Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2019-2022:

Core Funding

GP Support Funding

Country WA PHN

Approved by the Australian Government Department of Health, July 2019 (Version 1)

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

Proposed Activities	
ACTIVITY TITLE	**CF1: Integrated Chronic Disease Care**
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Population Health
Needs Assessment Priority	**Priority:** • P1.2 Support primary care providers to improve the management of patients with chronic conditions and reduce unnecessary hospitalisations through effective care pathways, service coordination and service linkages. (p.94) **Possible Options:** • Improve access to chronic disease management programs i.e. integrated chronic disease program, diabetes education. (p.96) • Commission community-based care coordination and navigation services for patients with specific conditions that result in potentially preventable hospitalisations. (p.96) **Priority**: • P1.5 Promote the effectiveness of digital health technologies to optimise patient care (telehealth). **Possible Option:** • Partner with health service providers to implement innovative methods of care using digital technologies (p.96) **Priority**: • P1.9 Assist primary health care providers to adopt culturally appropriate models of care for Aboriginal populations and culturally and linguistically diverse (CALD) groups. (p.98) **Possible Options:** • Ensure commissioned services have undertaken cultural competency training and promote cultural competency training to other health service providers. (p.98) • Engage Aboriginal organisations and CALD groups and the wider community in consultation, co-design and decision-making opportunities to help shape models of care. (p.98)
Aim of Activity	Chronic disease is a major health burden in Australia. Vulnerable, disadvantaged and Aboriginal people are at higher risk of chronic health conditions. Clients living in rural Western Australia are generally unable to access multidisciplinary health care providers for the management of chronic conditions which hinder the effective management of their condition. The Integrated Chronic Disease Care (ICDC) Program was developed to improve patient access to primary health care, provide coordinated care, reduce

	potentially preventable hospitalisations and strengthen patient self-management for people suffering from chronic conditions. The chronic conditions targeted by this program include diabetes; respiratory conditions including Chronic Obstructive Pulmonary Disease (COPD) and asthma; obesity and cardiovascular conditions. The aim of this activity is to: • continue to fund integrated primary health care services in areas where need has been demonstrated • determine the degree to which both placed based and state-wide services for people with chronic conditions are making an impact on the health needs of the populations they serve through the support of core operational health systems improvement funding (activity HSI1: System Integration) • ensure that service providers are meeting their contractual obligations. The PHN will continue to work to structure supply in order to: • increase access to primary health services for people with chronic conditions • support self-management • sustain engagement with General Practitioners (GPs) and other primary health professionals • develop the capacity of the primary health workforce.
Description of Activity	ICDC services are regionally tailored and can consist of: • Multidisciplinary teams providing clinical and self-management support for vulnerable and disadvantaged persons with chronic diseases, with priority given to people with cardiovascular, diabetes and respiratory conditions. • Care coordinators/Nurse Practitioners to ensure that clients are followed-up, receive the best wrap around care and are linked successfully with general practice or appropriate health professionals. • Culturally appropriate support and information to enable patients to work towards self-management of their condition. • The use of evidence based self-management apps and other digital health technology in a patient's care plan to monitor their health and wellbeing. The model also includes group based self-management interventions. • Chronic Disease Officers to integrate the chronic disease services provided by the WA Country Health Services (WACHS) with the WA Primary Health Alliance (WAPHA) funded community based primary health care services. Funding will continue for the following PHN-wide services: • Asthma, COPD and Diabetes Telehealth Services: These services work in partnership with local GPs and healthcare professionals to ensure continuity of care for patients. They provide one on one support/ consultations and education to patients in country WA via video-conferencing. The Diabetes WA telehealth service also provides Diabetes Education support to those locations where this service does not exist such as Carnarvon and the Goldfields regions. It is proposed to continue recurrent funding for the following Country WA Regional ICDC Services: • Goldfields: Three Integrated Chronic Disease Care Services across three sub-regions. • Great Southern: One Integrated Chronic Disease Care Service and One Primary Health Nurse Practitioner (Katanning and Merredin).

	• Kimberley: Three Integrated Chronic Disease Care Services and a Community Dietician Education Service to promote effective food access and security to prevent and manage existing chronic conditions in the Aboriginal population. • Midwest: Two Integrated Chronic Disease Care Services across two sub-regions, and a Chronic Conditions Project Officer. • Pilbara: Four Integrated Chronic Disease Care Services targeting regional and remote communities, and a Chronic Conditions Project Officer. • South West: One Integrated Chronic Disease Care Service, an Aboriginal Integrated Care Service and a Chronic Conditions Officer. • Wheatbelt: Two Integrated Chronic Disease Care Services across two sub-regions, and one Nurse Practitioner to support self-management. • Great Southern, Wheatbelt and South West: Health Navigator: This service uses phone and telehealth technology to support people with chronic conditions to develop a personal plan to enable them to effectively self-manage their chronic health conditions. The above services integrate closely with the Integrated Team Care (ITC) Activity that is provided in all regions, ensuring that primary health services to address chronic conditions are available to Aboriginal people throughout WA. The PHN will continue to develop and maintain close working relationships with contracted service providers and will formally review services at six- and twelve-months intervals using a diverse range of data collection methods (i.e. provider reports, referral agency feedback, patient options) to determine: • how well targeted and efficient services are, and • how effective services and systems are in relation to: o patient experience o patient health outcomes o service/system integration o service sustainability including provider experience/governance. Using revised outcome maps and evaluation reports which provide both provider and client reported outcomes and other relevant data, the PHN will evaluate the performance of services and determine whether, and to what extent, a reshaping of the structure of supply is required.
Target population cohort	The ICDC program targets those people who are financially disadvantaged and vulnerable, including those of Aboriginal and Torres Strait Islander descent, who have co-existing chronic conditions including those in remote locations of the PHN.
Indigenous specific	No
Coverage	The ICDC activity covers the whole of Country WA PHN, including the Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, Great Southern and South West, targeting specific communities within these regions where the need is greatest.
Consultation	In developing and implementing ICDC services, Country WA PHN consulted with a wide range of stakeholders. Major stakeholders common to all regions include: • WA Country Health Services (WACHS) – Director of Population Health • WACHS – Community District Health Advisory Councils • Local Governments • Aboriginal Medical Services

