Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks Core Funding

Primary Health Networks After Hours Funding

Activity Work Plan 2016-2018

- Annual Plan 2016-2018
- Annual Operational and Flexible Funding Streams Budget 2016-2017
- After Hours Budget 2016-2017

Country WA PHN

Version 2.0 – August 2016

Introduction

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.

Each PHN must make informed choices about how best to use its resources to achieve these objectives.

Together with the PHN Needs Assessment and the PHN Performance Framework, PHNs will outline activities and describe measurable performance indicators to provide the Australian Government and the Australian public with visibility as to the activities of each PHN.

This document, the Activity Work Plan template, captures those activities.

This Activity Work Plan covers the period from 1 July 2016 to 30 June 2018. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of 12 months or 24 months. Regardless of the proposed duration for each activity, the Department of Health will still require the submission of a new or updated Activity Work Plan for 2017-18.

The Activity Work Plan template has the following parts:

1. The Core Funding Annual Plan 2016-2018 which will provide:
    a) The strategic vision of each PHN.
    b) A description of planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding.
    c) A description of planned general practice support activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding.
2. The indicative Core Operational and Flexible Funding Streams Budget for 2016-2017.
3. The After Hours Primary Care Funding Annual Plan 2016-2017 which will provide:
    a) The strategic vision of each PHN for achieving the After Hours key objectives.
    b) A description of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Care Funding.
4. The indicative Budget for After Hours Primary Care funding stream for 2016-2017.

Annual Plan 2016-2018

Annual plans for 2016-2018 must:

- provide a coherent guide for PHNs to demonstrate to their communities, general practices, health service organisations, state and territory health services and the Commonwealth Government, what the PHN is going to achieve (through performance indicator targets) and how the PHN plans to achieve these targets;
- be developed in consultation with local communities, Clinical Councils, Community Advisory Committees, state/territory governments and Local Hospital Networks as appropriate; and
- articulate a set of activities that each PHN will undertake, using the PHN Needs Assessment as evidence, as well as identifying clear and measurable performance indicators and targets to demonstrate improvements.

Activity Planning

The PHN Needs Assessment will identify local priorities which in turn will inform and guide the activities nominated for action in the 2016-2018 Annual Plan. PHNs need to ensure the activities identified in the annual plan also correspond with the PHN Objectives; the actions identified in Section 1.2 of the PHN Programme Guidelines (p. 7); the PHN key priorities; and/or the national headline performance indicators.

PHNs are encouraged to consider opportunities for new models of care within the primary care system, such as the patient-centred care models and acute care collaborations. Consideration should be given to how the PHN plans to work together and potentially combine resources, with other private and public organisations to implement innovative service delivery and models of care. Development of care pathways will be paramount to streamlining patient care and improving the quality of care and health outcomes.

Primary Health Networks After Hours Funding

From 2016-17, PHNs will have greater flexibility to commission programme specific services, having completed needs assessments for their regions and associated population health planning. PHNs are funded to address gaps in after hours service provision and improve service integration within their PHN region.

Measuring Improvements to the Health System

National headline performance indicators, as outlined in the PHN Performance Framework, represent the Australian Government's national health priorities.

PHNs will identify local performance indicators to demonstrate improvements resulting from the activities they undertake. These will be reported through the six and twelve month reports and published as outlined in the PHN Performance Framework.

Activity Work Plan Reporting Period and Public Accessibility

The Activity Work Plan will cover the period 1 July 2016 to 30 June 2018. A review of the Activity Work Plan will be undertaken in 2017 and resubmitted as required under Item F.22 of the PHN Core Funding Agreement between the Commonwealth and all Primary Health Networks.

Once approved, the Annual Plan component must be made available by the PHN on their website as soon as practicable. The Annual Plan component will also be made available on the Department of Health's website (under the PHN webpage). Sensitive content identified by the PHN will be excluded, subject to the agreement of the Department.

1 (a) Strategic Vision

WA Primary Health Alliance (WAPHA) exists to facilitate a better health system for all Western Australians, achieving improved outcomes for patients and delivering better value to our community.

The primary health care system in WA is fragmented and lacks strong, integrated general practitioner (GP) led care at its core. Through collaboration with the three WA PHNs, WAPHA is committed to addressing the many access barriers that exist for people trying to navigate the current system – particularly those at risk of poor health outcomes. These barriers contribute to more than 62,000 Western Australians presenting at hospital emergency departments each year, when care would be best managed through a co-ordinated and responsive primary health care system. WAPHA is committed to enabling patients to stay well in the community.

In the 24 months of this Activity Work Plan, the Country WA PHN intends to demonstrate improvement in equity, efficiency and effectiveness of primary health care services and in better enabling patients to stay well in the community. The founding principles of this plan include:

- Transitioning from a programmatic based approach to supporting Comprehensive Primary Care where General Practitioners lead and are central to the care team/model which is underpinned by the 10 building blocks of high performing primary care and the Quadruple aim;
- Reducing fragmented care by supporting the provision of person-centred coordinated care for vulnerable and disadvantaged people in rural and remote locations. Models of care will aim to facilitate integrated community and acute care within the regional health system, facilitate patient self-management and improve the patient's navigation of the health system; and
- A place based health approach to commissioning whereby local activities are implemented to engage the community, social and health care providers, local government and other key stakeholders to knit together services to more effectively meet the needs of local citizens.

Our commissioning effort and resources are focussed on a small number of high impact activities that can demonstrate our success in facilitating changes to the health system. These changes will lead to improved health outcomes, deliver better value to the community and meet one or more of the following five priority areas, identified through the Needs Assessments:

- Keeping people well in the community;
- People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs;
- Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage;
- System navigation and integration to help people get the right services at the right time and in the right place; and/or
- Capable workforce tailored to these priorities.

It is essential for WAPHA to build sustainable relationships across the health and social care systems to effectively address the barriers impacting on the health care outcomes of people in metropolitan, regional, rural and remote Western Australia.

The Country PHN will work collaboratively with key stakeholders within the seven regions to design, develop and commission models of service delivery that reinforce the strategic vision. Central to this are the Regional Clinical Commissioning Committees, chaired by local GPs and with memberships comprised of interdisciplinary health care clinicians who are well informed of local health care needs. Sustained engagement of clinicians and the community in the commissioning of services will assist in identifying, and subsequently meeting, priority needs at a regional level for the WA community.

Based on the services gaps and the priorities identified in the WA Primary Health Network Needs Assessments, the PHN will plan and commission for quality, cost effective and integrated services that are sustainable, evidence based and outcomes focused. This will require:

- Establishment of a sustainable commissioning capability;
- Increasing the system's capacity to support patients through non-hospital primary health care pathways;
- Collaboration and establishment of a shared sense of purpose with those within the 'authorising environment'; and
- Building an organisational culture that supports innovation, good governance and sustainability.

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Definitions applied

Canterbury Health System Outcomes Framework - an outcome measurement approach utilised within the Canterbury Health Network in New Zealand. The framework identifies the key outcomes sought at a population level and tracks performance using an evolving set of indicators, moving the health system away from tracking of inputs and aligning resource of the wider system to patient rather than provider outcomes.

Clinical governance - the systems and processes that organisations use to audit care, train staff, obtain feedback from clients and manage clinical risk to ensure that the services provided are safe and good quality.

Co-design - where service users, providers and commissioners are equal partners in the design of systems and services that affect them.

Co-production - In practice, involves people who use services being consulted, included and working together from the start to the end of any things that affect them. (*Often used as the operational description of how co-design is achieved, but also gets used interchangeably).*

Collective impact - an approach that brings a range of organisations together to focus on an agreed common change agenda that results in long-lasting benefits.

CREMs – clinician reported experience measures.

Evidence based care - care that research has shown is effective in providing the desired result.

HealthPathways - an online management tool to assist general practitioners (GPs) provide consistent conditions-specific care and referrals. Each pathway provides GP's with up to date information about local referral pathways.

Multidisciplinary team - A term used to describe a variety of different health professionals working together. (Also called inter-professional or interdisciplinary team).

Outcome based commissioning - planning and purchasing services based on **what** positive differences are made, over **how** they are done. This is a key concept in reforming our health services.

An example would be where a government replaces a block contract to buy 2000 hip replacements a year, with a contract to deliver an agreed level of hip mobility for a group of people in a region, ensuring people are mobile and not in pain. Hip replacements might be the right answer in some cases, but probably in fewer cases than before, and most importantly that decision is directed much more by the outcomes that the patient wants.

Person centred care - when decisions about the way health care is designed and delivered puts the needs and interests of the person receiving the care first. (Also called Consumer Centric Care).

Place based approach - a way of addressing issues within a defined place, community or region in a systemic way.

PREMs - Patient reported experience measures.

Primary care - the first point of contact with health care provided in the community most commonly with a GP. Does not require and external referral at point of entry.

PROMs - Patient reported outcome measures.

Quadruple aim - is widely accepted as a compass to optimise health system performance. The Quadruple aim includes – enhancing patient experience, improving population health, reducing costs and improving healthcare provider experience and satisfaction.

Secondary care - care provided by a specialist often in a clinic or hospital requiring an external referral.

Shared care - care provided by a team of people in a coordinated way.

An example would be arrangements between a local hospital and GP for pregnancy care where some appointments are with the GP, and some are at the hospital.

Stepped care - A key concept in mental health. In this model the care is "stepped" up or down in intensity and scope, depending on the severity and complexity of the patient's needs, rather than care "dosing" according to diagnosis and service specification.

For example, someone suffering depression related to a specific incident in their life such as sickness or job loss, will require a different level of care to a person with long-term chronic depression or psychiatric conditions. With a stepped care approach, all patients with depression start with low intensity intervention, usually 'watchful waiting', as around half will recover spontaneously within 3 months. Progress is monitored by a mental health professional and only those who don't recover sufficiently move up to higher intensity intervention – which might involve guided self-help. There are two more levels or steps: brief one-on-one therapy; and then for those still badly impacted by depression, longer-term psychotherapy and antidepressant medication.

Systems approach - a way of tackling issues by looking at all the services that exist and the connections between them and making changes that can affect the whole system rather than just individual parts within it.

Social determinants of health - the conditions within which people are born, develop, grow and age – they include social, economic, cultural and material factors surrounding people's lives, such as housing, education, availability of nutritional food, employment, social support, health care systems and secure early life.

Tertiary care - specialised care usually provided in hospital that usually requires referral from a primary or secondary care provider.

Wrap around care - this is a key concept within person centred care. The patient and their family form a partnership with their primary care provider team and other services "wrap around" this partnership as required.

Key Projects underpinning proposed activities

Mental Health Atlas project -The project maps by primary function, all of the free to access mental health and AOD services in WA including their reach. Once completed (due September 2016) the project will provide a planning tool that helps health commissioning organisations to understand current service availability by locality.

My Health Record project - My Health Record is a secure online summary of a person's health information, provided to all Australians by the Commonwealth Department of Health. The individual can control what goes into the record and who can access it. The My Health Record makes it possible for an individual to share their health information with a variety of healthcare services and providers such as GP's, hospitals and specialists. Everyone granted access to the record is able to see information about an individual's health condition, allergies, test results or medications depending on what the individual elects to share, and with whom. The benefits are significant – the electronic record is a convenient way for people to store all of their health information and also in reducing duplication and potential errors through health professionals having access to the right information all in one place.

A note on Country WA PHN's commissioning approach and performance management

Current Programs receiving flexible funding in Country WA, deliver services based on historical assumptions and imperatives. For chronic disease management without exception, services are comprised of allied health professionals providing a range of services. Health promotion programs provide information and education on nutrition, harmful alcohol consumption and falls and injury prevention. Other allied health programs provide diabetes education and support; podiatry; and cardiovascular rehabilitation education.

For flexibly funded mental health services, which are small in number and scope, there has generally been a failure to consider needs, in and between regions in a systematic way and current service provision reflects this.

A review of all services receiving flexible funding across country WA has showcased the limited scope of the flexibly funded suite of services; an uncoordinated approach to service provision; and an underdeveloped planning and implementation framework. The target populations have generally been poorly characterised in existing contracts so it is unclear if the most vulnerable and disadvantaged people are receiving the services they need to keep well in the community.

To facilitate and support the move from single service/programme funding to outcome based commissioning the WA PHNs, supported by WAPHA and in collaboration with the community, providers and other stakeholders, will develop a State-wide primary care outcomes framework ('the framework').

This framework will include a suite of indicators (process, output and outcome). It will also be available for use by other stakeholders in the primary care sector. Wherever possible it will draw on and align with existing work at a national and State level (for example, the National Primary Health Care Strategic Framework, WA Department of Health's Aboriginal Health and Wellbeing Framework 2015-2030, and the Partnering in Procurement Guidelines produced by the WA Council of Social Services and the WA Department of Health).

In line with the Department of Health's guidance documents on designing and contracting services the framework will be developed with the following principles:

- Indicators will be developed in collaboration with the community, providers and other stakeholders;
- Duplication in data collection and reporting for providers will be minimised wherever possible – for example, by collaborating with other funders to agree shared performance measures;
- Timely and responsive feedback on performance will be provided to service providers;
- Measurement will be at patient-level (de-identified) wherever possible;
- Providers will be supported to develop their capacity to identify and report appropriate outcomes and indicators; and
- Annual changes to local indicators will be minimised.

It is intended to complete a first iteration of this work by the end of October 2016.

Approach taken to prioritising activities

During 2016, Country WA PHN undertook a baseline needs assessment of its resident population in partnership with Curtin University. While a broad range of health needs were identified within the community, key stakeholders were involved in a prioritisation process to agree high level priority needs. The following needs were determined:

- Keeping people well in the community;
- People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs;
- Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage;
- System navigation and integration to help people get the right services, at the right time and in the right place; and/or
- Capable workforce tailored to these priorities.

These priority needs will guide resource allocation in the commissioning process.

1 (b) Planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage.
Activity Title / Reference (eg. NP 1.1)	**NP 1.1 - Goldfields chronic conditions: risk reduction and condition management (existing) Transition to Integrated Care Co-ordination**
Description of Activity	Flexible funding for chronic disease early intervention and management is allocated to 4 providers operating mainly from Kalgoorlie and Esperance and providing Podiatry, Physiotherapy, Diabetes/Dietetics and Occupational Therapy (OT). The aims of the programs provided are to modify risk factors associated with chronic health conditions such as diabetes, obesity, chronic heart and respiratory disease, and arthritic conditions and to promote and enhance self-management to slow the progression of chronic disease. An evaluation of the programs found: • Limited service provision to smaller communities e.g. Norseman and intermittent service provision to remote areas apart from a dedicated Occupational Therapist in Ngaanyatjarra Lands; • Fewer and less focused services than other regions given the extent of health issues, large geographic mass and the sizable diverse Aboriginal population scattered across the Goldfields Esperance Lands region; • The relationship and integration with other services in the region is fragmented and problematic often competing for limited resources and drawing from a limited skills pool; and • Some of the programs being delivered under flexible funding are more appropriately the responsibility of State funded health services (e.g. post discharge service from hospital) and the Rural Primary Health Services Program providing allied health services in the centres outside Kalgoorlie require further assistance to better align with the objectives of the PHN on behalf of the Commonwealth government. The assessment of the PHN is therefore that other investments and modelling will have better outcomes for the health of the community and the reduction in preventable hospital admissions than providing the current allied health programs.

Proposed Activities		
Collaboration	Country WA PHN will work in collaboration with WA Country Health Services (WACHS) and WA Mental Health Commission to develop targeted co-commissioning and integrated delivery plans which take account of existing service provision and regional needs.	
Indigenous Specific	One program in the Ngaanyatjarra Lands focuses on management of chronic conditions and self-management education with Aboriginal people.	
Duration	July 2016 - March 2017.	
Coverage	Goldfields region. Kalgoorlie/Boulder LGA, Esperance LGA, NG Lands, Leonora LGA, Laverton LGA, Wiluna LGA, Menzies LGA, Sandstone LGA.	
Commissioning approach	The contract for these services will be extended until 31 March 2017 with additional specifications. In the next 9 months accountability for activity and performance will be tightened. To address the current mismatch between service provision and the priorities and directions the Country WA PHN has established, during 2016-17 effort will be concentrated on developing a joint Services plan with WA Country Health Service and Rural Health West. For Indigenous specific programs planning will include regional aboriginal health services and planning forums. Commissioning will be guided by the Goldfields Esperance Lands Regional Clinical Commissioning Committee (CCC).	
Performance Indicator	Performance indicators for the 9 month contract period will remain as currently contracted with additional requirements for target population detail and patient reported outcome measures (PROMS)	
Local Performance Indicator target	• Maintain targets from current contracts; • Increase number of services specifically targeting Aboriginal people; and • Increase number of Aboriginal people receiving services from existing service providers (10% increase from baseline) to be reported in 6 monthly report.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$751,924	Commonwealth
	$0	nil

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity Title / Reference (eg. NP 1.1)	**NP 1.2 - Great Southern chronic conditions: risk reduction and condition management (existing) Transition to Integrated Care Co-ordination**
Description of Activity	Two service providers are in receipt of Flexible Funding in the Great Southern. Amity Health provides a diabetes self-management and education program to smaller communities in the Great Southern using local General Practice to provide a broadened service program that targets chronic disease management and risk reduction for diabetes. The Albany Community Care Centre provides a continence care program. An evaluation of these programs found: • The chronic disease management program (diabetes self-management) is limited in scope but is well regarded as it provides a reasonably priced program; • Utilising local General Practice seems to have been a successful option to ensure better integration; and • Whilst in line with Country WA PHN priorities, the programs are small scale, focused on a single condition and not integrated into a longer-term collaborative plan. The region is considerably less resourced than other regions and its reach into the local Aboriginal community does not appear to be effective. The assessment of the PHN is therefore that there may be other more effective ways of reducing the need for hospitalisation and addressing health inequity. These programs will continue for 12 months to enable the re-alignment of services through joint planning processes. Consideration will be given to directing funding towards other PHN priorities in the region.
Collaboration	Country WA PHN will work in collaboration with WA Country Health Services (WACHS) and Rural Health West to develop targeted co-commissioning and integrated delivery plans which take account of existing service provision and regional needs.
Indigenous Specific	Whilst there are no Indigenous specific programs funded through flexible funding in this region, the Amity Health service works with Aboriginal clients, especially in smaller communities.
Duration	July 2016 - June 2017.
Coverage	The services cover the communities of Albany (SA 3), Denmark (SA 2), Mount Barker Plantagenet (SA 2), Jerramungup, Bremer Bay and Gnowangerup (SA2) and Kojonup (SA 2) in the Great Southern.

