care across country South Australia.

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

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

Health Connections – Care Planning

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

Aboriginal and Torres Strait Islander health across country South Australia

This activity will aim to contribute to improving Aboriginal and Torres Strait islander health outcomes, with a focus on prevention, early identification and treatment of chronic conditions in the Aboriginal and Torres Strait Islander population.

Activity will address the following:

- Diabetes support in line with the Aboriginal Chronic Disease Consortium Road Map for Action.
- Promotion of health risk behaviour modification, education and services for people with or at risk of chronic and complex conditions.
- Support for the reduction of COPD and associated Respiratory conditions, including smoking cessation support.
- Support Aboriginal and Torres Strait Islander understandings of health and the complex interplay between cultural, spiritual, physical, social and emotional health.
- Supporting these activities through building the local Aboriginal and Torres Strait Islander health workforce and service capacity.

Integrating primary care in remote and very remote SA

The aim of this activity is to enable people in remote and very remote locations with or at risk of chronic and complex conditions to have access to appropriate services that will assist in improving their health outcomes.

Key aspects of the program are that services:

- Address an identified need through a collaborative approach with general practice (inclusive of ACCHOs and RFDS) and the community.
- Are the result of a GP referral (unless otherwise specified).
- Delivery approach is person centred, evidence based and focuses on client education and activation along with enabling self-management.
- Are integrated with the health system including other health care providers, both public and private .
- Support continuity of care.
- Work to agreed models of care and through local referral pathways.
- Upload health care 'event summaries' to My Health Record.
- Participate in the use of a shared care platform under the Health Care Home reform (as determined by the company).

Improving the patient journey

This activity is aimed at service and system interventions to enhance communication across the primary and tertiary interface and support integrated patient-centred care.

The activity aims to support the seamless transition for patients across the care continuum, ensuring appropriate clinical handover and continuity of care particularly for at risk patients by:

- Enabling improved communication and collaboration to ensure clinical handover between the sectors supports the delivery of safe, appropriate and timely care for patients. Appropriate conduits will be enacted including, virtual, digital, telephonic and face-to-face.
- Supporting patient self-management and health system navigation with Patient Navigator / Care Coordinator roles functioning in a virtual setting.

- Identifying and supporting at risk patients to receive time appropriate care through community paramedicine and nurse practitioner models.

Mental health comorbidity support

Activities will complement and integrate with Primary Mental Health funded programs and Stepped Care ideology while also meeting the unique support and coordination needs of rural and remote communities. Innovative region-wide approaches with a focus on sustainability, cost neutrality, wrap-around care and community capacity building and resilience.

- Focus on wellness promotion and prevention by providing access to information, advice and self-help resource with a focus on children and young people.
- Increase early intervention through access to lower cost, evidence-based alternatives to face-to-face psychological therapy services.
- Provide wrap-around coordinated care for disadvantaged rural people with complex needs.
- Bridge the gap between acute episode discharge and re-entry to primary mental health services and wrap around supports via coordinated care and appropriate clinical triage.
- Promote a comorbid approach centred on drug and alcohol and shared servicing.

General Practice support

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

This activity will support the general practice function as a whole in its encounter and management of patients, data, systems and process to enable best practice options of patient care.

- Implement digital health changes for the meaningful use of the My Health Record and enabling technologies.
- Increase general practice capacity and sustainability through increased appropriate use of Medicare Benefits Scheme and Incentive payments.
- Support practice nurse and general practice staff with clinical quality improvement and accreditation.
- Support care planning and the Medical Home model changes.
- Support change management and implementation of the MBS review and other future changes.
- Improve data quality and use of clinical information systems.
- Provide clinical care updates, current preventative health information and other resources.
- Facilitate the delivery of continuing professional development to general practice including culturally appropriate training.
- Facilitate support for international medical graduates and procedural general practitioners.
- Promote mental wellness awareness for GPs and the general practice community.
- Connect general practitioners to medical specialist advice.
- Promote engagement and participation in Practice Incentives Program (PIP) and the PIP Quality Improvement (QI) incentive.
- Support the uptake of systems such as HealthPathways and online care planning access to improve coordination of care and integration with specialist and allied health.