	• Aboriginal Health Planning Forums • Chronic Conditions Networks • Local Health Professionals located in the regions • Regional Clinical Commissioning Committees across the 7 regions of the PHN. Major stakeholders at a state level that were consulted include: • Australian Government Department of Health • WA Department of Health • Carers WA • WA Aboriginal Community Controlled Health Organisations • Heart Foundation WA • Asthma WA • Diabetes WA • Cancer Council of WA • Pharmaceutical Society of Australia (WA) • Australian Medical Association Council of General Practice (WA) • Rural Health West • WA Mental Health Association • Royal Australian College of General Practitioners WA Faculty • WA GP Education and Training • Australian Medical Association Council of General Practice (WA) • Private Health Insurers including Medibank Private and HBF
Collaboration	Country WA PHN collaborates with a range of stakeholders to inform the design of services – these bodies are listed above. In addition, there are regionally specific groups and organisations that are collaborated with in each region in Country PHN. Stakeholders that play a particularly significant role in designing and/or implementing regional services include: • WA Country Health Service and Rural Health West in designing and implementing services • WACHS in co-design and co-commissioning of services • Regional Clinical Committees across the 7 regions of the PHN in the design of services.
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2021 Service delivery start date: July 2019 Service delivery end date: June 2022 Any other relevant milestones? Six and 12-month reviews of services occur in February and August of each year following receipt of service provider reports.
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details)

	2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes
Decommissioning	1a. Does this activity include any decommissioning of services? Yes 1b. If yes, provide a description of the proposed decommissioning process and any potential implications. • Wheatbelt: WACHS Wundowie Complex Care Coordination – contract ceased 31 Dec 2018. Remaining funds have been temporarily moved to WACHS Self-Management Service and will transition to fund a new service on the Turquoise Coast. • Wheatbelt: WACHS Self-Management – contract to cease 30 June 2019 and will transition to fund a new service on the Turquoise Coast. • South West Diabetes Education Program – funding ceasing. • Kimberley WACHS contract for Chronic Conditions – contract completed.
Total Planned Expenditure	

Funding Source	2019-2020	2020-2021	2021-2022	Total
Planned Commonwealth Expenditure - Core Flexible Funding	$10,429,781	$10,694,510	$0	$21,124,291
For Approval – 17/18 Unspent Funds				
For Approval – 18/19 Unspent Funds				
Funding from other sources	$0	$0	$0	$0

Funding from other sources	Nil

Proposed Activities	
ACTIVITY TITLE	**CF 2: Developing System Capacity/Integration**
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Population Health
Needs Assessment Priority	**Priorities:** • CGP1.2: Support primary care providers to improve the management of patients with chronic conditions and reduce unnecessary hospitalisations through effective care pathways, service coordination and service linkages. (p.94) **Possible Option:**

	• Encourage general practice to utilise health pathways to direct patients to appropriate health care providers. (p.95) **Priorities:** • CGP1.5: Promote the effectiveness of digital health technologies to optimise patient care. (p.96) **Possible Options:** • Build capacity of primary care and general practice to intervene early in conditions that might progress for people with risk factors. (p.95) • Provide support and education to general practice, to identify patients at risk of developing chronic disease and comorbidities through analysis of clinical data and provide early intervention. (p.96) • Partner with health service providers to implement innovative methods of care using digital technologies. (p.96)
Aim of Activity	The aim of this activity is to: • support the primary health care sector by providing an online health information portal (HealthPathways) for general practitioners and primary health care clinicians, to assist with management and appropriate referral of patients when specialist input is required. • facilitate integrated holistic services to reduce the impact of chronic disease by providing enablers for service and patient level integration.
Description of Activity	**HealthPathways License and Support** The PHN will continue to purchase the HealthPathways license and associate support. The license allows the PHN to use the online system for GPs and primary health clinicians that provides additional clinical information to support their assessment, treatment and management of individual patient's medical conditions, including referral processes to local specialists and services. **PenCAT License** The PHN will continue to purchase the PenCAT license. The license allows the PHN to extract general practice data for practice analysis and aggregates general practice data for service planning, reporting and population health needs. Supports patient centred care. Note: More detailed information about these programs is provided in GPS 2.
Target population cohort	Primary Health Care patients who are at risk of poor health outcomes, and the health/social care workforce who work with this population.
Indigenous specific	No
Coverage	Country WA PHN
Consultation	When a HealthPathways' clinical stream is localised or reviewed, a multi-disciplinary working group meeting is held. Working groups vary in composition, however they generally include clinicians such as GPs, Specialists and Nurses along with Allied health professionals, as well as with representation from relevant peak bodies. On completion of a clinical pathway (or where a pathway has undergone significant changes post review) a wide consultation is conducted in collaboration with the WA Department of Health - Health Networks. This

	involves notifying all relevant stakeholders that the pathway is available for review on the draft site and providing an appropriate mechanism for input.
Collaboration	The PHN team works in partnership with a range of stakeholders, including: **Providers:** • Streamliners **Partners:** • The WA Health system – partnership agreement to enable endorsement of process and provision of subject matter experts o WA Country Health Services o WA Department of Health - Health Networks o Metropolitan Area Health Services • HealthPathway Communities **Contributors and content reviewers:** • Cancer Council WA • Communicable Disease Control Directorate • Western Australian Department of Health - Health Networks • Peak bodies • Health, allied health and social care sector organisations • General practitioners – expert opinion • Medical specialists– expert opinion • Pharmacists – subject matter expertise • Nurses – subject matter expertise • Allied health clinicians – subject matter expertise
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022 Service delivery start date: July 2019 Service delivery end date: June 2022
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No b. Is this activity this result of a previous co-design process No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No
Total Planned Expenditure	

Funding Source	2019-2020	2020-2021	2021-2022	Total
Planned Commonwealth Expenditure - Core Flexible Funding	$235,652	$125,000	$0	$360,652
For Approval – 17/18 Unspent Funds				
For Approval – 18/19 Unspent Funds				
Funding from other sources	$0	$0	$0	$0
Funding from other sources	Nil			

Proposed Activities	
ACTIVITY TITLE	**CF 3: Chronic Heart Failure**
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Population Health
Needs Assessment Priority	**Priority:** • P1.2: Support primary care providers to improve the management of patients with chronic conditions and reduce unnecessary hospitalisations through effective care pathways, service coordination and service linkages. **Possible Option:** • Strategies to develop integrated care pathways in partnership with local hospital networks, health services, general practices and other clinicians. (p.23-24). **Priority:** • P1.6: Work with Local Hospital Networks, primary care providers and other health service providers to reduce high rates for chronic disease morbidity and mortality. **Possible Option:** • Improve care coordination and communication between general practice, local hospital networks and other health service providers. (p.23-24) In 2015/16 there were 6,207 potentially preventable hospital admissions to Western Australian hospitals due to congestive heart failure, with an average length of inpatient stay of approximately 6 days. At an estimated average cost of $9,500 per episode, this represents a potentially avoidable cost of approximately $59 million per annum for the hospital system. (WAPHA *Chronic Heart Failure: Building a Collaboration to implement Multidisciplinary Care 2018* – unpublished) The rate of potentially preventable hospitalizations for heart failure is markedly higher among Aboriginal and Torres Strait Islander people compared with other