Proposed Activities		
Commissioning approach	The contract for these services will be extended until 30 June 2017 with additional specifications. In the next 12 months accountability for activity and performance will be tightened as previous reporting has not shown effective activity levels or costs per occasions of service and a requirement will be in place that efforts are focused on the local Aboriginal community. To address the current mismatch between service provision and the priorities and directions the Country WA PHN has established, during 2016-17 effort will be concentrated on developing a joint Services plan with WACHS and Rural Health West. For Indigenous specific programs, planning will include regional aboriginal health services and planning forums. Commissioning will be guided by the Great Southern Regional CCC.	
Performance Indicator	Performance indicators for the 12 month contract period will remain as currently contracted. Patient Reported Outcome Measures to be negotiated.	
Local Performance Indicator target	Maintain existing targets overall with a 10% increase in the number of Aboriginal people receiving services.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$294,000	Commonwealth
	$xx	NIL

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity Title / Reference (eg. NP 1.1)	**NP 1.3.1 - Kimberley chronic conditions: risk reduction and condition management (existing) Transition to Integrated Care Co-ordination**
Description of Activity	Five service providers offer flexibly funded programs for risk reduction and chronic condition management in the Kimberley. Programs differ in focus, reach and approach: • Ord Valley Aboriginal Health Service (OVAHS) is funded for a child ear health service through the employment of an audiologist; • Boab Health Services provides primary health care and chronic condition management; • Broome Regional Aboriginal Medical Service (BRAMS) and Kimberley Aboriginal Medical Service (KAMS) are two Aboriginal controlled organisations funded to focus on chronic disease; and • WA Country Health Service (WACHS) is funded to focus on nutrition education and health promotion. Evaluations of the services across the region highlight the need to revisit the objectives and allocation of flexible funds to ensure they align with the Country WA PHN objectives and are well integrated with the services across the whole region. There are also many visiting services to the Aboriginal communities outside the major centres but these are not well coordinated. The Country WA PHN plans to use these five existing contracts as a springboard for a broader discussion with Kimberley Aboriginal Health Planning Forum, Rural Health West, DHAC, WACHS and the Country WA PHN Kimberley Regional Commissioning Committee to ensure a coordinated effort from providers in the region.
Collaboration	Country WA PHN will collaborate with WACHS and Rural Health West to clarify and agree the scope of commissioning for each funder to avoid duplication.
Indigenous Specific	All programs use their flexible funding to target Indigenous clients. • The Broome Regional Aboriginal Medical Service employs a chronic disease care coordinator; • The Kimberley Aboriginal Medical Service (KAMS) employs a rheumatic heart disease care coordinator. KAMS is also funded to provide 1.3 FTE Aboriginal liaison officers to support regional dialysis services; OVAHS ear health service focuses on Indigenous children, preventing development of chronic ear problems; • The visiting Boab Health Service dietetics and podiatry services primarily target Indigenous clients; and • The WACHS health promotion program is focused on Indigenous clients.
Duration	July 2016 – June 2017.

Proposed Activities		
Coverage	The KAMS Aboriginal liaison service is based out of Broome and Kununurra with a visiting schedule to remote communities. The KAMS rheumatic heart disease coordinator provides a regional support service to ACCHO services across the Kimberley Region. The Boab dietetics and podiatry program is offered on a region-wide basis. The OVAHS audiologist position is funded to service Kununurra and its surrounding Aboriginal communities. The WACHS health promotion program is Broome based.	
Commissioning approach	The contracts for these services will be extended until 30 June 2017. A joint Country WA PHN, WACHS, Rural Heath West commissioning and Services plan for the region, consistent with established health information and evidence, will be developed to address agreed health priorities and risks for the community as a whole. Commissioning will be guided by the Kimberley Regional CCC.	
Performance Indicator	Performance indicators for the 12 month contract period will remain as currently contracted. Patient reported outcome measures to be negotiated.	
Local Performance Indicator target	Local indicators for this program will focus on number of the Indigenous people serviced, and specifically, the number of GP Management Plans in place and reviewed.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$1,287,065	Commonwealth
	$0	Contributions from WACHS to be identified during development of joint plan

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity Title / Reference (eg. NP 1.1)	**NP 1.3.2 - Kimberley Mental Health: Sexual Assault Counselling Service (existing)**
Description of Activity	This service is provided by Anglicare, located in Broome and serving the Kimberley Region. The aim of the service is to: • Reduce the harmful effects of sexual violence for individuals, families and the community; • Help break the taboo by providing community education; and • Reduce the likelihood of sexual abuse for vulnerable children through the provision of protective behaviours. The service is respected and integrated with other services. It has a high level of use by Aboriginal people and is used by other services as a referral point for individuals and families with trauma associated with sexual assault and past abuse.
Collaboration	The Country WA PHN will enter into a collaborative planning process with WACHS, the WA Mental Health Commission and Kimberley Aboriginal Health Planning Forum as part of the development of the Mental Health Annual Activity Plan for 2017-18.
Indigenous Specific	Focus is on Aboriginal clients.
Duration	July 2016 – June 2017 .
Coverage	• Broome, Kununurra, Derby and Wyndham - weekly to fortnightly and as the situation requires; • Halls Creek, Warmun, Fitzroy Crossing and Dampier Peninsula – monthly; and • Kalumburu and Balgo in a crisis only when flight is provided.
Commissioning approach	The contract for this service will be extended until 30 June 2017. A joint Country WA PHN, WACHS, Rural Heath West and Mental Health Commission commissioning and Services plan for the region, consistent with agreed health information and evidence, will be developed to address agreed health priorities and risks for the community as a whole. Commissioning will be guided by the Kimberley Regional CCC.
Performance Indicator	Performance indicators for the 12 month contract period will remain as currently contracted. Patient reported outcome measures to be negotiated.

Proposed Activities		
Local Performance Indicator target	Local indicators for this program will focus on the number of Indigenous people serviced.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$353,796.00	Commonwealth
	$0	Contributions from WACHS to be identified during development of joint plan

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage.
Activity Title / Reference (eg. NP 1.1)	**NP 1.4 - Midwest chronic conditions: risk reduction and condition management (existing) Transition to Integrated Care Co-ordination**
Description of Activity	Flexible funding for chronic disease early intervention and management is allocated to 7 providers in this region for risk modification and enhanced patient self-management programs. The programs are primarily located in and service the two population centres Geraldton and Carnarvon with some visiting capacity to smaller communities. Service providers are 360 Health + Community; Geraldton Ankle and Foot; Carnarvon Physiotherapy; Central West Health and Rehab; Durlacher Dietetic Service; Geraldton Podiatry; WA Country Health Service (Midwest); WA Country Health Service (Murchison); WA Country Health Service (Gascoyne). Service assessment by the Country WA PHN and an external assessor found: • Duplication and a general lack of coordinated and integrated service design; • Over-servicing some areas and under-servicing many others - historically programs were run by the previous Medicare Local and this was seen to be in competition with local services; • There is a very strong focus on allied health type services rather than traditional primary health care services; and • Several small service providers are well-integrated with local GPs and the Geraldton Aboriginal Medical Service. The assessment of the PHN is therefore that generally it is difficult to justify the current level of resourcing to allied health chronic disease management programs in the Region. The services delivered by the 2 largest contract holders are not clearly aligned to Country WA PHN objectives and will have a marginal impact on preventable hospitalisation when compared to alternative programs.
Collaboration	The Country WA PHN Midwest team will work in collaboration with WACHS, and Rural Health West to develop targeted co-commissioning and an integrated service delivery plan for the region. The specific services targeted at the Aboriginal community will be conducted in partnership with local aboriginal medical services. Additionally, the Midwest team will work with the Carnarvon Medicare 19 (2) Exemption Advisory Committee to maximise joint funding opportunities for the Gascoyne region.

Proposed Activities		
Collaboration	Building workforce capacity in the Midwest region is paramount to the sustainability of services. Country WA PHN will explore potential for collaboration with rural health education and training organisations to identify shared workforce upskilling and training opportunities for the region.	
Indigenous Specific	There are no Indigenous specific programs funded from flexible funding in this region. The local podiatry service operating from Geraldton is integrated with the Geraldton Regional Aboriginal Medical Service mobile clinic which visits small communities in the Midwest and is well targeted to Aboriginal people.	
Duration	July 2016 – March 2017.	
Coverage	Many smaller services are based in and cover Geraldton and to a lesser degree Carnarvon. The services provided by 360 Health + Community in Midwest/Murchison (population centre Geraldton) and the Gascoyne (population centre Carnarvon) are based in and cover Geraldton and to a lesser extent Carnarvon with no evidence of good coverage to outlying areas. The allied health services provided by WACHS cover 19 small communities on a visiting basis.	
Commissioning approach	The contracts for these services will be extended until 31 March 2017 with additional specifications. During this time accountability for activity and performance will be tightened, with a requirement for effort to be focussed on local Aboriginal communities. During 2016 – 17 effort will be concentrated on developing a joint Services plan with WACHS and, for Indigenous specific programs, local Aboriginal regional planning forums and medical services. Commissioning will be guided by the Midwest Regional Clinical Commissioning Committee (CCC)	
Performance Indicator	Performance indicators for the 9 month contract period will remain as currently contracted. Patient reported outcome measures to be negotiated.	
Local Performance Indicator target	Local indicators for this program will focus on number of the Indigenous people serviced, seeing an increase of 10% in the number of Aboriginal clients.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$2,277,887	Commonwealth
	$0	Contributions from WACHS to be identified during development of joint plan

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage.
Activity Title / Reference (eg. NP 1.1)	**NP 1.5 - Pilbara chronic conditions: risk reduction and condition management (existing) Transition to Integrated Care Co-ordination**
Description of Activity	Flexible funding for chronic disease early intervention and management is allocated to 4 providers in this region for risk modification and chronic disease care and management. Service providers are Mawarnkarra Health Service; Pilbara Health Network; WA Country Health Service Pilbara and Wirraka Maya Health Service. Service assessment by Country WA PHN has found that: • The contracted services are largely aimed at allied health services rather than traditional primary health care services; • Their alignment to Country WA PHN objectives is not well demonstrated or clear; and • The two chronic disease nurses are integrated into the local Aboriginal Medical Services and are delivering well-targeted programs especially to Aboriginal people in two medium sized communities. Country WA PHN's assessment is that there may be more effective investments to improve health outcomes and address the clear inequity in health outcomes for Aboriginal people. The intention of the Country WA PHN in this region is to redirect services in 2017 – 18 in accordance with an agreed Services plan with WACHS after full consultation with the Pilbara Aboriginal Health Planning forum.
Collaboration	Country WA PHN will work in collaboration with WA Country Health Services (WACHS) and Rural Health West to develop targeted co-commissioning and integrated delivery plans which take account of existing service provision and regional needs with consultation with local Aboriginal service providers and regional planning forums.
Indigenous Specific	The two Chronic Disease Nurse Programs in Aboriginal communities are Indigenous specific.
Duration	July 2016 – June 2017.

Proposed Activities		
Coverage	Outreach allied health teams from WACHS and Pilbara Health Network are funded to visit 10 inland communities in the Pilbara providing a range of education and other services aimed at managing the health impacts of chronic disease. Frequency of service provision is variable and often impacted by staff turnover and recruitment issues. Other allied health services are delivered from Port Hedland and Karratha, the 2 main population centres in the Pilbara.	
Commissioning approach	The contracts for these services will be extended until 30 June 2017 with additional specifications. During this time accountability for activity and performance will be tightened, with a requirement for effort to be focussed on local Aboriginal communities and more frequent and reliable service provision to small inland communities. During 2016 – 17 effort will be concentrated on developing a joint Services plan with WACHS and, for Indigenous specific programs with local Aboriginal health services and planning forums. Commissioning will be guided by the Pilbara Regional CCC.	
Performance Indicator	Performance indicators for the 12 month contract period will remain as currently contracted. Patient reported outcome measures to be negotiated.	
Local Performance Indicator target	Local indicators for this program will focus on the number of Indigenous people serviced, seeing an increase of 10% in the number of Aboriginal clients.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$1,306,257	Commonwealth
	$0	Contributions from WACHS to be identified during development of joint plan

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage.
Activity Title / Reference (eg. NP 1.1)	**NP 1.6.1 - South West chronic conditions: risk reduction and condition management (existing) Transition to Integrated Care Co-ordination**
Description of Activity	Flexible Funding for chronic disease early intervention and management is allocated to a single provider in the South West, GP Down South, and is limited to diabetes education in and around the main population centre, Bunbury. The aim of the service is to promote risk reduction and self-management strategies in people at high risk of diabetes or who are living with diabetes. Assessment of the service concluded that: • The service is well integrated with other services, well targeted and consistent with Country WA PHN objectives; and • Analysis has shown an inequitable distribution of flexible funding resources in chronic disease risk reduction and condition management in the South West as compared with other country regions. Country WA PHN aims to address inequities in flexible funding and access to services that align with Country WA PHN objectives and the 5 priorities that were articulated in the Needs Assessment submission from Country WA PHN to the Department of Health.
Collaboration	Country WA PHN will work in collaboration with WA Country Health Services (WACHS) and Rural Health West to develop targeted co-commissioning and integrated delivery plans which take account of existing service provision and regional needs.
Indigenous Specific	There are no Indigenous specific programs funded from Flexible Funding in this region although this service is well integrated with the South West Aboriginal Medical Service.
Duration	July 2016 – June 2017.
Coverage	GP Down South diabetes education provides services to six smaller centres (Harvey, Bridgetown, Margaret River, Augusta, Pemberton and Collie) in addition to the major population centre, Bunbury.
Commissioning approach	The contract for this service will be extended until 30 June 2017 with additional specifications. In the next 12 months accountability for activity and performance will be tightened. During 2016 – 17 effort will be concentrated on developing a joint Services plan with WACHS and, for Indigenous specific programs, with the South West Aboriginal Medical Service.
Performance Indicator	Performance indicators for the 12 month contract period will remain as currently contracted. Patient reported outcome measures to be negotiated.

Proposed Activities		
Local Performance Indicator target	Maintain existing targets overall with a 5% increase in the number of Aboriginal people receiving services.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$172,000	Commonwealth
	$0	Contributions from WACHS to be identified during development of joint plan.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage
Activity Title / Reference (eg. NP 1.1)	**NP 1.6.2 - South West mental health: rural primary health services (existing)**
Description of Activity	Flexible funding for mental health early intervention and management is allocated to a single provider in the South West, GP Down South, and complements the current ATAPS and MHSRRA funding. The aim of the service is to promote risk reduction and self-management strategies in people at risk of mental illness. This program will be aligned over time with the Country WA PHN mental health programs.
Collaboration	Country WA PHN will work in collaboration with WA Country Health Services (WACHS), Rural Health West and the WA Mental Health Commission to develop targeted co-commissioning and integrated delivery plans which take account of existing service provision and regional needs.
Indigenous Specific	No.
Duration	July 2016 – June 2017.
Coverage	GP Down South mental health program provides services to four smaller centres (Busselton, Harvey, Bridgetown, Manjimup) in addition to the major population centre, Bunbury.
Commissioning approach	The contract for this service will be extended until 30 June 2017 with additional specifications. In the next 12 months accountability for activity and performance will be tightened. During 2016 – 17 effort will be concentrated on developing a joint Services plan with WACHS and WA Mental Health Commission.
Performance Indicator	Performance indicators for the 12 month contract period will remain as currently contracted with more emphasis on identification of at-risk populations within service target group. Patient reported outcome measures to be negotiated.
Local Performance Indicator target	Maintain existing targets overall with a 10% increase in the number of at-risk people accessing the service.
Data source	Contracted services.

Proposed Activities		
Planned Expenditure 2016-2017 (GST exc) to match budget	$95,000	Commonwealth
	$0	Contributions from WACHS to be identified during development of joint plan.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage.
Activity Title / Reference (eg. NP 1.1)	**NP 1.7 - Wheatbelt chronic conditions: risk reduction and self-management (existing) Transition to Integrated Care Co-ordination**
Description of Activity	Two major providers of chronic condition-oriented services in the Wheatbelt - WACHS and the Wheatbelt GP Network, currently hold flexible funding contracts. Allied health services with the aim of providing education and support to people to manage the impacts of chronic conditions such as diabetes, cardiac and respiratory conditions; and health promotion to encourage healthy lifestyle choices are provided. There are substantial funds invested in the two contracts (over $1.7 million per annum). Assessment of the services concluded: • There was a lack of information about performance and a general lack of coordination with other services in the region by one of the contracted service providers; and • The other service demonstrated more consistent activity and integration with local GPs, reaching targeted communities, especially Aboriginal clients. Country WA PHN assesses that whilst one service is well regarded and has a clear focus there will be other more effective means of reducing hospitalisations and addressing health inequity in the region. Country WA proposes to reinvest flexible funding into areas of high need in the region after undertaking coordinated planning with WACHS and Rural Health West. The existing services will be extended to allow this to occur.
Collaboration	Country WA PHN will work in collaboration with WA Country Health Services (WACHS) and Rural Health West to develop targeted co-commissioning and integrated delivery plans which take account of existing service provision and regional needs through consultation with local Aboriginal service providers and planning groups.
Indigenous Specific	One service, Boodjari Yorga, is Indigenous specific.
Duration	July 2016 – June 2017.