Population health planning and engagement

The aim of this activity it to understand the health needs of the population in the CSAPHN region and support stakeholders to provide best integrated care to improve the health outcomes of that population.

- Key engagement with SA Health, Country Health SA Local Health Network (CHSALHN) regarding strategic and local population planning and leverage for system improvement.
- Key partnerships relating to peak bodies and national agencies re collaborative approach to chronic co-morbidities and screening initiatives.
- Stakeholder engagement with upwards of 5,000 health and associated services sites across the region.
- CSAPHN needs assessment processes, supported by a multi-organisation Joint Needs Assessment Advisory Group, also informing regionally mapped services and population health data for publication and use by a range of organisations and communities.
- Progressing partnerships relating to digital health solutions to enable uploading of coordinated care and other activity across disconnected systems for country patients and services.

After hours access to primary health care and support

Investigate potential models for support to, or coordination of, activity to assist the management of high or frequent users of the health system, as an avenue for hospital avoidance and support for patients with complex needs.

Work with the CHSALHN to identify options for improvements in after-hours primary health services to redirect or improve primary health after hours service demand.

This activity provides:

- Training and education throughout the CSAPHN region to CHSALHN nurses who work in SAVES sites. These are sites that don't have a local on-call GP, with nurses at the front line of patient care. This education enhances triage, communication

and management skills to enable the remotely located on-call GP to assess via a video consultation and prescribe treatment to be undertaken by the nurse.

- Expands country access to Cardiac Health (CATCH) into the after-hours to cover all of the CSAPHN region. CATCH includes operation of central referral point for patients that have experienced a cardiac event, maintains a referral database and provision of virtual health coaching to patients.

Umoona severe mental illness gaps

The aim of this activity is to provide culturally appropriate support to Aboriginal people with severe mental illness in their recovery in the after hours by providing support in a hospital setting that encourages the person to remain admitted and receive appropriate follow up care in order to get the best recovery outcome possible.

After hours innovation grants

The aim of the activity is to increase the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes and to enhance timeliness of care by enabling innovative local approaches to after-hours access to primary health care.

By providing support and education, health literacy and knowledge is increased in vulnerable populations. This enhances confidence in navigating the primary health care system and hence prevents unnecessary hospital presentations.

headspace and psychological therapies extended access

People with a mental illness often require flexible opening hours to support help seeking behaviour and provide increased opportunities to access services.

- An extension to existing funded services will enable psychological therapies to be offered in the after hours time period to provide access to clients who are unable to access services during business hours.
- The alcohol and other drugs program will be provided by the West Coast Youth Community Services to the Aboriginal population in the far west town of Ceduna, which identified as a high need area.

Youth drug and alcohol extended access

People with a mental health and drug and alcohol issues often require flexible opening hours to support help seeking behaviour and provide increased opportunities to access services.

The alcohol and other drugs program will be provided by the West Coast Youth Community Services to the youth with a focus on the Aboriginal population in the far west town of Ceduna which identified as a high need area.

After hours healthy weight & lifestyle grants

The aim of this activity is to encourage and support prevention of chronic conditions through education around lifelong healthy lifestyle choices and physical activity behaviours.

The aim of this activity is a catchment wide, evidenced-based healthy weight and lifestyle programs to address healthy eating, obesity and lifestyle-related factors. This activity takes a preventative approach to address escalation of complex and chronic conditions.

Regional medication management support service

The aim of this activity is to upskill the primary health care workforce on quality use of medicines, medicines optimisation and the prevention of medication related factors that contribute to hospitalisations.

The focus will be on the following activities:

- Coordinating and supporting face-to-face regional multidisciplinary medication advisory meetings between GPs, RACF staff, allied health providers and pharmacists.
- Providing after-hours access for health professionals to the DATIS Therapeutic Advice Line.
- Providing face to face visits to rural and remote regions and meet with GPs, pharmacists, RACFs and the wider multidisciplinary team to focus on medicines optimisation and medication related factors that contribute to potentially preventable hospital admissions.
- Promoting the use of e-technologies as a platform for multidisciplinary communication and education.
- Providing material support and promotional activities/ programs.