	Australians, with the largest differential evident between Aboriginal and non-Aboriginal Australians occurring in Western Australia.[1] • In 2014/15, the potentially preventable age and sex standardized hospitalization rate for heart failure among Aboriginal Western Australians was the highest rate in the nation, and nearly 5 times the rate for non-Aboriginal Western Australians. • The comparison between Aboriginal Western Australians and the experience of other Aboriginal and Torres Strait Islander Australians is also stark: the potentially preventable hospitalization rate for heart failure for Aboriginal Western Australians was 1.7 times the rate for Aboriginal and Torres Strait Islander people nationally. Rates of hospitalisation for heart failure are markedly higher in remote areas. Within Western Australia, the Kimberley had the highest rate, and the second highest rate nationally after Barkly in the Northern Territory. Identified areas with high rates of avoidable deaths, hospitalizations and risk factors for heart failure as indicated in Country WA PHN 2018 Needs Assessment (p.23-24) are: Kimberley, Pilbara, Goldfields, Midwest, Bunbury and the Wheatbelt. • The Kimberley had significantly higher rates of avoidable deaths from circulatory diseases and ischaemic heart disease, and significantly higher rates of hospital admissions for circulatory system diseases. Figures for risk factors and diabetes prevalence are not available for the Kimberley. • The Pilbara had significantly higher rates of avoidable deaths from circulatory diseases and ischaemic heart disease. Figures for risk factors and diabetes prevalence are not available for the Pilbara. • The Goldfields had significantly higher rates of avoidable deaths from circulatory disease and ischaemic heart disease, and high rates of hospitalizations for circulatory system disease. Additionally, the Goldfields had a high rate of residents with diagnosed diabetes. • The Midwest had significantly higher rates of circulatory system disease. The Midwest also had a high rate of residents with diagnosed diabetes and a significant proportion of males and females with one of four risk factors, i.e. current smoker, high alcohol intake, obesity and low exercise levels. • Bunbury had identified hotspots for angina and congestive heart failure, hospitalizations for circulatory system diseases and a significant proportion of males and females with one of four risk factors. • Populations residing in the Wheatbelt had been identified as an at-risk population with significant proportion of males and females with one of four risk factors, high blood pressure, and high blood cholesterol and diagnosed circulatory system diseases.
Aim of Activity	The aim of the Chronic Heart Failure (CHF) Project is to: • enhance the role of Primary Care in the management of CHF in line with the newly accepted[1] National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand (2018) *Guidelines for the Prevention, Detection and Management of Heart Failure in Australia 2018;* and • to reduce Potentially Preventable Hospitalisations (PPH) through an integrated person-centered model of care for CHF.

[1] Australian Commission on Safety & Quality in Health Care (2017) *The Second Australian Atlas of Healthcare Variation.* Chapter 1.2 Heart Failure.

	Consistent with these guidelines WAPHA is interested in exploring opportunities for collaborative, integrated action on chronic heart failure, recognizing: • The significant burden of disease CHF represents in the Western Australian community, and in particular locations. • The opportunity to shift the focus of care more towards management of patients with chronic heart failure in primary care, with appropriate support from the acute and community care sectors. • The evidence of unmet need in specific communities across Western Australia, as indicated by WAPHA's needs assessment work. • The strength of the evidence-base for primary care involvement in the multidisciplinary care of patients with chronic heart failure. • The opportunity to shape a collaboration with State health services and partners, including the National Heart Foundation and School of Public Health at Curtin University, to translate evidence into practice for the benefit of this important patient cohort. Heart failure, which typically involves multiple comorbidities, frequent referrals between primary and secondary/tertiary services, and the involvement of a broad range of community, primary care and specialist service providers in the effective management of patients, would provide important learnings for future integrated care initiatives. Working with its partners, WAPHA would like to develop initiatives that target improvements in the management of patients who have chronic heart failure in order to achieve the principles that underpin Patient Centered Medical Home (PCMH) the Quadruple Aim: • Patient Experience – improve patient care and satisfaction • Population Health – improve the health of populations • Cost of Care – reduce the per capita cost of health care • Provider Wellbeing – improve the work lives of health care providers, clinicians and staff.
Description of Activity	This activity will be delivered in two Phases. **Phase 1** Prior to 30 June 2019, WAPHA is engaging in a short-term process to resolve gaps in services; opportunistically funding activities that will build capacity in the primary care sector to work in the area of Chronic Heart Failure. Examples include but are not limited to: • upskilling GPs in accordance with the new guidelines • provision of patient resources to improve literacy and engagement, and ensuring cultural sensitivity • virtual cardiac rehabilitation in community, particularly in country WA • better integration with hospitals • enhanced cardiac rehabilitation in the community • enhanced multi-disciplinary team-based care in primary care for CHF management **Phase 2** A longer process to co-design significant activities that will occur over the financial years of 19/20 and 20/21. This will be inclusive of major stakeholders and will look to develop activities in the following areas: • Multidisciplinary Heart Failure Team Care:

	○ Facilitating involvement of GPs and other primary health care practitioners (e.g. practice nurses, community pharmacists, physiotherapists) in the multidisciplinary care of patients with heart failure; • Development and implementation of shared care models which incorporate GP access to cardiologist support for the management of heart failure patients in primary care, including: ○ Access to timely advice and support in monitoring signs and symptoms and symptom management ○ Referral pathways to acute care for patients with heart failure who are deteriorating, or at risk of deterioration • Country Metropolitan Linkages ○ Trialing models to strengthen integrated care for heart failure patients living in country WA, with a focus on the needs of Aboriginal country residents with chronic heart failure. • Workforce Capacity ○ Developing capacity in the primary care workforce to be effective partners in the multidisciplinary care of heart failure patients.
Target population cohort	People who are financially disadvantaged and vulnerable, including those of Aboriginal and Torres Strait Islander descent, who are at risk or who have chronic heart failure in the Hotspots that have been identified below.
Indigenous specific	No
Coverage	Potentially preventable hospitalisations hotspots for Congestive Heart Failure for Country WA PHN: 1. **Kimberley**: Derby-West Kimberley, Halls Creek, Kununurra, Roebuck 2. **Pilbara**: Ashburton, Newman, Roebourne, South Hedland 3. **Goldfields**: Boulder, Kalgoorlie, Leinster-Leonora 4. **Midwest**: Geraldton East, Meekatharra 5. **South West**: College Grove-Carey Park, Koombana 6. **Great Southern**: Gnowangerup
Consultation	The PHN consults and has consulted with a range of key stakeholders. Major stakeholders common to all regions include: • WA Country Health Service (WACHS) – Director of Population Health • WACHS – Community District Health Advisory Councils • Local Governments • Aboriginal Medical Services • Aboriginal Health Planning Forums • Chronic Conditions Networks • Local Health Professionals located in the regions • Regional Clinical Commissioning Committees across the 7 regions of the PHN. • People living with CHF, their family and carers Major stakeholders at a state level include: • Commonwealth Department of Health • WA Department of Health • Carers WA • WA Aboriginal Community Controlled Health Organisations • Heart Foundation WA • Pharmaceutical Society of WA