Proposed Activities		
Coverage	Wheatbelt GP Network provides services across the region with the actual breakdown of the communities serviced requiring further analysis. The WGPN program includes a community suicide prevention/counselling service which will transition to the mental health flexible funding. WACHS – Central Wheatbelt based in Northam, servicing Bakers Hill, Clackline, Grass Valley, Toodyay and Wundowie. WACHS – Eastern Wheatbelt servicing Bruce Rock, Kellerberrin, Koorda, Merredin, Mt Marshall, Mukinbudin, Narembeen, Nungarin, Trayning, Westonia, Wyalkatchem and Yilgarn.	
Commissioning approach	The contract for these services will be extended until 31 March 2017 with additional specifications. In the next 9 months accountability for activity and performance will be tightened to address issues of reporting accountability, including the provision of full details of service geographic coverage and services provided to disadvantaged or vulnerable clients. During 2016 – 17 effort will be concentrated on developing a joint Services plan with WACHS and this will include Rural Health West where appropriate. For Indigenous specific programs planning will include Aboriginal Health and Regional Planning Forums. Commissioning will be guided by the Wheatbelt Regional CCC	
Performance Indicator	Performance indicators for the 9 month contract period will remain as currently contracted. Patient reported outcome measures to be negotiated.	
Local Performance Indicator target	Maintain existing targets overall with a 10% increase in the number of Aboriginal people receiving services.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$1,267,009	Commonwealth
	$0	Contributions from WACHS to be identified during development of joint plan.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.1.1 Goldfields chronic conditions: integrated care coordination (New)**
Description of Activity	The aim of the proposed Regional Chronic Conditions: Integrated Care Coordination approach is to integrate primary care with other forms of care to improve equity of access to informed, responsive, holistic and culturally appropriate solutions. To achieve this Country WA PHN will work with stakeholders to design and commission services that feature; 1. Productive relationships for connected, cohesive and consistent local and outreach servicing; 2. Early identification and intervention via effective assessment and referral pathways, assertive follow-up and facilitated support; 3. Successful transitioning of consumers between services in a way that is seamless, involve a 'warm handover' and case coordination of acute/bed based, chronic/community treatment and support/therapeutic services e.g. hospital to home; 4. Collaborative agreement on individual and team care arrangements and care packages; and 5. Continuous improvement based on research, evaluation and capacity building. The primary targets of services are people whose access to GP/clinical services and coordination and system navigation is compromised by their illness, remoteness, the social determinants of health or a combination of all of these. Remote Aboriginal communities in the Region are of special concern.
Collaboration	Collaboration between WACHS, RHW, Aboriginal Health and Planning Forum and service, Regional CCC and local stakeholder groups will inform service design.
Collaboration	The establishment of regional consortia to facilitate effective delivery will be a feature of new service models, with primary health organisations, Aboriginal medical services, general practice and allied health clinicians working collaboratively to deliver shared patient outcomes.
Indigenous Specific	Yes. A number of programs in the region will be Aboriginal specific depending on the identified needs of communities, current coverage by WACHS and Rural Health West, and the details of the joint Services plan. These include remote telehealth, chronic disease nurse and nurse coordinators in communities and GPs available for telemedicine.
Duration	April 2017 – June 2018.

Proposed Activities	
Coverage	Goldfields (including Kalgoorlie, Esperance, the Ngaanyatjarra Lands, Leonora and Laverton). Country WA PHN will take a regional approach to service delivery, mirroring the WACHS Regions, with the possible exception of Wiluna which may be included within the Goldfields. In some instances this approach will be supplemented by PHN wide services, for example through the use of tele-diabetes education for self-management.
Commissioning approach	The recommended Services approach is a co-commissioned consortium approach to market where the accepted applications will be from service provider alliances articulating regional integrated service delivery to identified targets. The approach will be guided by the Goldfields Esperance Lands Regional CCC Commissioning partners will include WACHS and Rural Health West (RHW).
Performance Indicator	To facilitate and support the move from block funding to outcome based commissioning, the Country WA PHN in collaboration with the community, providers and other stakeholders, will develop a primary care outcomes framework. This framework will align with the WACHS Primary Health Strategy and Chronic Conditions Prevention and Management Strategy 2015 – 20 and Aboriginal Health and Wellbeing Framework 2015 – 2030. This outcomes framework will be used to plan and evaluate the services commissioned by the Country WA PHN and will be available to providers for program development. It will also be available for use by other stakeholders in the primary care sector. The outcomes framework draws upon the Canterbury Health System Outcomes Framework[1].
Performance Indicator	It is anticipated that the outcomes framework will include a suite of indicators (process, output and outcome). Indicators will be developed in collaboration with the community, providers and other stakeholders, utilising the principles of: • Minimising the duplication in data collection and reporting for providers wherever possible; • Provision of timely and responsive feedback on performance to service providers; and • Person centred performance measurement, utilising de-identified data wherever possible. Providers will be supported to develop their capacity to identify and report appropriate outcomes and indicators. Examples of appropriate indicators using the Canterbury Framework are: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; and • People are seen and treated early – process measure.

1 Canterbury Health System Outcomes Framework, Canterbury Clinical Network, http://ccn.health.nz/Resources/OutcomesFramework.aspx, last accessed 15/04/16

Proposed Activities		
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the joint regional primary health plan.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth – 16/17 flexible funding plus 3 months and further investment in integrated care models. Refer to Commonwealth Funding NP 1.1 above.
	$0	Contributions from WACHS and Rural Health West as identified in the joint Services plan.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.1.2 - Goldfields Comprehensive Primary Care Practice Transformation Program (new)**
Description of Activity	Increasing evidence and international experience shows strong potential for a Comprehensive Primary Care (CPC) model to deliver efficiencies and improvements in experience and health outcomes for patients with multiple illnesses[2]. The CPC Program will implement transformation strategies that can be embedded in Goldfields General Practice. The program will provide an understanding of and evidence for rolling out this model across the wider GP system[3]. Practice Transformation activities which support General Practice to transition to a more integrated team-care approach underpinned by the Building Blocks of High Performing Primary Care[4] and the Quadruple Aim.[5] Goldfields practices (and Aboriginal Medical Services where appropriate) will be given some flexibility to test and recommend the most effective mechanisms to support locally responsive team-based care. Practices will work with a range of services and providers to best manage the individual needs of enrolled patients[6]. The PHN will support participating practices by: • Investing in knowledge and GP leadership of Comprehensive Primary Care principles and best practice; • Implementation of the 10 Building Blocks of High Performing Primary Care; • Measuring the impact of quality metrics and developing practice dashboards; • Reinforcing primary care as the foundation for integrated care; • Strengthening collegiality and change readiness among GPs, allied health providers, WACHS and internally; and • Building practice capability in team care arrangements including self-management for enrolled patients.

[2] PHN Needs Assessment, priority 1: Keeping people well in the community, b. Commission strategies to keep people connected to their GP or General Practice
[3] PHN Needs Assessment, Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions, b. Assist GPs in the management of multiple morbidities and complex care by establishing integrated care pathways in partnership with State and Area Health Services, GPs and other clinicians
[4] Bodenheim. T, Ghorob. A, Willard-Grace. R, Grumbach. K. The 10 Building Blocks of High Performing Primary Care. Annals of Family Medicine. Mar-Apr 2014.
[5] Bodenheim. T, Sinsky. C. From Triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine. Nov-Dec 2014.
[6] PHN Needs Assessment, priority 5: Capable workforce tailored to these priorities, g. Develop strategies to increase the capacity of Multi-disciplinary team to understand and implement the concept of person centred wrap around care coordination

Proposed Activities	
Description of Activity	Patient and clinician feedback and outcomes will be measured throughout the CPC implementation and changes will be made to improve the model throughout the duration. Patients with chronic conditions (including mental health), which may be unstable or poorly controlled, and/or recent frequent admissions to hospital will be targeted to participate[7].
Collaboration	GP and education training bodies, professional colleges, universities, GP's in the region and those involved in the innovation hub, other WA PHNs, health service providers and Patients, Family and Carers.
Indigenous Specific	There will be a focus on practices in the Goldfields providing primary health care to Aboriginal people and local Aboriginal Medical Services will be supported to participate.
Duration	January 2016 – September 2016 strategic planning. September 2016 – December 2016 commissioning services. October 2016 – June 2018 service delivery and monitoring and evaluation.
Coverage	General practices across Country WA PHN will be invited to respond. Practices that demonstrate innovation and capacity to test the CPC principles and contribute to the evidence base, may also be invited to participate.
Commissioning approach	Regional CCC's will have input to the commissioning approach/design with Expressions of Interest (EOI) sought from across the Country WA PHN region. The EOI will provide details of key elements of the CPC construct, parameters and funding options. Shortlisted respondents from the EOI process will be engaged on a 1:1 basis to co-create the details of contracts. Appropriate measures and indicators (including PREMs and PROMs) will be agreed in partnership with general practices and their associated allied health providers and/or practice networks. Six monthly reporting is expected to include identification of the barriers and enablers to delivery of the CPC model. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Liaison role to build relationships and continuous feedback. Third party evaluation of the program a whole will be conducted by a research partner, providing an evidence base to inform future scaling and implementation.

[7] PHN Needs Assessment, priority 4: System navigation and integration to help people get the right services at the right time and in the right place, h. Commission strategies which incorporate service integration, consortia approaches person-centred support and system navigation

Proposed Activities		
Performance Indicator	Using the Canterbury Health System Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; • People are seen and treated early – process measure.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the regional primary health plan.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth Funding
	$1,500,000	Commonwealth Funding After Hours Carry Forward from 2015-16.Note this funding is for the whole of the PHN and will be allocated across the seven regions. The distribution of funds per region has not yet been determined.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.2.1 Great Southern chronic conditions: Integrated care coordination (new)**
Description of Activity	Integrated Care Coordination for Chronic Conditions in the Great Southern will be focused on multiple condition management and coordination, primarily using a GP led model in major centres and a primary health nurse practitioner model in smaller centres. The aim of the activity is to enable people with chronic conditions to self-manage their condition and remain in their local community. Country WA PHN will partner with WACHS in 2016 – 18 to expand the reach and scope of the existing primary health nurse practitioner program through a combination of extended primary care and nurse practitioner led models of coordinated care. As this region has been sparsely funded through flexible funding an analysis will be undertaken to determine if funds from other regions should be to be diverted to the Great Southern in order to have a region wide collaborative commissioning approach to chronic conditions management. This activity may be linked with other opportunities to support the scope and scale of the program, including co-commissioning, utilisation of students on placement and telehealth linkages.
Collaboration	All strategies to coordinate and manage the care for people with chronic conditions in the Great Southern will be developed collaboratively through a joint Services plan by Country WA PHN and WACHS with consultation with the local Aboriginal Health Planning Forum. Co-design of services will be facilitated through the Regional Clinical Commissioning Committee. Country WA PHN will work with local government and health services in the Great Southern to enhance/expand student country placements across various primary health disciplines to encourage students to return to the region
Collaboration	after graduation and support ongoing CPD for health professional by offering region wide professional development opportunities.
Indigenous Specific	Some programs will target Aboriginal people specifically and will dovetail with the Integrated Team Care commissioning activities. Services in Katanning and surrounding communities will also be informed by consultations being undertaken by the Commonwealth Department of Health through a 'placed based' pilot.
Duration	August 2016 – December 2016 (Planning). Jan 2017 – June 2018.

Proposed Activities	
Coverage	The Great Southern Region, with a particular focus on smaller inland communities, within Country WA PHN will be covered by the integrated service.
Commissioning approach	The planned commissioning approach is intended to create integration through consortia expressions of interest. The co-commissioning of services with WACHS is a high priority for Country WA PHN. All proposals will demonstrate coordination and integration of services both within the flexible funding for chronic condition care and management across the region. Proposals will be required to integrate with the GP practices implementing the CPC Practice Transformation in the Region. The Regional Clinical Commissioning Committee will engage with local stakeholders in the co-design of models of service, tailored to the identified local priorities.
Performance Indicator	The outcomes framework developed to plan and evaluate the services commissioned by the Country WA PHN will be available to providers for program development. It will also be available for use by other stakeholders in the primary care sector. The outcomes framework draws upon the Canterbury Health System Outcomes Framework[8]. It is anticipated that the outcomes framework will include a suite of indicators (process, output and outcome). Indicators will be developed in collaboration with the community, providers and other stakeholders, utilising the principles of: • Minimising the duplication in data collection and reporting for providers wherever possible; • Provision of timely and responsive feedback on performance to service providers; and • Person Centred performance measurement, utilising de-identified data wherever possible.
Performance Indicator	Providers will be supported to develop their capacity to identify and report appropriate outcomes and indicators. Examples of appropriate indicators using the Canterbury Framework are: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care - output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; and People are seen and treated early – process measure.
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the regional primary health plan.

8 Canterbury Health System Outcomes Framework, Canterbury Clinical Network, http://ccn.health.nz/Resources/OutcomesFramework.aspx, last accessed 15/04/16

Proposed Activities		
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$103,162	Commonwealth – 16/17 flexible funding and further investment in integrated care models.
	$0	Contributions from WACHS and Rural Health West as identified in the joint Services plan.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.2.2 - Great Southern Comprehensive Primary Care Practice Transformation Program (new)**
Description of Activity	The CPC program will implement transformation strategies that can be embedded in Great Southern General Practice. The program will provide an understanding of and evidence for rolling out this model across the wider GP system[9]. Practice Transformation activities which support General Practice to transition to a more integrated team-care approach underpinned by the Building Blocks of High Performing Primary Care[10] and the Quadruple Aim.[11] Great Southern General Practices will be given some flexibility to test and recommend the most effective mechanisms to support locally responsive team-based care. Practices will work with a range of services and providers to best manage the individual needs of enrolled patients[12]. The PHN will support participating practices by: • Investing in knowledge and GP leadership of Comprehensive Primary Care principles and best practice; • Implementation of the 10 Building Blocks of High Performing Primary Care; • Measuring the impact of quality metrics and developing practice dashboards; • Reinforcing primary care as the foundation for integrated care; • Strengthening collegiality and change readiness among GPs, allied health providers, WACHS and internally; and • Building practice capability in team care arrangements including self-management for enrolled patients.

[9] PHN Needs Assessment, Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions, b. Assist GPs in the management of multiple morbidities and complex care by establishing integrated care pathways in partnership with State and Area Health Services, GPs and other clinicians

[10] Bodenheim. T, Ghorob. A, Willard-Grace. R, Grumbach. K. The 10 Building Blocks of High Performing Primary Care. Annals of Family Medicine. Mar-Apr 2014.

[11] Bodenheim. T, Sinsky. C. From Triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine. Nov-Dec 2014.

[12] PHN Needs Assessment, priority 5: Capable workforce tailored to these priorities, g. Develop strategies to increase the capacity of Multi-disciplinary team to understand and implement the concept of person centred wrap around care coordination

Proposed Activities	
Description of Activity	Patient and clinician feedback and outcomes will be measured throughout the implementation and changes will be made to improve the model throughout the duration. Patients with chronic conditions (including mental health), which may be unstable or poorly controlled, and/or recent frequent admissions to hospital will be targeted to participate[13].
Collaboration	GP and education training bodies, professional colleges, universities, GP's in the region and those involved in the innovation hub, other WA PHNs, health service providers and Patients, Family and Carers.
Indigenous Specific	There will be a focus on practices in the Great Southern providing primary health care to Aboriginal people and local Aboriginal Health Services will be supported to participate.
Duration	January 2016 – September 2016 strategic planning. September 2016 – December 2016 commissioning services. October 2016 – June 2018 service delivery and monitoring and evaluation.
Coverage	General practices across Country WA PHN will be invited to respond. Practices that demonstrate innovation and capacity to test the CPC principles and contribute to the evidence base, may also be invited to participate.
Commissioning approach	Regional CCC's will have input to the commissioning approach/design with Expressions of Interest (EOI) sought from across the Country WA PHN region. The EOI will provide details of key elements of the CPC construct, parameters and funding options within which a general practice can participate. Shortlisted respondents from the EOI process will be engaged on a 1:1 basis to co-create the details of contracts. Appropriate measures and indicators (including PREMs and PROMs) will be agreed in partnership with general practices and their associated allied health providers and/or practice networks.
Commissioning approach	Six monthly reporting is expected to include identification of the barriers and enablers to delivery of the CPC model. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback. Third party evaluation of the program as a whole will be conducted by a research partner, providing an evidence base to inform future scaling and implementation.
Performance Indicator	Using the Canterbury Health System Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care - output measure; • Decreased acute care rate/Increased planned care rate – output measure;

[13] PHN Needs Assessment, priority 4: System navigation and integration to help people get the right services at the right time and in the right place, h. Commission strategies which incorporate service integration, consortia approaches person-centred support and system navigation

Proposed Activities		
	• Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; and • People are seen and treated early – process measure.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the regional primary health plan.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth Funding.
	$0	Other funding sources. Refer to Commonwealth Funding NP 2.1.2 above.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.3.1 - Kimberley chronic conditions: integrated care coordination (new)**
Description of Activity	The Kimberley chronic conditions: integrated care program to be commissioned in 2017-18 will build on initiatives in the Kimberley currently providing primary health care through chronic disease coordinators in two Aboriginal medical services in the region. The expanded Kimberley integrated care program will be a product of a joint WACHS/Country WA PHN Services plan where priority is given to service models which support each other to ensure that people in transition from hospital to community are provided with continuity of care and management (especially to remote communities) and attention is paid to Kimberley/Perth transitions for specialist care related to chronic disease treatment and management. Current services will be reoriented to this aim of linking with the CPC models (described at 2.3.2 below) where possible and other multidisciplinary care planning and coordination models, which incorporate tele health capabilities and other technical solutions.
Collaboration	Country WA PHN will collaborate with WACHS, Rural Health West and local Aboriginal health planning groups to ensure that commissioned services are integrated with local needs, existing coordinated services and shared strategic directions developed in 2016 – 17.
Indigenous Specific	Yes. A number of programs within the integrated care suite of services in the Kimberley will specifically target Aboriginal people. These services will be designed with Integrated Team Care Program funding in mind.
Duration	July 2017 – June 2018
Coverage	Coverage is the Kimberley region within the Country WA PHN, with a focus especially on remote communities in the region.
Commissioning approach	Joint Country WA PHN, WACHS, Rural Health West commissioning and Services will be undertaken with the option of an approach to market that specifies integration through consortia or other partnership models. The commissioning approach will be guided by the Kimberley Regional CCC.