	• Australian Medical Association Council of General Practice (WA) • Rural Health West • WA Association for Mental Health
Collaboration	A Chronic Heart Failure Workshop for interested stakeholders representing primary care, acute care, prevention, research, consumers with lived experience and Aboriginal people and organisations occurred in November 2018 to commence the project. This group contributed to an initial consultation regarding gaps in services, and what was possible in the management of Chronic Heart Failure in the community. These ideas have been progressed in Phase 1 of the project. Phase 2 of this project will further identify all stakeholders and collaborators to reduce PPHs for CHF. These collaborators have already been identified above in the section on Consultation and are already actively involved in the Steering Committee for the project. They include the WA Health Department, Consumers, Cardiac Specialists, Area Health Services policy makers. An expert panel will also be formed to guide the co-design process and will have greater involvement from collaborators including – academics, specialists, GPs, Peak Not for Profits, Hospital Service Providers, Aboriginal Medical Services and Aboriginal Controlled Community Health Organisations. The co-design process will enable collaboration which is patient centred and across sectors – government, primary care, not for profit and private.
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2021 Once service providers are contracted, 6 and 12-month reviews of services will occur in February and August of each year.
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☒ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No

Total Planned Expenditure				
Funding Source	2019-2020	2020-2021	2021-2022	Total
Planned Commonwealth Expenditure - Core Flexible Funding	$740,000	$740,000	$0	$1,480,000
For Approval – 17/18 Unspent Funds				
For Approval – 18/19 Unspent Funds				
Funding from other sources	$0	$0	$0	$0
Funding from other sources	Nil			

1. (b) Planned PHN activities for 2019-20 to 2021-22 – Core Health Systems Improvement Funding Stream – General Practice Support funding

Proposed Activities	
ACTIVITY TITLE	**HSI 1: System Integration**
Existing, Modified, or New Activity	Existing
Needs Assessment Priority	Not applicable
Aim of Activity	**Strategic Direction** The WA Primary Health Alliance is committed to tackling the long-term challenges in our system – fragmented care, duplication, an ageing population, chronic disease that is complex and co-occurring, sustainability and building a capable, accessible primary care workforce to respond to these challenges. Health services need to be better co-ordinated around the individual to ensure that the right care is available at the right time and the right place. The purpose of this activity is to develop the landscape for joint planning, coordinated commissioning and shared accountability; positioning WAPHA as a leader in primary care to steward system integration across WA; and cultivating regionally appropriate governance structures both state-wide at the system manager level with WA Health and the Mental Health Commission, and at the local level with General Practitioners, primary care providers, public/private hospitals and other stakeholders with a vested interest in improving health outcomes. **Population Health Planning** • Identify the health priorities of the local populations in WA with a key focus on those who are disadvantaged and vulnerable. • Understand supply and demand and identify service shortages based on a broad range of qualitative and quantitative data that we have either collected ourselves, have had provided to us by external partners, or which is publicly available. • Identify barriers and enablers for access to primary health care for people with a key focus on those who are disadvantaged and vulnerable. • Work towards effective partnerships with other organisations for shared data capture and linkage to inform planning. **Commissioning** • Identify opportunities for state-wide and place-based joint planning and commissioning. • Utilise frameworks, e.g. Outcomes, Commissioning and Prioritisation, to apply a consistent, state-wide and yet locally tailored, place-based approach to the design, commissioning, monitoring and evaluation of outcome based-interventions to address prioritised health and service needs.

	• Ensure that commissioned services in WA are evidence based, meet local identified population health needs effectively and efficiently, and are nested in pathways to ensure integration and access. • Encourage the coordination and partnership of local services to meet the needs of their community and to ensure system integration. • Join up the system and improve access. • Continue to monitor and respond to emerging trends in health needs and service needs. • Contract manage performance of contracted providers through a relationship-based approach and evaluate the impact of commissioned programs.
Description of Activity	**Strategic Direction** WA Primary Health Alliance: • Develops, aligns and operationalises WA population primary health priorities within the context of Commonwealth primary health care policy, the evidence base and by application of a systems approach and outcomes-based commissioning. • Leads the work of the 3 WA PHNs in respect to relevant primary health care policy and strategy and its impact on commissioning priorities, service design and implementation. • Leads in the development of evidence based, innovative, best practice models of primary health care service delivery and funding models. • Informs Federal and State Government policy and strategic direction based on identified priority health and service needs. • Embeds relevant Commonwealth and State strategies and frameworks into its commissioning activity. **Population Health Planning** • WAPHA, in conjunction with our academic partner, Curtin University, undertakes analysis to identify service and supply shortages based on a broad range of qualitative and quantitative data that we have either collected ourselves, have had provided to us by external partners, or that is publicly available. This analysis is used to inform primary care workforce planning and identify the health and service need priorities of the local population. **Commissioning** The WAPHA Commissioning cycle for both state-wide and place-based services involves: • Planning - identifying local needs and service gaps based on data and service analysis and consultation with key stakeholders. • Designing - using best practice models and working with local and state-wide service providers and stakeholder to develop appropriate service responses. • Procuring - using a range of approaches based on an analysis of the market place including EOIs, Requests for Proposal and Requests for Tenders. • Monitoring and Review - outcome based contracts and reporting are developed and implemented across WAPHA. • Evaluating - the performance of services is evaluated, and it is determined whether, and to what extent, a reshaping of the structure of supply is

	required. This process uses the Outcome Maps, provider and client reported outcomes and other relevant data. • The PHN continuing to focus on managing performance (applying sound principles of relationship management) of contracted providers including reviewing/monitoring and evaluating services to determine: o How well targeted and efficient services are - using a diverse range of data collection methods (i.e. provider reports, referral agency feedback, patient opinion) that, for each of the commissioned services, will provide the PHN with the information to: o Assess improvements to health outcomes. o Help shape future service provision and/or seek alternative commissioning activity. o How effective services and systems are in relation to: • Patient experience • Patient health outcomes with focus on the efficacy of treatment to deliver a positive client outcome • Service/system integration • Service sustainability including provider experience/governance. • Findings of formal evaluation (if conducted externally) **Commissioning for Better Health** WAPHA has prepared a Commissioning for Better Health program to guide its future development as a commissioning agency on behalf of the Australian Government. The Commissioning for Better Health program contains specific commitments and deliverables in the areas of strategic planning, service procurement, and monitoring and evaluation and has a timeframe of 18 months for full implementation. Commissioning for Better Health complements the Western Australian Government's Sustainable Health Review, released April 2019, with its strong emphasis on integrated service planning across primary and acute care, identification of key priorities for targeted intervention, and incorporation of evidence-based guidelines and consumer input into service design. The program will be delivered through a collaborative approach involving WAPHA staff and in partnership with our stakeholders. Key components of the plan include establishing a Commissioning for Better Health Advisory Board, preparation of a 5 Year Health Plan, development of a Resource Allocation Formula to guide future commissioning decisions, implementing program management for all Australian Government funded programs, drawing up a Commissioning Skills Development program, implementing local best practice guidelines for commissioning activities, implementing a Performance Management Framework, and preparing a Primary Care Workforce Development Strategy and a Primary Care Digital Health Strategy.
Associated Flexible Activity	Not applicable
Target population cohort	Not applicable
Indigenous specific	Not applicable
Coverage	Country WA PHN

Consultation	At a local level, Regional Clinical Committees and District Health Advisory Committees provide a valuable consultation forum through which to gain insight and input to the integration of WAPHA's work within local health pathways and providers.
Collaboration	WAPHA will continue to work with the following key stakeholders to design and implement integrated models and systems of care: • WA Department of Health • Health Service Providers – particularly WA Country Health Service • Mental Health Commission • Royal Australian College of General Practice • Western Australian General Practice Education and Training • Primary Care Providers • Consumer advocacy bodies including Health Consumers' Council WA • Sector peak bodies including WA Network of Alcohol and other Drug Agencies, WA Association for Mental Health, WA Council of Social Services, Aboriginal Health Council of WA, Rural Health West and WA Local Government Association • Relevant local service providers and networks in the priority areas identified in the Needs Assessment. WAPHA sees these collaborators as partners in decision making and in the development of alternatives. Their insight, experience, knowledge and remit from across all parts of the health system, are essential to identifying solutions at individual, service and system levels.
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	Not applicable
Total Planned Expenditure	

Funding Source	2019-2020	2020-2021	2021-2022	Total
Planned Commonwealth Expenditure - Core Health Systems Improvement Funding	$3,418,362	$3,389,881	$0	$6,808,243
Planned Commonwealth Expenditure – General Practice Support Funding	$0	$0	$0	$0
Total Planned Commonwealth Expenditure	$3,418,362	$3,389,881	$0	$6,808,243
For Approval – 17/18 Unspent Funds				
For Approval – 18/19 Unspent Funds				
Funding from other sources	$0	$0	$0	$0

Funding from other sources	Nil

Proposed Activities	
ACTIVITY TITLE	**HSI 2: Stakeholder Engagement and Communications**
Existing, Modified, or New Activity	Existing
Needs Assessment Priority	Not applicable
Aim of Activity	Communications and stakeholder engagement activities are focussed on establishing strong and meaningful relationships with the diverse stakeholders who affect and are affected by our work. Establishing and maintaining trusting and purposeful relationships is essential to achieving our vision of improved health equity. The strength of our relationships with stakeholders enables us to work collaboratively with others and to engage a diversity of knowledge, skills and experience through all aspects of commissioning. Demonstrating and maintaining a positive reputation is essential as an approach to managing risks for WAPHA as a local commissioner, and for risks to the PHN program as a whole. Delivery of targeted communications through relevant channels, and messaging, ensures that key information reaches the relevant stakeholder audiences of the PHN. Communications is an enabler to practice support and broader commissioning activities. Effective communication activities also ensure identification and understanding of the role and scope of WAPHA. Upholding a strong reputation with stakeholders improves our ability to engage all relevant stakeholders in codesign throughout the commissioning cycle. Engaging our stakeholders appropriately, and with purpose, informs the planning, design, delivery and evaluation of our work and that of the primary care service sector. Stakeholder Engagement activities work to increase levels of support and enthusiasm for innovation and change, and seek to bring stakeholders on the commissioning journey, creating collective leadership and ownership in achieving the intended outcomes.
Description of Activity	**Communications and Marketing** WAPHA Corporate Affairs team will be focusing on strategic communication activities to build and strengthen awareness and understanding of WAPHA's role, and therefore that of the overall PHN program, in shaping and integrating the health sector and commissioning primary care activities. This will include: • Developing our strategic key messages, mainly targeted at specific high interest/ high influence groups and educating our staff, Board and Council members on these to ensure we speak to our stakeholders consistently. • Building our audiences and engaging with them in a targeted manner, consistently and appropriately.

	• Refining our communication approach and channels, ensuring cultural appropriateness, and building on those which are most effective. • Developing our online/ digital presence to ensure our voice is heard and that we are part of strategically important online conversations. **Stakeholder Engagement** WAPHA will continue to develop best practice stakeholder engagement across all areas of work. WAPHA will continue to define and prioritise stakeholders to ensure we maximise the value, or potential value, of the stakeholders' relationships with WAPHA. This will include due consideration of stakeholders' ability to impact our strategic goals and meet commissioning needs and expectations, the geographic location and the potential reach to the population - with particular reference to more vulnerable and disadvantaged groups. WAPHA will foster a culture of prioritising strategic stakeholder engagement through leadership and change management. WAPHA will focus on developing commissioning approaches and practices that work towards increasing engagement with stakeholders in the involve, collaborate, and (where appropriate) empower levels of the IAP2 participation spectrum. Developing our practice will include skills development internally and for stakeholders, particularly as we continue to improve the ways in which community, consumers, family and carers are engaged across the commissioning cycle. Internally, the focus will be on developing more consistency to the structures and methods WAPHA uses when undertaking engagement activities. This includes projects such as refinement and implementation of policies and tools to help manage stakeholder expectations and to support purposeful engagement. Externally, WAPHA will be working to increase the reach of engagement through the online platform, Primary Health Exchange. This will include supporting use of the platform in partnership with key stakeholders such as the WA Department of Health, WA Country Health Service and Health Consumers' Council. Primary Health Exchange will also be used to support the growth and further development of the Online Stakeholder Panel, to provide a pool for consultation with health professionals and community, consumers, family and carers. New open forums will be hosted for all stakeholders, through which current priorities and future directions will be shared. These will respond to requests from stakeholders for greater transparency over the remit and scope of PHNs and to support a shared understanding of the local context and direction of the PHN. WAPHA will continue to develop and strengthen relationships with Members and Partners through formal Memorandums of Understanding and Membership arrangements with like-minded organisations. The Stakeholder Engagement Team will manage and support Clinical and Community Councils and Committees to ensure they remain integral to the engagement strategy and are able to provide meaningful and timely advice to the Board.
Associated Flexible Activity	Not applicable