Proposed Activities		
Performance Indicator	The outcomes framework developed to plan and evaluate the services commissioned by the Country WA PHN will be available to providers for program development. It will also be available for use by other stakeholders in the primary care sector. The outcomes framework draws upon the Canterbury Health System Outcomes Framework[14]. It is anticipated that the outcomes framework will include a suite of indicators (process, output and outcome). Indicators will be developed in collaboration with the community, providers and other stakeholders, utilising the principles of: • Minimising the duplication in data collection and reporting for providers wherever possible; • Provision of timely and responsive feedback on performance to service providers; and • Person Centred performance measurement, utilising de-identified data wherever possible. Providers will be supported to develop their capacity to identify and report appropriate outcomes and indicators. Examples of appropriate indicators using the Canterbury Framework are: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; and • People are seen and treated early – process measure.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the regional primary health plan.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth – 16/17 Flexible funding and further investment in Integrated care models. Refer to Commonwealth Funding at NP 1.3.1 and NP 1.3.2 above.
	$0	Contributions from WACHS and Rural Health West as identified in the joint Services plan.

14 Canterbury Health System Outcomes Framework, Canterbury Clinical Network, http://ccn.health.nz/Resources/OutcomesFramework.aspx, last accessed 15/04/16

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.3.2 - Kimberley Comprehensive Primary Care Practice Transformation Program (new)**
Description of Activity	The CPC program will implement transformation strategies that can be embedded in Kimberley General Practice. The program will provide an understanding of and evidence for rolling out this model across the wider GP system[15]. Practice Transformation activities which support General Practice to transition to a more integrated team-care approach underpinned by the Building Blocks of High Performing Primary Care[16] and the Quadruple Aim.[17] Kimberley General Practices (including Aboriginal Medical Services where appropriate) will be given some flexibility to test and recommend the most effective mechanisms to support locally responsive team-based care. Practices will work with a range of services and providers to best manage the individual needs of enrolled patients[18]. The PHN will support participating practices by: • Investing in knowledge and GP leadership of Comprehensive Primary Care principles and best practice; • Implementation of the 10 Building Blocks of High Performing Primary Care; • Measuring the impact of quality metrics and developing practice dashboards; • Reinforcing primary care as the foundation for integrated care; • Strengthening collegiality and change readiness among GPs, allied health providers, WACHS and internally; and • Building practice capability in team care arrangements including self-management for enrolled patients.

[15] PHN Needs Assessment, Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions, b. Assist GPs in the management of multiple morbidities and complex care by establishing integrated care pathways in partnership with State and Area Health Services, GPs and other clinicians

[16] Bodenheim. T, Ghorob. A, Willard-Grace. R, Grumbach. K. The 10 Building Blocks of High Performing Primary Care. Annals of Family Medicine. Mar-Apr 2014.

[17] Bodenheim. T, Sinsky. C. From Triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine. Nov-Dec 2014.

[18] PHN Needs Assessment, priority 5: Capable workforce tailored to these priorities, g. Develop strategies to increase the capacity of Multi-disciplinary team to understand and implement the concept of person centred wrap around care coordination

Proposed Activities	
Description of Activity	Patient and clinician feedback and outcomes will be measured throughout the implementation and changes will be made to improve the model throughout the duration. Patients with chronic conditions (including mental health), which may be unstable or poorly controlled, and/or recent frequent admissions to hospital will be targeted to participate[19].
Collaboration	GP and education training bodies, professional colleges, universities, GP's in the region and those involved in the innovation hub, other WA PHNs, health service providers and Patients, Family and Carers.
Indigenous Specific	There will be a focus on practices in the Kimberley providing primary health care to Aboriginal people and local Aboriginal Health Services will be supported to participate.
Duration	January 2016 – September 2016 strategic planning September 2016 – December 2016 procuring services October 2016 – June 2018 service delivery and monitoring and evaluation
Coverage	General practices across Country WA PHN will be invited to respond. Practices that demonstrate innovation and capacity to test the CPC principles and contribute to the evidence base may also be invited to participate.
Commissioning approach	Regional CCC's will have input to the commissioning approach/design with Expressions of Interest (EOI) sought from across the Country WA PHN region. The EOI will provide details of key elements of the CPC construct, parameters and funding options within which a general practice can participate. Shortlisted respondents from the EOI process will be engaged on a 1:1 basis to co-create the details of contracts. Appropriate measures and indicators (including PREMs and PROMs) will be agreed in partnership with general practices and their associated allied health providers and/or practice networks.
Commissioning Approach	Six monthly reporting is expected to include identification of the barriers and enablers to delivery of the CPC model. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback. Third party evaluation of the program as a whole will be conducted by a research partner, providing an evidence base to inform future scaling and implementation.
Performance Indicator	Using the Canterbury Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; • People are seen and treated early – process measure.

[19] PHN Needs Assessment, priority 4: System navigation and integration to help people get the right services at the right time and in the right place, h. Commission strategies which incorporate service integration, consortia approaches person-centred support and system navigation

Proposed Activities		
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the regional primary health plan.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth Funding..
	$0	Other Funding - Refer to Commonwealth Funding NP 2.1.2 above

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.4.1 - Midwest chronic conditions: integrated care (New)**
Description of Activity	The Midwest Chronic Conditions: Integrated Care program aims to implement models of care providing people with chronic conditions, especially those with multi-morbidities to ensure seamless access to condition maintenance and self-management strategies and education through improved service integration and coordination. The integrated care model offered in the Midwest and Gascoyne regional centres will link with the CPC model described at 2.4.2 and will: • Focus areas will be on the interface between hospital to community, improving transitions and for people in at risk groups (Aboriginal people, people with serious and persistent mental illness and people with a developed chronic condition); • Provide sufficient flexibility for redistribution of resources away from individually funded and unconnected services to a planned and joined up service system; and • Provide sufficient flexibility to explore a Primary Health Nurse led model with GP support and input via telehealth or other technical supports in smaller and isolated communities. The PHN will: • Redirect funding currently allocated to the Gascoyne for allied health services to bolster General Practitioner and Nurse Practitioner services into the at risk remote and Aboriginal communities and the establishment of a primary health service plan in conjunction with the WACHS and relevant organisations; • Concurrently explore opportunities to direct funding from 19(2) into an integrated allied health service across the Gascoyne, centred in Exmouth and Carnarvon; and • Improve equity across the Midwest/Murchison regions and focus on leveraging effort through a combined Services plan with WACHS in this region and exploring more effective programs designed to address the main. In this respect all the service effort directed towards the Aboriginal community, working collaboratively with the Regional Aboriginal Health Planning Forum and relevant stakeholders, building on existing culturally appropriate and respected approaches evidenced by some organisations.

Proposed Activities	
Collaboration	The PHN will work in collaboration with the WACHS as joint commissioning and Services plans are developed. Additionally the team will collaborate with Rural Health West, the WA MHC and local health advisory councils to develop targeted co-commissioning and an integrated service delivery plan for the region. Specific services targeted at the Aboriginal community will be developed in partnership with the Geraldton Regional Aboriginal Medical Services. In order to maximise joint funding opportunities for the Gascoyne region the Midwest team will work with the Carnarvon Medicare 19 (2) Exemption Advisory Committee. To ensure the sustainability of services with a capable workforce the Country WA PHN Midwest team will continue to work with Rural Health Education and Training organisations to upskill the primary health workforce and co-develop training opportunities for the region.
Indigenous Specific	Yes. A number of Programs within the integrated care suite of services in the Midwest will specifically target Aboriginal people. These services will be designed with Integrated Team Care Program funding in mind.
Duration	April 2017 - June 2018.
Coverage	The Midwest region (includes Murchison and Gascoyne) in the Country WA PHN.
Commissioning approach	The commissioning approach planned is intended to create an integrated approach through consortia expressions of interest. The co-commissioning of services with WACHS is a high priority for Country WA PHN. All proposals will demonstrate coordination and integration of services both within the flexible funding for chronic condition care and management across the region. Proposals will be required to integrate with the GP practices participating the CPC program in the region. The Regional Clinical Commissioning Committee will engage with local stakeholders in the co-design of models of service, tailored to the identified local priorities.

Proposed Activities		
Performance Indicator	It is anticipated that the outcomes framework will include a suite of indicators (process, output and outcome). Indicators will be developed in collaboration with the community, providers and other stakeholders, utilising the principles of: • Minimising the duplication in data collection and reporting for providers wherever possible; • Provision of timely and responsive feedback on performance to service providers; and • Person Centred performance measurement, utilising de-identified data wherever possible. Providers will be supported to develop their capacity to identify and report appropriate outcomes and indicators. Examples of appropriate indicators using the Canterbury Framework are: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care - output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; and • People are seen and treated early – process measure.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the regional primary health plan.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth – 16/17 budget. Refer Commonwealth Funding NP 1.4 above.
	$0	Contributions from WACHS and Rural Health West as identified in the joint Services plan.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.4.2 - Midwest Comprehensive Primary Care Practice Transformation Program (new)**
Description of Activity	The CPC program will implement transformation strategies that can be embedded in Midwest General Practice The program will provide an understanding of and evidence for rolling out this model across the wider GP system[20]. Practice Transformation activities which support General Practice to transition to a more integrated team-care approach underpinned by the Building Blocks of High Performing Primary Care[21] and the Quadruple Aim.[22] Country WA General Practices (and Aboriginal Medical Services where appropriate) will be given some flexibility to test and recommend the most effective mechanisms to support locally responsive team-based care. Practices will work with a range of services and providers to best manage the individual needs of enrolled patients[23]. The PHN will support participating practices by: • Investing in knowledge and GP leadership of Comprehensive Primary Care principles and best practice; • Implementation of the 10 Building Blocks of High Performing Primary Care; • Measuring the impact of quality metrics and developing practice dashboards; • Reinforcing primary care as the foundation for integrated care; • Strengthening collegiality and change readiness among GPs, allied health providers, WACHS and internally; and • Building practice capability in team care arrangements including self-management for enrolled patients.

[20] PHN Needs Assessment, Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions, b. Assist GPs in the management of multiple morbidities and complex care by establishing integrated care pathways in partnership with State and Area Health Services, GPs and other clinicians

[21] Bodenheim. T, Ghorob. A, Willard-Grace. R, Grumbach. K. The 10 Building Blocks of High Performing Primary Care. Annals of Family Medicine. Mar-Apr 2014.

[22] Bodenheim. T, Sinsky. C. From Triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine. Nov-Dec 2014.

[23] PHN Needs Assessment, priority 5: Capable workforce tailored to these priorities, g. Develop strategies to increase the capacity of Multi-disciplinary team to understand and implement the concept of person centred wrap around care coordination

Proposed Activities	
Description of Activity	Patient and clinician feedback and outcomes will be measured throughout the implementation and changes will be made to improve the model throughout the duration. Patients with chronic conditions (including mental health), which may be unstable or poorly controlled, and/or recent frequent admissions to hospital will be targeted to participate[24].
Collaboration	GP and education training bodies, professional colleges, universities, GP's in the region and those involved in the innovation hub, Country WA PHN, and Patients, Family and Carers.
Indigenous Specific	There will be a focus on practices in the Midwest providing primary health care to Aboriginal people and local Aboriginal Medical Services will be supported to participate.
Duration	January 2016 – September 2016 strategic planning. September 2016 – December 2016 procuring services. October 2016 – June 2018 service delivery and monitoring and evaluation.
Coverage	General practices across Country WA PHN will be invited to respond. Practices that demonstrate innovation and capacity to test the CPC principles and contribute to the evidence base, may also be invited to participate.
Commissioning approach	Regional CCC's will have input to the commissioning approach/design with Expressions of Interest (EOI) sought from across the Country WA PHN region. The EOI will provide details of key elements of the CPC construct, parameters and funding options within which a general practice can participate. Shortlisted respondents from the EOI process will be engaged on a 1:1 basis to co-create the details of contracts. Appropriate measures and indicators (including PREMs and PROMs) will be agreed in partnership with general practices and their associated allied health providers and/or practice networks.
Commissioning Approach	Six monthly reporting is expected to include identification of the barriers and enablers to delivery of the CPC model. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback. Third party evaluation of the program as a whole will be conducted by a research partner, providing an evidence base to inform future scaling and implementation.

[24] PHN Needs Assessment, priority 4: System navigation and integration to help people get the right services at the right time and in the right place, h. Commission strategies which incorporate service integration, consortia approaches person-centred support and system navigation

Proposed Activities		
Performance Indicator	Using the Canterbury Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; and • People are seen and treated early – process measure.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the Regional primary health plan.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth Funding.
	$0	Refer to Commonwealth Funding NP 2.1.2 above.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.5.1 - Pilbara chronic conditions: integrated care (new)**
Description of Activity	Flexible funding for chronic conditions: integrated care, will be directed towards the needs based, locally developed Services plan developed with WACHS and Rural Health West in the Pilbara. • There will be a focus upon the feasibility of care coordination and navigation strategies in the outer parts of the region particularly in remote communities; • Two existing targeted chronic disease nurse led programs in the region will be explored for more general application in smaller communities; • Integrated Care will link with the Comprehensive Primary Care concept which will be implemented in the larger population centres. Nurse led care and with other models of coordination and management will be explored in smaller centres. Country WA PHN will focus on the patient's journey from hospital to GP care in the community and from the Pilbara to other large centres for treatment e.g. Perth for specialist services; and • It is anticipated that models of navigation such as hospital to community Aboriginal liaison workers will be explored targeting vulnerable people to reduce hospital readmission rates. The intention of the WA Country PHN in this region is to redirect services in 2017-18 in accordance with an agreed Services plan with WACHS after full consultation with the Aboriginal Regional Health Planning Forum.
Collaboration	Collaboration between Country WA Health Service, Rural Health West, Pilbara Regional Aboriginal Health Forum and Aboriginal Health Services will inform the development of a shared health services plan and the regional chronic conditions Services plan for the Pilbara. The establishment of regional consortia to facilitate effective delivery will be a feature of new service models, with primary health organisations, Aboriginal medical services, general practice and allied health clinicians working collaboratively to deliver shared patient outcomes.

Proposed Activities	
Collaboration	A capable and skilled rural health workforce remains a major issue for the delivery of high quality primary healthcare in the Pilbara (RA5) due to high staff turnover and difficulty in attracting and retaining suitably qualified workforce. As members of the Greater Northern Australia Regional Training Network (GNARTN) the PHN will work in collaboration with WACHS to build the health workforce utilising a common planning methodology and workforce recruitment strategy including growing the local Aboriginal and Torres Strait Islander workforce and exploring options for placement and upskilling of allied health practitioners to rural generalist positions. The PHN will collaborate with WACRH & Karratha Super Clinic, Wirraka Maya Aboriginal Medical Service in Hedland and other rural health education and training providers to promote and support clinical skill development, encourage mutually agreed opportunities for student supervision and the auspicing of clinical placements and networking opportunities. Contracts with service providers will include clauses and outcome reporting requirements to support workforce in this capacity.
Indigenous Specific	Yes. A number of programs within the integrated care suite of services in the Pilbara will specifically target Aboriginal people. These services will be designed with Integrated Team Care Program funding in mind.
Duration	July 2017 – June 2018.
Coverage	Pilbara region.
Commissioning approach	The commissioning approach planned is intended to create an integrated approach through consortia expressions of interest. The co-commissioning of services with WACHS is a high priority for Country WA PHN. All proposals will demonstrate coordination and integration of services both within the flexible funding for chronic condition care and management across the region. Proposals will be required to integrate with the GP practices implementing the CPC program in the region. The Regional Clinical Commissioning Committee will engage with local stakeholders in the co-design of models of service, tailored to the identified local priorities.
Local Performance Indicator target	The development of targets for each indicator is to be done in collaboration with stakeholders in WACHS, Rural Health West and service providers.