Target population cohort	Engagement and Communication with the following key stakeholder groups has been identified as a priority: • General Practitioners • Industry and Sector Peak Bodies • Community, Consumers, Family and Carers • Locally relevant stakeholders as identified.
Indigenous specific	All Corporate Affairs and Stakeholder Engagement activities are informed by the WAPHA Aboriginal Health Team where activities are related to the health and wellbeing of Aboriginal people. This ensures that the communications and proposed engagement are culturally appropriate and supports meaningful engagement.
Coverage	Country WA PHN
Consultation	WAPHA has utilised the skills of expert strategic communications and engagement consultants, received advice through the WAPHA Board, Clinical and Community Councils as well as undertaking consultation as part of other related stakeholder workshops to guide the focus and priorities for these activities.
Collaboration	WAPHA will continue to work with the following key stakeholders to design, implement and monitor the effectiveness of Communications, Marketing and Stakeholder Engagement activities: • Australian Government Department of Health • WA Department of Health • WA Country Health Service • Rural Health West • Health Service Providers • WA Mental Health Commission • Royal Australian College of General Practitioners WA Faculty • WA General Practitioner Education and Training • Service Providers • Consumer advocacy bodies including Health Consumers' Council WA Sector peak bodies including: • WA Network of Alcohol and other Drug Agencies, • WA Association for Mental Health, • WA Council of Social Services, • WA Local Government Association • Relevant local service providers and networks in the priority areas as identified in the Needs Assessment. Workforce groups such as Australian Primary Health Care Nurses Association and Australian Practice Managers Association will also be consulted as appropriate. Where possible, WAPHA will work in collaboration with relevant stakeholders on the delivery of communications messages and materials and in the design and development of stakeholder engagement activities.
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2021 Any other relevant milestones? No
Commissioning method and	Not applicable

approach to market				
Total Planned Expenditure				
Funding Source	2019-2020	2020-2021	2021-2022	Total
Planned Commonwealth Expenditure - Core Health Systems Improvement Funding	$372,941	$369,834	$0	$742,775
Planned Commonwealth Expenditure – General Practice Support Funding	$0	$0	$0	$0
Total Planned Commonwealth Expenditure	$372,941	$369,834	$0	$742,775
For Approval – 17/18 Unspent Funds				
For Approval – 18/19 Unspent Funds				
Funding from other sources	$0	$0	$0	$0
Funding from other sources	Nil			

Proposed Activities	
ACTIVITY TITLE	**HSI 3: Obesity Collaborative**
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Population Health
Needs Assessment Priority	**Priority:** • P1.3 Engage with primary health care providers and local hospital networks to improve transitions of care, care coordination and service linkages. **Possible Option:** • Strategies to develop integrated care pathways in partnership with local hospital networks, health services, general practices and other clinicians. (p.21) **Priority:** • P1.5 Reduce rates of potentially preventable hospitalisations by working with primary care providers to target specific areas where there are higher than state rates. **Possible Option**: • Build capacity of primary care and general practice to intervene early in conditions that might progress for people with risk factors. (p.21) General Practitioners are often well placed to identify overweightness and obesity. Patient engagement in management is critical, as for any chronic disease. Treatment needs to be evidence based and focused on a broad range

	of health outcomes, not simply on weight. Ideal management of obesity in time-poor, busy general practice requires a team care approach involving staff or access to providers specifically trained and experienced in obesity management. These may include dietitians, practice nurses, specialists (Endocrinologists, general physicians and bariatric surgeons), commercial weight management programs, exercise physiologists and psychologists. Note that team care arrangements are not currently available for patients who are not diagnosed with a chronic disease. In RACGP Health of the Nation report 2018[2], obesity was identified by GPs as their second most concerning health issue for the future and as a key area that the federal government should prioritise for action. WAPHA recognises that there is a lack of awareness and confusion within general practice about evidence-based interventions and a lack of confidence in starting a conversation with patients about their weight. Other health professional groups, such as podiatrists and pharmacists, report similar issues. Changes to general practice workflow will require incorporation of 'difficult conversations' about identification of weight issues and appropriate management. WAPHA will work intensively with general practices to collect patient data (height, weight and waist measurement) to measure a patient's BMI and use this data for quality improvement, applying PDSA cycles. Identification in general practice of at-risk patients for chronic disease is integral to preventing progression to potentially preventable hospitalisations. The funding sought will enable the Collective to develop a co-designed model of care that focuses on early detection and primary care sector interventions for the prevention of chronic disease through a targeted strategy to tackle Obesity in a structured and intensive way in general practice. WAPHA, in partnership with the Collective, will consult with Clinical and Consumer Committees and key stakeholders, to review and evaluate current programs to ascertain the best fit for our regional contexts and roll out into general practice. Consultation is required to assess the appropriateness and value of proposed models and tools. It is important that primary care is also linked in with schools, workplaces, urban planning, food environment and social media. Evaluation of the Collective's general practice initiative will require development of a suite of evaluation measures against the Quadruple Aim and is intended to demonstrate return on investment, value for money and system impact.
Aim of Activity	Planned activities are early detection and primary care intervention to prevent chronic disease through a targeted strategy to tackle overweight and obesity in a structured and intensive way in general practice. WAPHA intends to provide funding for early intervention and management of overweightness and obesity to support General Practitioners and other primary health care professionals and their patients with innovative, scalable and sustainable approaches to weight management. General practitioners and practice nurses will be encouraged to identify, engage and regularly communicate with local weight management providers. These may include

[2] https://www.racgp.org.au/FSDEDEV/media/documents/Special%20events/Health-of-the-Nation-2018-Report.pdf

	dieticians, practice nurses, exercise physiologists and psychologists as well as commercial weight management programs. The project will encourage clinical leadership of healthy weight strategies, an understanding of exceptions for surgery based on BMI and management of overweight and obese patients whilst on surgical wait lists. WAPHA will focus on creating sustainable behaviour change for GPs, other practice staff and allied health professionals and patients. The focus for interventions will be on achieving an initial 5-10% decrease in patients' weight to reduce health risk. This target will encompass measurement and demonstration of the impact of dedicated funding on uptake of healthy weight interventions in general practice. This work will be used to inform the development of WA's Healthy Weight Policy, in partnership with WA Health and the Health Consumers' Council, from a primary care perspective
Description of Activity	The overweight and obesity management strategy in General Practice could include the following strategies and actions: 1. Provision of evidence-based tools for the management of weight and prevention of obesity for General Practice. • Survey of GPs and Practice Nurses regarding gaps, barriers and opportunities for better management of overweight and obesity in general practice. • Development of practice toolkit for GPs including synthesis of current guidelines. • Implementation of a general practice of GP led, evidence-based weigh management program (e.g. ANU Change program which is free to PHNs). • Use of Chronic Disease Management Plans through the MBS for people with complex obesity. • GP and GP Registrar education regarding prevention, detection and management. Awareness of stigmatization and inequity. • Use of PDSA cycles (coaching and support from WAPHA practice support staff). • Consider what can be dons in the practice waiting room (e.g. use of iPads to record patient information). 2. Provision of information and advice on referral pathways in General Practice. • Multi-disciplinary team care pilot. • Up to date information on local programs and services for general practices. • Further development and promotion if HealthPathways, referral and management pathways for overweight adults and older adults, childhood obesity and bariatric surgery. 3. General Practice Support. • Information on new eating disorders item numbers. • Difficult conversations – scripting and support for GPs using NHS and WA Health resources. • Assistance with MBS items that can assist in weight management and obesity. • WAPHA branded measuring tape and scales for consult rooms – and coaching for use.