Proposed Activities		
Performance Indicator	It is anticipated that the outcomes framework will include a suite of indicators (process, output and outcome). Indicators will be developed in collaboration with the community, providers and other stakeholders, utilising the principles of: • Minimising the duplication in data collection and reporting for providers wherever possible; • Provision of timely and responsive feedback on performance to service providers; and • Person centred performance measurement, utilising de-identified data wherever possible Providers will be supported to develop their capacity to identify and report appropriate outcomes and indicators. Using the Canterbury Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; • People are seen and treated early – process measure.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth Flexible funds 16/17 with additional scope for funds for integrated services. Refer to Commonwealth Funding NP 1.5 above.
	$0	Contributions from WACHS and Rural Health West as identified in the joint Services plan.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.5.2 - Pilbara Comprehensive Primary Care Practice Transformation Program (new)**
Description of Activity	The CPC program will implement transformation strategies that can be embedded in Pilbara General Practice The program will provide an understanding of and evidence for rolling out this model across the wider GP system[25]. Practice Transformation activities which support General Practice to transition to a more integrated team-care approach underpinned by the Building Blocks of High Performing Primary Care[26] and the Quadruple Aim.[27] Country WA General Practices (and Aboriginal Medical Service where appropriate) will be given some flexibility to test and recommend the most effective mechanisms to support locally responsive team-based care. Practices will work with a range of services and providers to best manage the individual needs of enrolled patients[28]. The PHN will support participating practices by: • Investing in knowledge and GP leadership of Comprehensive Primary Care principles and best practice; • Implementation of the 10 Building Blocks of High Performing Primary Care; • Measuring the impact of quality metrics and developing practice dashboards; • Reinforcing primary care as the foundation for integrated care; • Strengthening collegiality and change readiness among GPs, allied health providers, WACHS and internally; and • Building practice capability in team care arrangements including self-management for enrolled patients. •

[25] PHN Needs Assessment, Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions, b. Assist GPs in the management of multiple morbidities and complex care by establishing integrated care pathways in partnership with State and Area Health Services, GPs and other clinicians

[26] Bodenheim. T, Ghorob. A, Willard-Grace. R, Grumbach. K. The 10 Building Blocks of High Performing Primary Care. Annals of Family Medicine. Mar-Apr 2014.

[27] Bodenheim. T, Sinsky. C. From Triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine. Nov-Dec 2014.

[28] PHN Needs Assessment, priority 5: Capable workforce tailored to these priorities, g. Develop strategies to increase the capacity of Multi-disciplinary team to understand and implement the concept of person centred wrap around care coordination

Proposed Activities	
Description of Activity	Patient and clinician feedback and outcomes will be measured throughout the implementation and changes will be made to improve the model throughout the duration. Patients with three or more chronic conditions (including mental health), which may be unstable or poorly controlled, and/or recent frequent admissions to hospital will be targeted to participate[29].
Collaboration	GP and education training bodies, professional colleges, universities, GP's in the region and those involved in the innovation hub, other WA PHNs, health service providers and Patients, Family and Carers.
Indigenous Specific	There will be a focus on practices in the Pilbara providing primary health care to Aboriginal people and local Aboriginal Medical Services will be supported to participate.
Duration	January 2016 – September 2016 strategic planning. September 2016 – December 2016 procuring services. October 2016 – June 2018 service delivery and monitoring and evaluation.
Coverage	General practices across Country WA PHN will be invited to respond. Practices that demonstrate innovation and capacity to test the CPC principles and contribute to the evidence base, may also be invited to participate.
Commissioning approach	Regional CCC's will have input to the commissioning approach/design with Expressions of Interest (EOI) sought from across the Country WA PHN region. The EOI will provide details of key elements of the CPC construct, parameters and funding options within which a general practice can participate. Shortlisted respondents from the EOI process will be engaged on a 1:1 basis to co-create the details of contracts. Appropriate measures and indicators (including PREMs and PROMs) will be agreed in partnership with general practices and their associated allied health providers and/or practice networks. Six monthly reporting is expected to include identification of the barriers and enablers to delivery of the CPC model. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback.
Commissioning Approach	Third party evaluation of the program as a whole will be conducted by a research partner, providing an evidence base to inform future scaling and implementation.
Performance Indicator	Using the Canterbury Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure;

[29] PHN Needs Assessment, priority 4: System navigation and integration to help people get the right services at the right time and in the right place, h. Commission strategies which incorporate service integration, consortia approaches person-centred support and system navigation

Proposed Activities		
	• Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; People are seen and treated early – process measure.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the regional primary health plan.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth Funding.
	$0	Refer to 2.1.2 Commonwealth Funding above.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.6.1 - South West Integrated Care (new)**
Description of Activity	The design of the service will prioritise service co-ordination to inform, enable and support patients to navigate the healthcare system. The approach will be a bio-psychosocial one and will seek to integrate with the Comprehensive Primary Care model (CPC) in the larger coastal hubs. The service will also have linkages with Mental Health service navigation and coordination models and the Mental Health Nurse Program (refer WA Country PHN Mental Health Annual Activity Plan). A collaborative approach between General Practices, the South West Aboriginal Medical Service and health service providers will be central to the approach, supporting patients to access a comprehensive, interdisciplinary health care team service. The aims of the service are to: • Manage chronic and complex conditions, including mental health within primary health care and community based social services; • Minimise potentially preventable hospitalisations associated with chronic disease and multiple morbidities; • Maximise communication between hospitals and primary health care services to minimise potential for readmission; • Minimise the emergence of associated conditions enabling optimal self-management for patients; • Ensure patients have access to integrated and coordinated service response pathways, consistent with the manifestation of their health care needs; and • Enable patients to engage in their health care, and determine optimal health and wellbeing outcomes.
Collaboration	Collaboration with key stakeholders in the region is a key strategy in design and implementation of the Program. These include West Australian Country Health Service; Mental Health Commission; general practitioners; allied health services; South West Aboriginal Medical Service; NGOs in the social services sector; University of Western Australia and Rural Clinical School.
Indigenous Specific	South West Aboriginal Medical Service will be one of the targeted practices and After Hours Program funding will be accessed to complete the model's comprehensive scope and coverage.

Proposed Activities		
Duration	October 2016 - June 2018. Evaluation throughout and finalised by March 2018 to inform any future direction/continuation/refinement or development of the Program. Expressions of interest will be disseminated in September 2016, with outcomes of EOIs determined by November 2016. Services to commence January 2017.	
Coverage	South West health region, including Bunbury, Busselton and Warren Blackwood health districts.	
Commissioning approach	The South West Regional CCC will inform the commissioning approach based on their clinical expertise and knowledge of health needs in the region. A direct engagement or Expression of Interest will be the procurement strategy and specifications will be based on the findings of the Naïve Enquiry which will establish best practice parameters for the model.	
Performance Indicator	Chronic disease outcome measures, for example (diabetes improved HbA1c%);Patient reported outcome measures; WACHS hospital admission quantitative data; Clinician/service provider qualitative data ; and Number of DNAs.	
Local Performance Indicator target	Targets will be negotiated with the service provider.	
Data source	Service Providers	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth 16/17 budget with additional investment in the region from flexible funding, CPC allocation to the region and innovation funds. Refer to Commonwealth Funding NP 1.6.1.
	$0	Funding from other sources

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.6.2 - South West Comprehensive Primary Care Practice Transformation Program (new)**
Description of Activity	The CPC program will implement transformation strategies that can be embedded in South West General Practice. The program will provide an understanding of and evidence for rolling out this model across the wider GP system[30]. Practice Transformation activities which support General Practice to transition to a more integrated team-care approach underpinned by the Building Blocks of High Performing Primary Care[31] and the Quadruple Aim.[32] Country WA General Practices (and Aboriginal Medical Service where appropriate) will be given some flexibility to test and recommend the most effective mechanisms to support locally responsive team-based care. Practices will work with a range of services and providers to best manage the individual needs of enrolled patients[33]. The PHN will support participating practices by: • Investing in knowledge and GP leadership of Comprehensive Primary Care principles and best practice; • Implementation of the 10 Building Blocks of High Performing Primary Care; • Measuring the impact of quality metrics and developing practice dashboards; • Reinforcing primary care as the foundation for integrated care; • Strengthening collegiality and change readiness among GPs, allied health providers, WACHS and internally; and • Building practice capability in team care arrangements including self-management for enrolled patients. •

[30] PHN Needs Assessment, Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions, b. Assist GPs in the management of multiple morbidities and complex care by establishing integrated care pathways in partnership with State and Area Health Services, GPs and other clinicians

[31] Bodenheim. T, Ghorob. A, Willard-Grace. R, Grumbach. K. The 10 Building Blocks of High Performing Primary Care. Annals of Family Medicine. Mar-Apr 2014.

[32] Bodenheim. T, Sinsky. C. From Triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine. Nov-Dec 2014.

[33] PHN Needs Assessment, priority 5: Capable workforce tailored to these priorities, g. Develop strategies to increase the capacity of Multi-disciplinary team to understand and implement the concept of person centred wrap around care coordination

Proposed Activities	
Description of Activity	Patient and clinician feedback and outcomes will be measured throughout the implementation and changes will be made to improve the model throughout the duration. Patients with three or more chronic conditions (including mental health), which may be unstable or poorly controlled, and/or recent frequent admissions to hospital will be targeted to participate[34].
Collaboration	GP and education training bodies, professional colleges, universities, GP's in the region and those involved in the innovation hub, other WA PHNs, health service providers and Patients, Family and Carers.
Indigenous Specific	There will be a focus on practices in the South West providing primary health care to Aboriginal people and local Aboriginal Medical Services will be supported to participate.
Duration	January 2016 – September 2016 strategic planning. September 2016 – December 2016 procuring services. October 2016 – June 2018 service delivery and monitoring and evaluation.
Coverage	General practices across Country WA PHN will be invited to respond. Practices that demonstrate innovation and capacity to test the CPC principles and contribute to the evidence base, may also be invited to participate.
Commissioning approach	Regional CCC's will have input to the commissioning approach/design with Expressions of Interest (EOI) sought from across the Country WA PHN region. The EOI will provide details of key elements of the CPC construct, parameters and funding options within which a general practice can participate. Shortlisted respondents from the EOI process will be engaged on a 1:1 basis to co-create the details of contracts. Appropriate measures and indicators (including PREMs and PROMs) will be agreed in partnership with general practices and their associated allied health providers and/or practice networks. Six monthly reporting is expected to include identification of the barriers and enablers to delivery of the CPC model. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback. Third party evaluation of the program as a whole will be conducted by a research partner, providing an evidence base to inform future scaling and implementation.
Performance Indicator	Using the Canterbury Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure;

[34] PHN Needs Assessment, priority 4: System navigation and integration to help people get the right services at the right time and in the right place, h. Commission strategies which incorporate service integration, consortia approaches person-centred support and system navigation

Proposed Activities		
	• Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; and • People are seen and treated early – process measure.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the regional primary health plan.	
Data source	Service Providers.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth Funding.
	$0	Funding from other sources - Refer to 2.1.2 Commonwealth Funding above

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity Title / Reference (eg. NP 1.1)	**NP 2.7.1 - Wheatbelt Chronic conditions self-management and integrated care projects (new)**
Description of Activity	The aim of the program is to improve the health and wellbeing of people living in the Wheatbelt by: • Providing and maintaining access to supplementary allied health and primary care services across the Wheatbelt region that are based on identified health needs in each community. Targeted vulnerable population groups will include Aboriginal people, low income, and remote communities, those with disabilities, CALD groups; • Promoting coordinated multidisciplinary team based approaches to the provision of integrated primary health care services; • Establishing and maintaining effective community consultation practices for the planning, management, flexible delivery and ongoing review of the program; • Provide and maintain access to relevant health promotion and preventative health programs and activities designed to promote health and wellbeing; • Supporting people in the Wheatbelt to adopt or modify behaviour to better manage their health and wellbeing; and • Utilising key learning's from the existing Primary Health Nurse Practitioner Program to explore expanding or developing this approach further. The Program uses a collaborative practice approach, and aims to triage, coordinate and case manage people with chronic health conditions in areas with limited access to general practitioners.
Collaboration	General practice – referral and location of outreach services. Current and potential service providers in the region. WACHS – joint Services plan to prevention duplication and ensure regional coverage and service relevance.
Indigenous Specific	Noongar Boodjar Group Diabetes Clinics are implemented for Aboriginal people. Services are available for Aboriginal and non-Aboriginal people and it is anticipated opportunities to extend the reach of such clinics will be explored as part of the design process.
Duration	April 2017 - June 2018.
Coverage	Wheatbelt region.

Proposed Activities		
Commissioning approach	Joint Services plan will be developed in partnership with WACHS Wheatbelt. This plan will finalise priorities in the region to be supported through a combined WACHS and WAPHA funded primary health plan. These activities could be integrated into the CPC Model. General practices will be central to this approach, from which patients will access a comprehensive, interdisciplinary health care team service in addressing their health care needs. The Regional Clinical Commissioning Committee will lead the process to develop co-designed models of service delivery.	
Performance Indicator	It is anticipated that the outcomes framework will include a suite of indicators (process, output and outcome). Indicators will be developed in collaboration with the community, providers and other stakeholders, utilising the principles of: • Minimising the duplication in data collection and reporting for providers wherever possible; • Provision of timely and responsive feedback on performance to service providers; and • Person Centred performance measurement, utilising de-identified data wherever possible. Providers will be supported to develop their capacity to identify and report appropriate outcomes and indicators. Using the Canterbury Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; • People are seen and treated early – process measure.	
Local Performance Indicator target	The development of targets for each indicator is to be done in collaboration with stakeholders in WACHS, Rural Health West and service providers.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth funding. Refer to NP 1.7 above.
	$0	

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity Title / Reference (eg. NP 1.1)	**NP 2.7.2 – Wheatbelt Comprehensive Primary Care Practice Transformation Program (new)**
Description of Activity	The CPC program will implement transformation strategies that can be embedded in Wheatbelt General Practice. The program will provide an understanding of and evidence for rolling out this model across the wider GP system[35]. Practice Transformation activities which support General Practice to transition to a more integrated team-care approach underpinned by the Building Blocks of High Performing Primary Care[36] and the Quadruple Aim.[37] Country WA General Practices will be given some flexibility to test and recommend the most effective mechanisms to support locally responsive team-based care. Practices will work with a range of services and providers to best manage the individual needs of enrolled patients[38]. The PHN will support participating practices by: • Investing in knowledge and GP leadership of Comprehensive Primary Care principles and best practice; • Implementation of the 10 Building Blocks of High Performing Primary Care; • Measuring the impact of quality metrics and developing practice dashboards; • Reinforcing primary care as the foundation for integrated care; • Strengthening collegiality and change readiness among GPs, allied health providers, WACHS and internally; and • Building practice capability in team care arrangements including self-management for enrolled patients.

[35] PHN Needs Assessment, Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions, b. Assist GPs in the management of multiple morbidities and complex care by establishing integrated care pathways in partnership with State and Area Health Services, GPs and other clinicians

[36] Bodenheim. T, Ghorob. A, Willard-Grace. R, Grumbach. K. The 10 Building Blocks of High Performing Primary Care. Annals of Family Medicine. Mar-Apr 2014.

[37] Bodenheim. T, Sinsky. C. From Triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine. Nov-Dec 2014.

[38] PHN Needs Assessment, priority 5: Capable workforce tailored to these priorities, g. Develop strategies to increase the capacity of Multi-disciplinary team to understand and implement the concept of person centred wrap around care coordination

Proposed Activities	
Description of Activity	Patient and clinician feedback and outcomes will be measured throughout the implementation and changes will be made to improve the model throughout the duration. Patients with chronic conditions (including mental health), which may be unstable or poorly controlled, and/or recent frequent admissions to hospital will be targeted to participate[39].
Collaboration	GP and education training bodies, professional colleges, universities, GP's in the region and those involved in the innovation hub, Country WA PHN, and Patients, Family and Carers.
Indigenous Specific	There will be a focus on practices in the Wheatbelt providing primary health care to Aboriginal people and local Aboriginal Medical Services will be supported to.
Duration	January 2016 – September 2016 strategic planning. September 2016 – December 2016 procuring services. October 2016 – June 2018 service delivery and monitoring and evaluation.
Coverage	General practices across Country WA PHN will be invited to respond. Practices that demonstrate innovation and capacity to test the CPC principles and contribute to the evidence base, may also be invited to participate.
Commissioning approach	Regional CCC's will have input to the commissioning approach/design with Expressions of Interest (EOI) sought from across the Country WA PHN region. The EOI will provide details of key elements of the CPC construct, parameters and funding options within which a general practice can participate. Shortlisted respondents from the EOI process will be engaged on a 1:1 basis to co-create the details of contracts. Appropriate measures and indicators (including PREMs and PROMs) will be agreed in partnership with general practices and their associated allied health providers and/or practice networks. Six monthly reporting is expected to include identification of the barriers and enablers to delivery of the CPC model. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback.
Commissioning Approach	Third party evaluation of the program as a whole will be conducted by a research partner, providing an evidence base to inform future scaling and implementation.

[39] PHN Needs Assessment, priority 4: System navigation and integration to help people get the right services at the right time and in the right place, h. Commission strategies which incorporate service integration, consortia approaches person-centred support and system navigation

Proposed Activities		
Performance Indictor	Using the Canterbury Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; • People are seen and treated early – process measure.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with the provider. Targets will be identified and agreed as part of the commissioning process and the regional primary health plan.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$0	Commonwealth Funding.
	$0	Refer to Commonwealth Funding 2.1.2 above.