	• GP Symposium (informative and academic, focused on general practice). CPD streams on difficult conversations; care management and team care; showcase the functions of allied health professionals in this space. 4. Commission integrated weight management services for General Practice. • Multi-disciplinary team care pilot. • Build on the Cockburn model – whole of system / suburb approach with GPs at the Centre. • Small grants program for practices to undertake team care in weight management – evidence-based interventions.
Target population cohort	Overweight and obese patients
Indigenous specific	No
Coverage	Country WA PHN region
Consultation	The Obesity Collaborative has harnessed the collective intelligence and experience of stakeholders to create the WA Healthy Weight Collective Action Plan. This consultation has included: • Connecting with hundreds of consumers who have shared their stories, experiences, and perspectives of weight loss, including their interactions with the health system. • Collaborating with numerous organisations and teams within the WA Health system willing to participate in the Obesity Collaborative, share insights and knowledge, and eager to support changes to the health system to provide a better service for Western Australians. • Connecting with the Healthy Weight Collective at the national level to find ways to align and support each other. • Delivering the Obesity Collaborative Summit with over 200 participants creating the actions for the WA Healthy Weight Action Plan that will provide the roadmap for WA Health and WAPHA to make system changes to reduce the impact of overweight and obesity on the WA community. The draft WA Healthy Weight Collective Action Plan focuses on key areas of action that can be adopted in the next 5 years across the health system and broader community targeted at early intervention and management of overweight and obesity. The final draft will also be released for public consultation via the Department of Health Consultation Hub.
Collaboration	This activity will be undertaken in collaboration with the WA Department of Health, which is contributing $700,000 to help establish the Healthy Weight Collective. The three WA PHNs will collaborate in the roll out of the project across Western Australia in the first six months of 2019. The Project Leadership Group consists of current Obesity Collaborative members, Health Service Provider, Department of Health, WAPHA and Health Consumers Council. The Leadership Group is being consulted on the Draft Healthy Weight Action Plan including developing detailed actions that identify ownership and timelines. Written endorsement and commitment to action will be secured before the launch of the Action Plan in 2019.
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2021

	Once service providers are contracted, 6 and 12-month reviews of services will occur in February and August of each year.
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☒ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No
Total Planned Expenditure	

Funding Source	**2019-2020**	**2020-2021**	**2021-2022**	**Total**
Planned Commonwealth Expenditure - Core Flexible Funding				
Approved – 17/18 Unspent Funds	$ 334,388			
For Approval – 18/19 Unspent Funds				
Funding from other sources	$0	$0	$0	$0

Funding from other sources	Nil

Proposed Activities	
ACTIVITY TITLE	**GPS 1: General Practice Support**
Existing, Modified, or New Activity	Existing Activity
Needs Assessment Priority	**Priority** • CGP1.8: Improve the rates of cancer screening and reduce avoidable deaths from cancer (p.98) Possible Option • Provide general practice support to increase cancer screening rates. (p.98)

Aim of Activity	This activity aims to support general practice staff and clinicians in providing high quality and evidence-based care for their patients, including preventive and proactive activities with a focus on those at risk of poor health outcomes, to improve population health. Support will be provided in response to practice need but will also include foci on the national cancer screening programs, immunisation, practice accreditation, health assessments and GP management plans. General Practice will be able to access support via a variety of mediums. Consequently, barriers to access will be removed by making support accessible to practices by the method they choose. This will also allow practices to receive help quickly when they need it, thus freeing them to focus on patient care. Consideration will also be given to flexible approaches to reaching identified vulnerable groups needing immunisation.
Description of Activity	General Practice support will be provided to all staff working within a general practice. This includes multidisciplinary staff e.g. GPs, practice managers, practice nurses and support staff. General Practice support will be provided via a number of mediums. • The Practice Assist website allows general practice staff to search through a comprehensive library of resources, templates and factsheets on a variety of topics. They can also search for upcoming education events and webinars, find information on research studies and surveys and links to the newsletter. Ongoing work includes reviewing and maintaining the website to keep the content up to date. It also includes generating new content in line with identified need and new policy or programs commencing. • The Practice Assist helpdesk provides non-clinical support by phone and email to all general practice staff with an aim to resolve simple queries within 1 business day and more complicated queries within 3 days. • Practice Support Staff regularly visit practices to provide more in-depth support and coaching centred around quality improvement and practice need. They also provide information and support on a range of topics including accreditation, cancer screening and immunisation. • Awareness raising and promotion of appropriate interventions to improve childhood, Aboriginal, Adolescent and Adult immunisation coverage is communicated to practices via the Practice Assist website, practice newsletter and through practice visits. • Education of practices about bowel, breast and cervical cancer screening programs and provision of support to implement into practice, is facilitated through the Practice Assist Website and reinforced by practice visits. • Contributions to service directories containing information that practices require when making referrals to specialist and community-based services. This includes HealthPathways request pages, NHSD and My Community Directory. • Networking and education events are facilitated to allow practice managers and practice nurses to share lessons both of what works well and also challenges their experience. Updates are also provided through these forums. • Updating practices on Commonwealth health policy initiatives such as PIP QI and WIP to support understanding and access.