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity Title / Reference (eg. NP 1.1)	**NP 3 - Country-wide Chronic Disease Education and Management (new)**
Description of Activity	This activity will enable the transition of patients from the current Flexibly Funded services to the new model of integrated care. Strategies will be developed in consultation with current service providers as part of their 'transition-out' plans. Patients will be linked with new service providers and General Practice as appropriate and will also be linked with a suite of Tele-health services which will be supported to play a vital role in assisting people living with chronic disease to develop self-management strategies to avert acute episodes; manage their condition and to adopt lifestyle strategies to prevent the exacerbation of symptoms or new symptoms. Tele-health services will link with local services and will supplement the provision of face to face services and will reduce the need for patients to travel from their home communities to larger regional or metropolitan areas to receive services. The Tele-health services will assist GPs to manage patients with chronic conditions when allied health/education services are not available locally. The aim of the State-wide Chronic Disease Education and Management strategy in Year 1 – is to provide Diabetes and COPD Management information to GPs, Patients, Practice Nurses and allied health professionals. In year 2 the program will be extended to include Cardiac conditions and other interventions which may be delivered remotely. The Tele-health services are operating in a limited way through funding from WACHS and it is the intention of Country WA PHN to co-commission a service with wider reach and utility.
Collaboration	Country WA PHN will work in collaboration with WA Country Health Services (WACHS), Diabetes WA and the Asthma Foundation and other relevant organisations to fully develop the State-wide service.
Indigenous Specific	The service will target hard to reach populations living with chronic conditions, particularly in remote areas. The Tele-health services will be co-designed with Aboriginal Medical Services for cultural safety and appropriateness.
Duration	July 2016 – June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

Proposed Activities		
Commissioning approach	Commissioning will be done through a direct engagement approach.	
Performance Indicator	Using the Canterbury Outcomes Framework the following indicators are suggested: • People are well and healthy in their own homes and communities – outcome measure; • Increased collaborative plans for care – output measure; • Decreased acute care rate/Increased planned care rate – output measure; • Acute community response – process measure; • Access to care improved – process measure; • 24 hour access to primary care intervention – process measure; and • People are seen and treated early – process measure.	
Local Performance Indicator target	Targets to be negotiated.	
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$2,336,840	Commonwealth Funding
	$0	nil

Proposed Activities	
Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity Title / Reference (eg. NP 1.1)	**NP 4 - Country-wide mental health stepped care transitional arrangements (new)**
Description of Activity	This activity will enable the transition of patients from the current ATAPS / MHSRRA funded services to the new model of stepped care for mental health. Strategies will be developed in consultation with current service providers as part of their 'transition-out' plans. This activity will be provided over a three month period. Patients will be linked with new service providers and General Practice as appropriate and will also be able to access a suite of Tele-health mental health services which will be commissioned or engaged to play a vital role in assisting people currently accessing mental health support through ATAPS and MHSRRA programs. See Country WA PHN Mental Health Activity Plan 2016 -17 for further detail. This transitional funding will ensure patients are able to complete any cycles of care currently being provided and will, where necessary, make warm-referrals and linkages with other providers should care be required beyond the three month transition period.
Collaboration	Country WA PHN will work in collaboration with existing ATAPS/MHSRRA providers, any new mental health service providers, GPs, and other relevant organisations.
Indigenous Specific	The service will ensure Aboriginal people currently receiving ATAPS/MHSRRA services are enabled to complete their care or linked with a culturally appropriate Aboriginal mental health or social and emotional wellbeing service provider.
Duration	April 2017 – June 2017.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach	Commissioning will be done through a direct engagement approach with current service providers.
Performance Indicator	Current ATAPS/MHSRRA indicators – ensuring a focus on completion of cycles of care.
Local Performance Indicator target	Targets to be negotiated dependant on the number of clients requiring additional ATAPS services during the three month period.

Proposed Activities		
Data source	Contracted services.	
Planned Expenditure 2016-2017 (GST exc) to match budget	$1,500,000	Commonwealth Funding
	$0	nil

2. Planned core activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding

Proposed support activities	
Activity Title / Reference (eg. OP 1)	**OP 1 – General practice support**
Description of Activity	The PHN facilitates optimal access to integrated primary health care for people with chronic and complex conditions through the development of strong connections across community, health and social service settings at the local level. In delivering its practice support activities the Country WA PHN works in conjunction with Rural Health West to maximise opportunities for support and minimise duplication of effort and resources. The key priority areas are Aboriginal and Torres Strait Islander health, mental health, population health, digital health, health workforce and aged care. The PHN supports general practice by: • Promoting general practice to be the first point of contact in primary health and to sustain ongoing relationships with their patients utilising strategies such as chronic disease management; • Assisting general practitioners in the management of multiple morbidities and complex care by providing on-line HealthPathways; • Conducting practice visits and facilitating networks and collaboration with practice staff; • Assisting general practices to adopt evidence based practice to improve quality of care; • Facilitating ongoing professional development, linking GP's with relevant and topical information; and • Supporting general practices to adopt patient centred models of care with a focus on the CPC program, Mental Health Medical Home, stepped care approach and the Mental Health Nurse Program.
Collaboration	The PHN team works in partnership with a range of stakeholders dependent upon local needs, including but not limited to WA Country Health Service, WA Health, Rural Health West, WAGPET, Aboriginal Medical Services, general practitioners, government agencies, universities, peak bodies, community, health and social care sector organisations.
Duration	July 2016 – June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

Proposed support activities		
Expected Outcome	The expected outcome of this activity is that general practice is supported to continually improve the quality of care for patients, with a focus on keeping patients well in the community. It is expected that initiatives introduced with general practice will see an increase in the: • Implementation of coordinated team care; • Development, implementation and review of care plans; • Use of evidence based practice; • Increased adoption of digital health; and • Adoption of patient centred models of care. These outcomes align to the PHN objectives as they will ensure the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes and will improve the coordination of care to ensure patients receive the right care, in the right place at the right time.	
Planned Expenditure 2016-2017 (GST exc)	$387,475	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed support activities		
Activity Title / Reference (eg. OP 1)	**OP 2 - General practice support – workforce capacity building**	
Description of Activity	The PHN supports general practice to build their workforce capacity in relation to recruitment, retention and regional training through: • Providing workforce training in contemporary models of primary and integrated care in partnership with relevant professional bodies; • supporting Aboriginal health worker training initiatives; • Developing strategies and supporting activities to increase the employment of primary care GP's nurses and nurse practitioners; • Facilitating professional networks and identifying high performing practices for student and graduate placements; • Supporting General Practice in the Practice Transformation aligned to the CPC initiatives outlined earlier in this Plan; and • Working with Rural Health West and other stakeholders on the implementation of the 'Finding My Place' report.	
Collaboration	WAPHA and the PHN will work in collaboration with the following agencies to support the above initiatives - Nursing and Midwifery Office (NMO), WAGPET, RACGP, AMA, ACCRM, Rural Health West, WA Centre for Rural Health, Rural Clinical School, ACHWA, APNA, AAPM, WACHS, WA Health, general practice and universities. Additionally, WAPHA works with the Clinical Training Network to look for opportunities to increase the primary care nursing workforce.	
Duration	July 2016 – June 2018.	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.	
Expected Outcome	The expected outcome of this activity is that general practice is able to build the capacity of their workforce by recruiting and retaining suitably qualified and experienced health professionals who are able to ensure the delivery of efficient and effective medical services for patients, particularly those at risk of poor health outcomes and improving the coordination of care to ensure patients receive the right care, in the right place at the right time. This activity is also aligned to the Commonwealth priority - health workforce.	
Planned Expenditure 2016-2017 (GST exc)	$62,839	Commonwealth funding.
	$0	Funding from other sources (e.g. private organisations, State and territory governments).

Proposed support activities		
Activity Title / Reference (eg. OP 1)	**OP 3 – General practice support - continuous quality improvement**	
Description of Activity	The PHN provides support to general practice in relation to continuous quality improvement by: • Dissemination of research working with the WA General Practitioners Research Group; • Support with accreditation and clinical audits; and • Support with the use and management of data for practice improvement including providing licenses to a suite of applications from PenCS to enable data extraction, integration and analysis.	
Collaboration	WAPHA and the Country WA PHN work collaboratively with general practice, Rural Health West, NPS Medicinewise, research groups and accreditation agencies. The PHN will work in conjunction with Curtin University to manage and govern datasets provided by a number of sources e.g. PenCS, WA Health, general practice and allied health.	
Duration	July 2016 – June 2018.	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.	
Expected Outcome	The expected outcome of this activity is that through the support provided by the PHN team to general practice, there will be an uptake of practice accreditation, and the use of data in the practice to inform quality improvement in health care, thus enabling general practice to increase 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.	
Planned Expenditure 2016-2017 (GST exc)	$86,587	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed support activities	
Activity Title / Reference (eg. OP1)	**OP 4 - General practice support - CQI – HealthPathways**
Description of Activity	HealthPathways is an online health information portal for general practitioners and primary health care clinicians, which assists with managing and referring patients to appropriate services with less waiting times. The HealthPathways team is part of the WAPHA backbone and works in collaboration with WA Health to: • Develop local clinical streams and pathways; • Prioritise pathways; • Identify subject matter experts and working group members; • Localise pathways relevant to the PHN region; and • Identify opportunities for system improvements and/or redesign. The PHN team supports general practice by: • Encouraging the uptake and required use of HealthPathways as a way to ensure consistency of care and the best use of resources; and • Encouraging general practitioners to engage with HealthPathways as subject matter experts and working group members.
Collaboration	WAPHA has entered into a partnership agreement with WA Health, binding the PHNs and Area Health Services, to develop HealthPathways and improve the integration between primary, secondary and tertiary care. The development of the clinical streams and pathways is a collaborative process involving WAPHA, WA Health, specialists, general practitioners, clinicians, allied health clinicians and subject matter experts. A relationship established between the WACHS Regional Population Health Directors, PHN regional managers and the HealthPathways staff facilitates the inclusion of local WACHS pathways.
Duration	Ongoing - July 2016 – June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Expected Outcome	The expected outcome of this activity is to: • Improve the coordination of patient care across the acute and primary care systems; • Improve the quality and appropriateness of referrals and management of waiting times; • Enhance clinical knowledge and promote best practice; • Strengthen relationships between general practitioners and hospital specialists; • Decrease in the number of patients inappropriately referred for treatment out of their regions; and • Increase care in the community.

Proposed support activities		
	The activity aligns to the PHN objectives by increasing the effectiveness and efficiency of medical services for patients, particularly those as risk of poor health outcomes and improving the coordination of care to ensure patients receive the right care, in the right place at the right time.	
Planned Expenditure 2016-2017 (GST exc)	$447,231	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed support activities		
Activity Title / Reference (eg. OP 1)	**OP 5 - General practice support - CQI - improve cancer screening rates**	
Description of Activity	WAPHA and the PHN supports general practice to build their capacity to identify patients who should be screened for cancer, through: • Assisting general practice to use data extraction tools to identify and support at risk groups; • Ensuring cancer screening information is culturally appropriate; • Including cancer screening pathways within HealthPathways WA; and • Providing assistance and information to general practice around targeted campaigns.	
Collaboration	Within the activity, the PHN works collaboratively with the Cancer Council WA, Breast Screen WA and the National Bowel Screening Program to support their targeted programs. The PHN works collaboratively with the Royal Australian College of General Practitioners (RACGP), WA Health, WACHS and Australian College of Rural and Remote Medicine (ACRRM).	
Duration	July 2016 – June 2018.	
Coverage	Country WA PHN covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.	
Expected Outcome	The expected outcome of this activity is to increase screening rates for breast, cervical and bowel cancer and subsequently improve population health. The activity aligns to the PHN objectives by increasing the effectiveness of medical services for patients as abnormalities will be detected earlier and ensuring patients receive the right care, in the right place at the right time. This activity also aligns directly with the Commonwealth national headline KPIs as it will promote and improve cancer screening of the breast, cervix and bowel.	
Planned Expenditure 2016-2017 (GST exc)	$11,915	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed support activities		
Activity Title / Reference (eg. OP 1)	**OP 6 - General practice support - CQI - improve immunisation rates**	
Description of Activity	The aim of this activity is to improve immunisation coverage and rates for children and adolescents, adults, including antenatal and Aboriginal people. The PHN supports general practice to build their capacity to identify patients who should be immunised by assisting general practice to use data extraction tools to identify at risk groups, ensuring immunisation information is culturally appropriate, including immunisation HealthPathways and providing assistance and information to general practice around targeted campaigns.	
Collaboration	The PHN is working in collaboration with the Communicable Disease Control Directorate (CDCD) to implement the WA Immunisation Strategy 2016 – 2020. CDCD's role is to lead the strategy and the PHN team will support the implementation of the strategy to general practice. In regional areas the PHN also works with WACHS immunisation co-ordinators and relevant staff from Aboriginal Medical Services.	
Duration	July 2016 – June 2018.	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.	
Expected Outcome	The expected outcomes of this activity are: • Improved childhood immunisation rates; • Improved timeliness of immunisation for Aboriginal children; • Improved completion rates for adolescent immunisation schedule; • Decreased hospitalisations for influenza like illness; and • Improved outcomes for mothers and babies with improved rates of antenatal immunisation. The activity aligns to the PHN objectives through increasing the efficiency of medical services for patients and ensuring patients receive the right care, in the right place at the right time. The activity also aligns to the Commonwealth's national headline indicators on childhood immunisation rates.	
Planned Expenditure 2016-2017 (GST exc)	$11,915	Commonwealth funding

Proposed support activities		
Activity Title / Reference (eg. OP 1)	**OP 7 - General practice support - digital health**	
Description of Activity	WAPHA, as the backbone organisation, is supporting a number of digital health initiatives including My Health Record, Telehealth, eReferrals and data management that will provide platforms for electronic transfer and coordination of care to improve integration and access to primary health care. WAPHA provides support and training to the PHN staff to ensure they are equipped to train and support general practice staff in a range of digital health initiatives particularly registering practises, uploading summaries and supporting patients to register for My Health Record. The Country WA PHN supports general practice by providing support and training in digital health and the uptake of My Health Record and data extraction tools.	
Collaboration	The PHN staff have worked with the National e-Health Transition Authority (NeHTA) and local hospitals in the Great Southern and South West to develop electronic discharge summaries, provided to GPs when patients exit hospitals. This work will continue and will be rolled out across other regions in 2016 -17. The PHN will work in conjunction with the Commonwealth Department of Health and the Australian Digital Health Agency to deliver My Health Record activities. The PHN will liaise, where relevant, with WA Health, WAGPET, RACGP, ACRRM and other primary health sector agencies to coordinate the implementation of My Health Record.	
Duration	July 2016 – June 2017.	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.	
Expected Outcome	The expected outcome of this activity will be an increase in the: • Use of digital health initiatives and data extraction tools in general practice; • Number of practices registering for, and using, My Health Record; • Number of patients registering to use My Health Record; • Access and use of integrated systems both within the practice and between service providers; and • Increased provision of electronic discharge summaries for patients who have been hospitalised.	
Expected Outcome	This activity aligns to the PHN objectives by increasing the effectiveness and efficiency of medical services for patients, particularly those as risk of poor health outcomes and improving the coordination of care to ensure patients receive the right care, in the right place at the right time.	
Planned Expenditure 2016-2017 (GST exc)	$54,491	Commonwealth funding
	$0	Funding from other sources (eg. private organisations, State and territory governments)

Proposed support activities	
Activity Title / Reference (eg. OP 1)	**OP 8 - Strategic Direction**
Description of Activity	WAPHA works with the Country WA PHN to create and develop the strategic framework which will facilitate the achievement of improved health care outcomes for the Western Australian community by: • Supporting the PHN to develop, align and operationalise WA population primary health priorities with Commonwealth primary health care policy direction utilising a systems approach and outcome based commissioning; • Advocating on behalf of primary care through submissions to government reviews and inquiries and driving WAPHA's policy stance through the corporate communications strategy and engaging with key stakeholder groups; • Working closely with PHN staff and external partners to develop a common vision for primary health care across the sector; • Providing guidance and advice to WAPHA, the Board and PHN in respect to relevant primary health care reform, reviews, inquiries and discussion papers and; and • Leading in the development of innovative, best practice models of primary health care service delivery and funding models.
Collaboration	Within this activity, WAPHA and the Country PHN work collaboratively with Commonwealth and State Government agencies, key primary health stakeholders, peak bodies and NGOs. These include, but are not limited to: • Commonwealth Department of Health and associated branches: • WA Country Health Service; • Rural Health West; • Mental Health Commission; • RACGP; • Australian Medical Association (AMA); • WA Association for Mental Health (WAAMH); • WA Network of Alcohol and Other Drug Agencies (WANADA); and • Aboriginal Health Council of WA (AHCWA).
Duration	July 2016 – June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

Proposed support activities		
Expected Outcome	The expected outcome of this activity is that a strategic framework is developed which facilitates the achievement of improved health care outcomes for the Western Australian community, to ensure efficient and effective medical services for patients, particularly those at risk of poor health outcomes and improving the coordination of care to ensure patients receive the right care, in the right place at the right time.	
Planned Expenditure 2016-2017 (GST exc)	$303,168	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed support activities		
Activity Title / Reference (eg. OP 1)	**OP 9 – Commissioning**	
Description of Activity	WAPHA and the PHN will take a collective impact approach working with key stakeholders from the primary health and social care sectors to commission local, high quality, cost effective and integrated services that are sustainable, meet the identified population health needs and that lead to the best possible health care outcomes for Western Australians. The Country WA PHN will commission services in line with the Commonwealth priorities of: • Aged Care; • Mental Health; • Population Health; • Aboriginal Health; • e-Health; and • Workforce. The Commissioning strategy will adopt a range of approaches including co-design, co-production and competitive dialogue processes to develop flexible and integrated approaches to service delivery. Measurement will be based upon outcomes as opposed to activities with a procurement framework that ensures contestability, transparency and offers value for money. Digital heath, a skilled workforce, building sustainable relationships across the health and social care systems and building knowledge and expertise in commissioning within the PHN will areas of focus as key success factors.	
Collaboration	Within this activity, WAPHA and the PHN work collaboratively with key stakeholders including but not limited to service providers, Commonwealth Department of Health, WA Health, Aboriginal health policy and planning organisations, WA MHC, WANADA, GP Professional bodies and colleges, workforce development and education organisations, patients their families and carers.	
Duration	July 2016 – June 2018.	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.	
Expected Outcome	The expected outcome of this activity is that the PHN will commission high quality, cost effective services that are sustainable, meet the identified population health needs, meet PHN objectives and lead to the best possible health care outcomes for Western Australians.	
Planned Expenditure 2016-2017 (GST exc)	$874,780	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed support activities	
Activity Title / Reference (eg. OP 1)	**OP 10 – Population health planning**
Description of Activity	The Country WA PHN undertakes population health planning on an ongoing basis to ensure that the current and future health and service needs of the PHN region are addressed and gaps are identified. Inequitable access to appropriate health care by disadvantaged and vulnerable groups is a key focus. WAPHA has engaged Curtin University to undertake population health planning for the PHN by assessing and analysing a broad range of qualitative and quantitative data sets, to identify priorities for health and service needs of the local population. With the baseline Needs Assessment completed, Curtin will continue to work with the PHN to build on the population health data on an ongoing basis and support the PHN to: • Continue population health planning based on an in-depth understanding of local health needs; • Undertake/develop issue specific population health planning e.g. mental health, AOD etc.; • Undertake sophisticated data analysis to inform population health trends; • Identify market factors and drivers around the provision of health and service needs; • Identify gaps and barriers in primary health care service delivery, particularly to those most vulnerable groups; • Identify and prioritise needs; • Undertake evaluations of the outcomes of commissioned services and use these evaluations to feed back into the commissioning cycle, on an ongoing basis; • Identify evidence-based opportunities for activity; and • Complete the 2016/17 and 2017/18 Needs Assessments.
Collaboration	This activity is a collaborative partnership between WAPHA and Curtin University's Health Systems and Health Economics Group, School of Public Health. The Country WA PHN has established the WA Country Primary Health Planning and Performance Working Group. The purpose of the working group is to develop strategic population-based, and outcomes oriented strategies, that provide the foundation of a consistent service delivery model for all health service providers in WA, to improve health outcomes for country people and improve health parity. Membership of the group includes the WACHS, Rural Health West, Aboriginal Health Council of WA, Aboriginal Health Improvement Unit and Curtin University.
Collaboration	The PHN's Council and Regional Clinical Commissioning Committees play a pivotal role in the ongoing population health planning.

Proposed support activities		
	The PHN undertakes broader consultation and engagement with service providers, communities, consumers, health professionals, funders etc.	
Duration	July 2016 – June 2018.	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.	
Expected Outcome	The expected outcome of this activity is that the PHN undertakes population health planning on an ongoing basis to ensure that health and service needs of the PHN region are addressed. The population health planning is used to inform the Needs Assessment and that the identified priorities and proposed options align to the PHN objectives.	
Planned Expenditure 2016-2017 (GST exc)	$136,150	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed support activities	
Activity Title / Reference (eg. OP 1)	**OP 11 - Stakeholder engagement**
Description of Activity	WAPHA, as the backbone organisation, supports the Country WA PHN by taking a shared approach to stakeholder mapping and engagement. WAPHA led activities include the: • Establishment of WAPHA's Stakeholder Engagement Working Group which provides a coordinated and consistent approach to engagement across all three PHNs; • Implementation of a centralised customer relationship management system; • Implementation of, and training in, International Association of Public Participation (IAP2) Programs. The engagement principles of IAP2 underpin all stakeholder engagement activity; and • Implementation of Primary Health Exchange (using Bang the Table - an online tool which will be one method of engagement with stakeholders). The Country WA PHN's stakeholder engagement and management involves: • Identifying and engaging key stakeholders identified in the Needs Assessment and population health planning; • Building strong and effective alliances with WA Health and key stakeholders to understand health issues specific to certain groups, improve primary care at the local level, improve care pathways and embed a patient centred and systems approach into primary care services; • Establishing and managing PHN Council, Seven Regional CCC and CEC 's; • Working with service providers to ensure contract deliverables are met and to build the capacity of the sector in outcomes based commissioning; • Supporting peak health bodies and academic institutions to conduct research and development; • Building capability for integrated care in local communities by facilitating stakeholder forums to identify priorities and develop foundations for long term sustainable change; and • Engaging meaningfully with disadvantaged and vulnerable groups to improve equitable service delivery in local communities and build cultural proficiency in services.
Collaboration	The PHN works meaningfully with all of its stakeholders.
Duration	Ongoing – July 2016 – June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Expected Outcome	The expected outcome of this activity is that the PHN will establish trusted and purposeful relationships and will work in collaboration with stakeholders, clinicians and community representatives to co-design and deliver the best possible health care outcomes for Western Australians, in line with the PHN objectives.

Proposed support activities		
Planned Expenditure 2016-2017 (GST exc)	$482,078	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed support activities		
Activity Title / Reference (eg. OP 1)	**OP 12 – Communication and marketing**	
Description of Activity	WAPHA supports the Country WA PHN to effectively communicate and market its activities through the delivery of a communications strategy. Key activities include: • Designing and publishing promotional collateral; • Developing marketing plans to support commissioning and general practice utilising traditional and digital channels; and • Coordinating sector events.	
Collaboration	WAPHA and the PHN work in collaboration with WA Health and associated Area Health Services, Curtin University, Mental Health Commission, key stakeholders and service providers.	
Duration	July 2016 – June 2017.	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.	
Expected Outcome	Our stakeholders know, trust and understand the worth of the PHN and their ability to increase the efficiency and effectiveness of primary health 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.	
Planned Expenditure 2016-2017 (GST exc)	$204,203	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed support activities		
Activity Title / Reference (eg. OP 1)	**OP 13 – Integrating primary health and social care innovation grant project**	
Description of Activity	This initiative will distribute seed grant funding to selected organisations to pilot new or existing innovative projects that deliver locally relevant health care outcomes. The grants will be made available through the Country WA PHN to health and social care organisations to develop improved models of care and to test innovative local collaborative models, with a focus on chronic disease factors. The service providers will establish place-based systems of care in which they work together with the common resources available to them to improve health and social care for the populations they serve. A further role of the PHN will be to facilitate collaborations between organisations and individuals to test models and share knowledge and learnings.	
Collaboration	The PHN will work collaboratively with relevant organisations that have the motivation, skills and resources to deliver innovation in primary health and social care.	
Duration	July 2016 – June 2018.	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.	
Expected Outcome	The expected outcome of this activity will assist the development and delivery of initiatives that promote and facilitate innovation in collaborative and integrated primary health and social care models, in line with the PHN objectives.	
Planned Expenditure 2016-2017 (GST exc)	$61,323	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

3 (a) Strategic Vision for After Hours Funding

The WA Primary Health Alliance (WAPHA) has a vision of efficient and effective after hours primary health care, well-coordinated, easily accessible and seamlessly navigated by all patients in the community where all people are empowered to make informed decisions on getting the right treatment in the right place and at the right time.

To achieve this vision, Country WA PHN will work closely with key local stakeholders, including local communities, health professionals and all levels of government, to develop and implement innovative service delivery solutions that aim to achieve higher levels of service coordination and integration.

The After Hours Program is aligned with all relevant government policies and directions and is focused on delivering better health outcomes for patients seeking care after hours. Better access and quality will be achieved through implementation of innovative health care service delivery models developed in close collaboration with other service providers both from the private and government sectors.

Our aim is to improve the delivery of primary health services in every region in Western Australia and achieve long term improvements for the current and potential patients of primary health as well as the service providers.

One of our main priorities is to empower patients to make informed choices and decisions about their health and make their journey across various health services seamless, effective and stress-free.

To accomplish this priority we will use outcome measures to assess and gauge performance of every initiative and project focusing on outcomes most relevant to patients. Greater weight will be given to qualitative sources of information about patient experience and outcomes, including patient experience surveys which will have a greater emphasis on collecting patient stories and narratives.

We will concentrate on areas of need identified through the Needs Analysis and focus on projects enabling better access to after hour's primary health care by patients from the disadvantaged groups. Our main effort with these groups will be to improve accessibility to first after hours care contact and enabling continuity of care. Vulnerable groups identified through the Needs Analysis include: mental health patients; residents of aged care facilities, Aboriginal populations and victims of domestic violence.

To meet our Program's main objectives, all After Hours projects and initiatives will be designed and implemented with a view for each of them to make an important contribution to system-wide goals of efficiency, effectiveness, equity, accessibility, appropriateness, continuity and integration in the delivery of healthcare services.

3(b) Planned activities funded by the Primary Health Network Schedule for After Hours Funding

Proposed Activities	
After Hours Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 5: Capable workforce tailored to these priorities.
After Hours Activity Title / Reference (eg. AH 1.1)	**A H 1 - After Hours Health Care Centres** *This activity will provide after-hours support to people with problematic drug and alcohol use and people with mental health problems and disorders. See Mental Health and Suicide Prevention Activity Work plan Activities Priority Areas 3-7 and the Drug and Alcohol Treatment Services Activity Plan DATS – 3 and 4 and DATS-ATSI 2 and 3*.
Description of After Hours Activity	The aim of this activity is to improve the efficiency of after hours (AH) primary health care in country areas to provide regional and rural communities with improved access to high quality, affordable after hours services. Evidence supports the implementation of targeted and collaborative approaches to address local gaps and market failure in the ability to deliver after hours healthcare services in country areas. Local After Hours Healthcare Centres will be designed and implemented based on input from relevant stakeholders about the specific local needs, resources available and the level of willingness from service providers to cooperate and participate in innovative projects. There will be sufficient flexibility in the service approach to allow a centre to be run by a single local after hour's provider, a GP cooperative or with other innovative approaches depending on the individual local circumstances.

Proposed Activities	
Description of After Hours Activity	The aim is to: • Attract local GPs to work after hours by achieving the right balance of financial incentives and service delivery arrangements to relieve pressure on GPs in country areas and make their after hours work less burdensome, better structured and financially viable; • Encourage improved integration and coordination among relevant health care providers such as the Western Australian Country Health Service (WACHS), etc.; • Support innovation in a sustainable and efficient manner with a focus on improved patient outcomes; and • Maximise the use of existing local resources and infrastructure. It should be noted that AH funding will NOT be used to cover any GP services for which they are eligible to receive an after hours practice incentive payment (regardless of whether the practice is claiming the payment or not).
Collaboration	The Country WA PHN will collaborate with a number of key stakeholders on the after hours activity particularly in regard to participation in innovation hubs to inform the design of the WA Outcome Framework and new services. Prioritised stakeholders include but are not limited to Professional colleges, medical and allied health peak bodies, GP education and training providers, Universities, consumer groups, other PHN's, primary and social care service providers, WA Health, WA Country Health Services (when feasible to co-locate the AH Health Care Centre at the local hospital to use the existing infrastructure and reduce costs), Aboriginal health service, policy and planning organisations, patients their families and carers.
Duration	July 2016 – June 2017.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern. Please refer to appendix A for more details.
Commissioning approach	• Expressions of Interest (EOI) will be sought from each region; and • Direct funding allocation to the existing services identified as capable to expand their scope to fill in the identified gap. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators to build relationships and continuous feedback on implementation.
Performance Indicator	Performance indicators will be negotiated with providers and other stakeholders in line with the WA Primary Care Outcomes Framework and commissioned services will be required to provide six and twelve monthly reports. Indicators that will be included for consideration for the service providers include: *Process* • Patient Reported Experience Measures (PREMs);

Proposed Activities	
Performance Indicator	• Clinician Reported Experience Measures (CREMs); • Identification of priority cohorts; • Increased alignment of client demographics with priority cohorts; • Evidence of co-design and quality improvement; and • Strategies implemented to build cultural proficiency of service provider. *Output* • Identification of at risk population; and • Number of clients and occasions of service. *Outcome* • Increased planned care and decreased acute care for identified cohorts; • Clinician Reported Outcome Measures (CREMs); and • Patient Reported Outcome Measures (PROMs). Indicators that will be included for consideration for the PHN include: *Process* • Measurement of Provider Reported Experience Measures (PREMs); • Increased number of after hours co-commissioned services and collaborative approaches; • Increased number of MBS items for reviews of GP management plans; • Increased utilisation of HealthPathways; and • Implementation of social marketing campaign. *Output* • Outcome framework is endorsed by PHN Committees; • Performance indicators are agreed with providers and endorsed by PHN Committees; • Increased utilisation of after hours budget; • Increased services contracted; and • Distribution of social marketing collateral. *Outcome* • Decreased age standardised rate of potentially preventable hospitalisations; • My Health Records activity; and • Decreased ED Presentations.

Proposed Activities		
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Data source	To be agreed in partnership with providers and stakeholders. Potential sources include provider patient-level (de-identified) data; State-wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$3,648,902	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed Activities	
After Hours Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
After Hours Activity Title / Reference (eg. AH 1.1)	**AH 2 - Dispensing Pharmaceuticals After Hours**
Description of After Hours Activity	The aim of the activity is to provide after hours patients with immediate access to medication to prevent them from reporting to an emergency department instead of a GP AH practice therefore reducing the risk of hospitalisation caused by delays in treatment. After hours GP practices advocate financial support for country pharmacies to stay open to match the opening times of local AH practises recognising that it is not financially viable for these businesses to remain open after 6 PM or at weekends. Flexible working arrangements for country pharmacies will be implemented that could involve one local pharmacy or a number of pharmacies working in a cooperative arrangement to have pharmacy services available when AH primary care services are open. Services may include on-call arrangements or home delivery to palliative care patients, the elderly (over 75 years of age) and to aged care facilities.
Collaboration	The PHNs plan to collaborate with a number of key stakeholders on the after hours activity particularly in regard to participation in innovation hubs to inform the design of the WA Outcome Framework and new services. Prioritises stakeholders include but are not limited to Professional Colleges and Associations, Country Health Services, Medical Education and Training organisations, Universities, Pharmacy Industry representatives, General practises and GP's, Consumer Advisory Groups, Primary and Social Care service providers, other WA PHN's and Patients Families and Carers.
Duration	July 2016 – June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

Proposed Activities	
Commissioning approach	• Expressions of Interest (EOI) will be sought from each region; and • Direct funding allocation to the existing services identified as capable to expand their scope to fill in the identified gap. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback on the implementation.
Performance Indicator	Performance indicators will be negotiated with providers and other stakeholders in line with the WA Primary Care Outcomes Framework and commissioned services will be required to provide six and twelve monthly reports. Indicators that will be included for consideration for the service providers include: *Process* • Patient Reported Experience Measures (PREMs); • Clinician Reported Experience Measures (CREMs); • Identification of priority cohorts; • Increased alignment of client demographics with priority cohorts; • Evidence of co-design and quality improvement ; and • Strategies implemented to build cultural proficiency of service provider. *Output* • Identification of at risk population; and • Number of clients and occasions of service. *Outcome* • Increased planned care and decreased acute care for identified cohorts; • Clinician Reported Outcome Measures (CREMs); and • Patient Reported Outcome Measures (PROMs). Indicators that will be included for consideration for the PHN include: *Process* • Measurement of Provider Reported Experience Measures (PREMs); • Increased number of after hours co-commissioned services and collaborative approaches; • Increased number of MBS items for reviews of GP management plans; • Increased utilisation of HealthPathways; and • Implementation of social marketing campaign. *Output* • Outcome framework is endorsed by PHN Committees; and • Performance indicators are agreed with providers and endorsed by PHN Committees.

Proposed Activities		
Performance Indicators	• Increased utilisation of after hours budget; • Increased services contracted; and • Distribution of social marketing collateral. *Outcome* • Decreased age standardised rate of potentially preventable hospitalisations; • My Health Records activity; and • Decreased ED Presentations.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Data source	To be agreed in partnership with providers and stakeholders. Potential sources include provider patient-level (de-identified) data; State-wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funding. Refer to Commonwealth Funding AH 1 above.
	$0	Funding from other sources (eg. private organisations, State and territory governments)

Proposed Activities	
After Hours Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
After Hours Activity Title / Reference (eg. AH 1.1)	**AH 3 - Support to at risk groups (new)** *This activity will provide after-hours support to people with problematic drug and alcohol use and people with mental health problems and disorders. See Mental Health and Suicide Prevention Activity Work plan Activities Priority Areas 3-7 and the Drug and Alcohol Treatment Services Activity Plan DATS – 3 and 4 and DATS-ATSI 2 and 3.*
Description of After Hours Activity	The aim of the activity is to increase the effectiveness of primary health care by developing innovative programs to provide people from vulnerable groups with better access to after hours services and ensuring those services are delivered in a culturally appropriate manner and in stress free, familiar setting. Programs to be developed and implemented for vulnerable groups include: ***Patients at Residential Aged Care Facilities (RACFs)*** The following strategies have been found to be effective in providing access to timely after hours primary care services for patients in RACF's and will be considered in local service planning and design: • On call GP service providing telephone triaging and visits to RACFs; and • Aged care specialist GP service providing care through a nurse practitioner and utilising video and teleconferencing options. ***Palliative Care Patients*** The aim of this initiative is to provide palliative and end of life care and support to patients and families in a holistic manner in their own home, in-country and when it is required.
Description of Activity	A project trial will include: • Employment of a visiting nurse with support from a GP(s) and close collaboration with the local hospital; • Telephone support to supplement face-to-face care to assist family members to better care for the palliative client; and • After death, the nurse will provide culturally appropriate bereavement support to the family.

Proposed Activities	
Description of Activity	***Remote Areas*** The purpose of this initiative is to improve patient health and reduce hospitalisation for marginalised people in regional and remote areas. It involves a mobile bulkbilling GP clinic staffed by a GP, a nurse and outreach workers. The options for this model include: • Providing services from a number of different locations at the town outskirts maintaining the same times and locations each week; and • Travelling through a region maintaining the same times and locations each month. To make the service more efficient and effective it can be combined with telehealth and/or travelling specialist clinics providing for example ear and eye checks. ***Victims of domestic violence*** • This is a nurse led outreach service providing mobile health care to victims of domestic violence in the community outside of business hours; • The nurse will work closely with local police to establish the links of providing care to those affected by domestic violence and will attend wounds and provide urgent care at various locations; • In addition to providing immediate care the nurse will attempt to engage the patient in taking care of their health - linking them to a GP and other health specialists participating in the Program where possible. It should be noted that after hours funding will NOT be used to cover any GP services that are currently eligible to receive an after hours practice incentive payment (regardless of whether the practice is claiming the payment or not).
Collaboration	The Country WA PHN will collaborate with a number of key stakeholders on the after hours activity particularly in regard to participation in innovation hubs to inform the design of the WA Outcome Framework and new services. Prioritised stakeholders include but are not limited to Professional colleges, medical and allied health peak bodies, GP education and training providers, Universities, consumer groups, other PHN's, primary and social care service providers, WA Health, Aboriginal health service, policy and planning organisations, patients their families and carers.
Duration	July 2016 – June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach	• Expressions of Interest (EOI) will be sought from each region; and • Direct funding allocation to the existing services identified as capable to expand their scope to fill in the identified gap. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback on the implementation.

Proposed Activities	
Performance Indicator	Performance indicators will be negotiated with providers and other stakeholders in line with the WA Primary Care Outcomes Framework. Commissioned services will be required to provide six and twelve month reports. Indicators that will be included for consideration for the service providers include: *Process* • Patient Reported Experience Measures (PREMs); • Clinician Reported Experience Measures (CREMs); • Identification of priority cohorts; • Increased alignment of client demographics with priority cohorts; • Evidence of co-design and quality improvement ; and • Strategies implemented to build cultural proficiency of service provider. *Output* • Identification of at risk population; and • Number of clients and occasions of service. *Outcome* • Increased planned care and decreased acute care for identified cohorts; • Clinician Reported Outcome Measures (CREMs); and • Patient Reported Outcome Measures (PROMs). Indicators that will be included for consideration for the PHN include: *Process* • Measurement of Provider Reported Experience Measures (PREMs); • Increased number of after hours co-commissioned services and collaborative approaches; • Increased number of MBS items for reviews of GP management plans; • Increased utilisation of HealthPathways; and • Implementation of social marketing campaign. *Output* • Outcome framework is endorsed by PHN Committees; • Performance indicators are agreed with providers and endorsed by PHN Committees; • Increased utilisation of after hours budget; • Increased services contracted; and • Distribution of social marketing collateral. *Outcome* • Decreased age standardised rate of potentially preventable hospitalisations; • My Health Records activity; and • Decreased ED Presentations.

Proposed Activities		
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Data source	To be agreed in partnership with providers and stakeholders. Potential sources include provider patient-level (de-identified) data; State-wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funding. Refer to Commonwealth Funding AH 1 Above.
	$0	Funding from other sources (eg. private organisations, State and territory governments)

Proposed Activities	
After Hours Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
After Hours Activity Title / Reference (eg. AH 1.1)	**AH 4 - After Hours Allied Health Services**
Description of After Hours Activity	The aim of this activity is to improve access, reduce inequity and provide more integrated after hours primary health care to help patients get the right service from capable workforce at the right time and in the right place. The purpose is to provide urgent allied health services after hours. Flexible approaches that use the resources that are available locally may include: • Development of formal agreement between an AH GP service and a local allied health service, such as psychology, physiotherapy, pharmacy, etc. to provide AH allied health services. • Allocation of additional allied health staff and resources to AH GP services. Additional staff could include mental health nurses/social workers, Aboriginal health practitioners; Aboriginal health/liaison workers; psychologists and physiotherapists; and • Other collaborative initiatives with the potential to improve GP practice capacity, integration and effectiveness of after hours primary health care across various disciplines.
Collaboration	In some country areas collaboration will be sought from a local hospital to provide accommodation and office space to an AH allied health worker. The PHNs plan to collaborate with a number of key stakeholders on the after hours activity particularly in regard to participation in innovation hubs to inform the design of the WA Outcome Framework and new services. Prioritised stakeholders include but are not limited to Professional colleges, medical and allied health peak bodies, GP education and training providers, Universities, consumer groups, other PHN's, primary and social care service providers, WA Health, Aboriginal health service, policy and planning organisations, patients their families and carers.
Duration	July 2016 – June 2018.

Proposed Activities	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach	• Expressions of Interest (EOI) will be sought from each region; and • Direct funding allocation to the existing services identified as capable to expand their scope to fill in the identified gap. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback on the implementation.
Performance Indicator	Performance indicators will be negotiated with providers and other stakeholders in line with the WA Primary Care Outcomes Framework. Commissioned services will be required to provide six and twelve month reports. Indicators that will be included for consideration for the service providers include: *Process* • Patient Reported Experience Measures (PREMs); • Clinician Reported Experience Measures (CREMs); • Identification of priority cohorts; • Increased alignment of client demographics with priority cohorts; • Evidence of co-design and quality improvement; and • Strategies implemented to build cultural proficiency of service provider. *Output* • Identification of at risk population; and • Number of clients and occasions of service. *Outcome* • Increased planned care and decreased acute care for identified cohorts; • Clinician Reported Outcome Measures (CREMs); and • Patient Reported Outcome Measures (PROMs). Indicators that will be included for consideration for the PHN include: *Process* • Measurement of Provider Reported Experience Measures (PREMs); • Increased number of after hours co-commissioned services and collaborative approaches; • Increased number of MBS items for reviews of GP management plans; • Increased utilisation of HealthPathways; and • Implementation of social marketing campaign.

Proposed Activities		
Performance Indicators	*Output* • Outcome framework is endorsed by PHN Committees; • Performance indicators are agreed with providers and endorsed by PHN Committees; • Increased utilisation of after hours budget; • Increased services contracted; and • Distribution of social marketing collateral. *Outcome* • Decreased age standardised rate of potentially preventable hospitalisations; • My Health Records activity; and • Decreased ED Presentations.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Data source	To be agreed in partnership with providers and stakeholders. Potential sources include provider patient-level (de-identified) data; State-wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funding. Refer to Commonwealth Funding AH 1 above.
	$0	Funding from other sources (eg. private organisations, State and territory governments)

Proposed Activities	
After Hours Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
After Hours Activity Title / Reference (eg. AH 1.1)	**AH 5 - After Hours Health Care System Promotion**
Description of After Hours Activity	The aim of this activity is to improve community health literacy by informing consumers on the variety of services available after hours and educating them how to best utilise these service to access the most appropriate after hours care. The purpose is to change consumer behaviour and reduce unnecessary visits to hospital emergency departments. A community awareness campaign will be run to promote after hours services widely using a range of different media including print and electronic media, interactive displays, flyers and posters at hospitals, GP Practices and pharmacies, community newsletters and through community sites such as libraries and through local radio. A special educational video will be developed and provided to GP practices and other relevant sites. Promotional strategies will reflect the diversity of local consumer groups and will be designed recognising cultural needs and literacy levels and people's capacity to access information electronically.
Collaboration	Collaboration with: • Other PHNs to reduce cost; • Local community radio stations to air messages, including Aboriginal and ethnic programs; • Local shopping centres, schools, libraries; and • GP practices, pharmacies, hospitals.
Duration	July 2016 – June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

Proposed Activities	
Commissioning approach	• Expressions of Interest (EOI) will be sought from each region; and • Direct funding allocation to the existing services identified as capable to expand their scope to fill in the identified gap. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback on the implementation.
Performance Indicator	Performance indicators will be negotiated with providers and other stakeholders in line with the WA Primary Care Outcomes Framework. Commissioned services will be required to provide six and twelve month reports. Indicators that will be included for consideration for the service providers include: *Process* • Patient Reported Experience Measures (PREMs); • Clinician Reported Experience Measures (CREMs); • Identification of priority cohorts; • Increased alignment of client demographics with priority cohorts; • Evidence of co-design and quality improvement ; and • Strategies implemented to build cultural proficiency of service provider. *Output* • Identification of at risk population; and • Number of clients and occasions of service. *Outcome* • Increased planned care and decreased acute care for identified cohorts; • Clinician Reported Outcome Measures (CREMs); and • Patient Reported Outcome Measures (PROMs). Indicators that will be included for consideration for the PHN include: *Process* • Measurement of Provider Reported Experience Measures (PREMs); • Increased number of after hours co-commissioned services and collaborative approaches; • Increased number of MBS items for reviews of GP management plans; • Increased utilisation of HealthPathways; and • Implementation of social marketing campaign.

Proposed Activities		
Performance Indicators	*Output* • Outcome framework is endorsed by PHN Committees; • Performance indicators are agreed with providers and endorsed by PHN Committees; • Increased utilisation of after hours budget; • Increased services contracted; and • Distribution of social marketing collateral. *Outcome* • Decreased age standardised rate of potentially preventable hospitalisations; • My Health Records activity; and • Decreased ED Presentations.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Data source	To be agreed in partnership with providers and stakeholders. Potential sources include provider patient-level (de-identified) data; State-wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funding. Refer to Commonwealth Funding AH 1 above.
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed Activities	
After Hours Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
After Hours Activity Title / Reference (eg. AH 1.1)	**AH 6 - After Hours CPC** *This activity will provide after-hours support to people with problematic drug and alcohol use and people with mental health problems and disorders. See Mental Health and Suicide Prevention Activity Work plan Activities Priority Areas 3-7 and the Drug and Alcohol Treatment Services Activity Plan DATS – 3 and 4 and DATS-ATSI 2 and 3.*
Description of After Hours Activity	CPC program practices will be given flexibility to propose an activity which helps them best manage the urgent health care needs of enrolled patients as long as the proposed activity does not duplicate funding provided by Medicare or other government funding including the after hours practice incentive payment (AH PIP). Proposed activities could include: • Urgent after hours discretionary fund for direct costs to prevent admission of enrolled patients to hospital such as gap payments for medications, equipment hire or a home nursing service; • Incentives for weekend opening hours; and • Multi-disciplinary team member's incentive targeted to urgent after hours health needs of the enrolled cohort, e.g. Aboriginal health worker, mental health nurse, social worker or translation services. In the after hours period practices will continue to implement the CPC program with a focus on methods of: • patient identification; • disease management; • identifying patient outcomes; • use of e-health; • data collection and sharing; • optimal use of available pooled funding; • patient engagement in their own care; and • identification of multi-disciplinary team members.

Proposed Activities	
Collaboration	The PHNs plan to collaborate with a number of key stakeholders on the after hours activity particularly in regard to participation in innovation hubs to inform the design of the WA Outcome Framework and new services. Prioritised stakeholders include but are not limited to Professional colleges, medical and allied health peak bodies, GP education and training providers, Universities, consumer groups, other PHN's, primary and social care service providers, WA Health, Aboriginal health service, policy and planning organisations, patients their families and carers.
Duration	July 2016 – June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach	• Expressions of Interest (EOI) will be sought from each region; and • Direct funding allocation to the existing services identified as capable to expand their scope to fill in the identified gap. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback on the implementation.
Performance Indicator	Performance indicators will be negotiated with providers and other stakeholders in line with the WA Primary Care Outcomes Framework. Commissioned services will be required to provide six and twelve month reports. Indicators that will be included for consideration for the service providers include: *Process* • Patient Reported Experience Measures (PREMs); • Clinician Reported Experience Measures (CREMs); • Identification of priority cohorts; • Increased alignment of client demographics with priority cohorts; • Evidence of co-design and quality improvement; and • Strategies implemented to build cultural proficiency of service provider. *Output* • Identification of at risk population; and • Number of clients and occasions of service. *Outcome* • Increased planned care and decreased acute care for identified cohorts; • Clinician Reported Outcome Measures (CREMs); and • Patient Reported Outcome Measures (PROMs).

Proposed Activities		
Performance Indicators	Indicators that will be included for consideration for the PHN include: *Process* • Measurement of Provider Reported Experience Measures (PREMs); • Increased number of after hours co-commissioned services and collaborative approaches; • Increased number of MBS items for reviews of GP management plans; • Increased utilisation of HealthPathways; and • Implementation of social marketing campaign. *Output* • Outcome framework is endorsed by PHN Committees; • Performance indicators are agreed with providers and endorsed by PHN Committees; • Increased utilisation of after hours budget; • Increased services contracted; and • Distribution of social marketing collateral. *Outcome* • Decreased age standardised rate of potentially preventable hospitalisations; • My Health Records activity; and • Decreased ED Presentations.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Data source	To be agreed in partnership with providers and stakeholders. Potential sources include provider patient-level (de-identified) data; State-wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funding. Refer to Commonwealth Funding AH 1 above.
	$0	Funding from other sources (eg. private organisations, State and territory governments)

Proposed Activities	
After Hours Priority Area (eg. 1, 2, 3)	Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
After Hours Activity Title / Reference (eg. AH 1.1)	**AH 7 - Innovation and Excellence**
Description of After Hours Activity	The purpose of this activity is to develop innovative sustainable solutions to address gaps in after hours service arrangements and to achieve excellence in service delivery in each country region. Since its inception, Country WA PHN has been exploring new options for service delivery models based on inter-agency collaborative arrangements whilst maximising the use of existing infrastructure searching for innovative solutions and thinking outside the box. This is an ongoing, continuous process, which needs to be flexible and responsive to arising needs and opportunities. Currently potential innovation projects include: • Introduction of a *Weekend After Hours Grant* to encourage GP practice to stay open on weekends. This concept has been designed in response to the identified gap in the new AH PIP incentive, which does not compensate practices for providing services on weekends unless they provide 24 hour service/seven days a week. International and national research indicates there is a direct link between the availability of GP practices on weekends, on Sundays in particular, and the number of patients reporting to the emergency department of local hospitals; and • A new model of working with Aboriginal clients using the influence of the family elders to achieve better compliance with regards to health needs and medical treatments.
Collaboration	The PHN plan to collaborate with a number of key stakeholders on the after hours activity particularly in regard to participation in innovation hubs to inform the design of the WA Outcome Framework and new services. Prioritised stakeholders include but are not limited to professional colleges, medical and allied health peak bodies, GP education and training providers, Universities, consumer groups, other PHN's, primary and social care service providers, WA Health, Aboriginal health service, policy and planning organisations, patients their families and carers.
Duration	July 2016 – June 2018.

Proposed Activities	
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach	• Expressions of Interest (EOI) will be sought from each region; and • Direct funding allocation to the existing services identified as capable to expand their scope to fill in the identified gap. Dialogues will be maintained with providers throughout, utilising the Regional Primary Health Coordinators role to build relationships and continuous feedback on the implementation.
Performance Indicator	Performance indicators will be negotiated with providers and other stakeholders in line with the WA Primary Care Outcomes Framework. Commissioned services will be required to provide six and twelve month reports. Indicators that will be included for consideration for the service providers include: *Process* • Patient Reported Experience Measures (PREMs); • Clinician Reported Experience Measures (CREMs); • Identification of priority cohorts; • Increased alignment of client demographics with priority cohorts; • Evidence of co-design and quality improvement ; and • Strategies implemented to build cultural proficiency of service provider. *Output* • Identification of at risk population; and • Number of clients and occasions of service. *Outcome* • Increased planned care and decreased acute care for identified cohorts; • Clinician Reported Outcome Measures (CREMs); and • Patient Reported Outcome Measures (PROMs). Indicators that will be included for consideration for the PHN include: *Process* • Measurement of Provider Reported Experience Measures (PREMs); • Increased number of after hours co-commissioned services and collaborative approaches; • Increased number of MBS items for reviews of GP management plans; • Increased utilisation of HealthPathways; and • Implementation of social marketing campaign.

Proposed Activities		
Performance Indicators	*Output* • Outcome framework is endorsed by PHN Committees; • Performance indicators are agreed with providers and endorsed by PHN Committees; • Increased utilisation of after hours budget; • Increased services contracted; and • Distribution of social marketing collateral. *Outcome* • Decreased age standardised rate of potentially preventable hospitalisations; • My Health Records activity; and • Decreased ED Presentations.	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Data source	To be agreed in partnership with providers and stakeholders. Potential sources include provider patient-level (de-identified) data; State-wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funding. Refer to Commonwealth Funding AH 1 above.
	$0	Funding from other sources (e.g. private organisations, State and territory governments)