	• Connecting General practices with quality, evidence-based services to support their patient needs in their catchment areas, including WAPHA commissioned services. • Data analysis regarding the practices' screening targets and service delivery to enable them to improve.
Associated Flexible Activity	**CF 2: Developing System Capacity/Integration**
Target population cohort	General Practice who support Country WA PHN community and health consumers.
Indigenous specific	No
Coverage	Country WA PHN
Consultation	During 2017, General Practice staff were surveyed, and information collected about the types of support they required and how they would like the support delivered. During 2018, Practice Nurses were surveyed to see if Practice Nurse networking sessions would be valuable. Information on potential topics and format was also captured. • Consultation to inform resource design: o Non-Government Organisations including Cancer Council, Diabetes WA, Asthma WA, The Lung Foundation o Rural Health West o Communicable Disease Control Directorate o General practices • Consultation to inform quality improvement activities: o Community, carers and consumers o health and social care sector organisations.
Collaboration	The PHN team works with a range of stakeholders, dependent upon place-based needs and including but not limited to: • Partner for education and quality improvement activities: o Australian Government Department of Health o Royal Australian College of General Practice o Australian College of Rural and Remote Medicine o Rural Health West o Australian Practice Nurse Association o Non-Government Organisations including Cancer Council, Diabetes WA, Asthma WA, The Lung Foundation, The Heart Foundation, Pharmaceutical Society of Australia o Pharmaceutical companies e.g. Novartis and Seqirus o Communicable Disease Control Directorate o Universities o WA Country Health Services o Health Networks • Co-designer and partner in implementation of Practice Assist: o Rural Health West
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension

	☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes
Total Planned Expenditure	

Funding Source	2019-2020	2020-2021	2021-2022	Total
Planned Commonwealth Expenditure - Core Health Systems Improvement Funding	$106,126	$105,242	$0	$211,368
Planned Commonwealth Expenditure – General Practice Support Funding	$161,487	$161,487	$0	$322,974
Total Planned Commonwealth Expenditure	$267,413	$266,729	$0	$534,342
For Approval – 17/18 Unspent Funds				
For Approval – 18/19 Unspent Funds				
Funding from other sources				

Funding from other sources	Nil

Proposed Activities	
ACTIVITY TITLE	**GPS 2: HealthPathways**
Existing, Modified, or New Activity	Modified Activity (Activity GPS 2: Integrating Services & Systems in 2018-19 AWP)
Needs Assessment Priority	**Priority** • CGP1.2 Support primary care providers to improve the management of patients with chronic conditions and reduce unnecessary hospitalisations through effective care pathways, service coordination and service linkages. (p.94) **Possible Option** • Encourage general practice to utilise health pathways to direct patients to appropriate health care providers. (p.95)

Aim of Activity	The HealthPathways team works across the three WA PHNs to develop and localise WA HealthPathways to ensure best practice clinical pathways are available, enabling patient care that is well coordinated, efficient and effective. In Country WA, there is a specific focus on the localisation of pathways in regions and support of effective transition/referral of patients to regional and/or metropolitan specialists where necessary. WA HealthPathways provides an opportunity for collaboration and integration between primary, secondary and tertiary care including general practice, pharmacy and allied health. This collaboration also contributes towards population health planning through the identification of service gaps.
Description of Activity	WA HealthPathways provides high quality, evidence based clinical and referral pathways for clinicians working in general practice to reference during patient consultations. The HealthPathways team consists of GP clinical editors who are supported by co-ordinators and project support staff. The team will develop and maintain the content and raise awareness of the product in general practice. The main activities of the team include: • Authoring the content; • Reviewing and incorporating best practice guidelines; • Facilitating multi-disciplinary working group meetings; • Facilitating education events; • Evaluation of HealthPathways uptake; • Mapping services and updating the provider databases (such as the NHSD, My community directory etc); • Maintaining and updating the HealthPathways website; • Facilitating pathway consultation in conjunction with WA department of health – health networks; • Monitoring uptake of the tool and presenting and providing education about HealthPathways.
Associated Flexible Activity	CF 2: Developing System Capacity/Integration
Target population cohort	General Practice who support Country WA PHN community and health consumers
Indigenous specific	No
Coverage	Country WA PHN
Consultation	When a HealthPathways' clinical stream is localised or reviewed, a multi-disciplinary working group meeting is held. Working groups vary in composition, however they generally include clinicians such as GPs, Specialists and Nurses along with Allied health professionals, and with representation from relevant peak bodies. On completion of a clinical pathway (or where a pathway has undergone significant changes post review) a wide consultation is conducted in collaboration with the DOH Health Networks. This involves notifying all relevant stakeholders that the pathway is available for review on the draft site.
Collaboration	The PHN team works in partnership with a range of stakeholders, including: **Providers:** • Streamliners **Partners:**

	• The WA Health system – partnership agreement to enable endorsement of process and provision of subject matter experts
	  o WA Country Health Services
	  o WA DoH - Health Networks
	  o Metropolitan Area Health Services
	• HealthPathway Communities
	Contributors and content reviewers:
	• Cancer Council
	• Communicable Disease Control Directorate
	• Western Australian Department of Health - Health Networks
	• Peak bodies
	• Health, allied health and social care sector organisations
	• General practitioners – expert opinion
	• Medical specialists– expert opinion
	• Pharmacists – subject matter expertise
	• Nurses – subject matter expertise
	• Allied health clinicians – subject matter expertise

Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes
Total Planned Expenditure	

Funding Source	2019-2020	2020-2021	2021-2022	Total
Planned Commonwealth Expenditure - Core Health Systems Improvement Funding	$70,313	$69,727	$0	$140,040
Planned Commonwealth Expenditure – General Practice Support Funding	$106,992	$106,992	$0	$213,984
Total Planned Commonwealth Expenditure	$177,305	$176,719	$0	$354,024

For Approval – 17/18 Unspent Funds				
For Approval – 18/19 Unspent Funds				
Funding from other sources				

Funding from other sources	Nil

Proposed Activities	
ACTIVITY TITLE	**GPS 3: Enabling Practice Improvement**
Existing, Modified, or New Activity	Modified Activity (Activities GPS 1: Supporting General Practice and GPS 2: Integrating Services & Systems in the 2018-19 AWP)
Needs Assessment Priority	**Priority** • CGP1.5 Promote the effectiveness of digital health technologies to optimise patient care. (p.96) **Possible Options** • Build capacity of primary care and general practice to intervene early in conditions that might progress for people with risk factors. (p.95) • Provide support and education to general practice, to identify patients at risk of developing chronic disease and comorbidities through analysis of clinical data and provide early intervention. (p.96) • Partner with health service providers to implement innovative methods of care using digital technologies. (p.96)
Aim of Activity	This activity will build capacity and capability of WA General Practice to work in an integrated manner and respond to Commonwealth policy direction. The activity is aimed at enabling general practice to provide holistic care to their patient population through data driven quality improvement initiatives and by leveraging technology. The activity will be underpinned by Bodenheimer's ten building blocks of high performing primary care (with an initial focus on blocks one to four). This activity will support practices by providing access to The CAT Plus solution which provides decision support to health providers at the point of engagement, extracts general practice data for practice analysis and aggregates general practice data for service planning, reporting and population health needs, including the Needs Assessment. It is also intended practices will be supported to leverage technology and digital health systems to support them to develop and sustain a quality improvement culture.
Description of Activity	Enabling practice transformation will have a whole of General Practice approach to support data driven quality improvement activities to improve the health outcomes of the practice population. This will be done by: • Providing Pen CS licences at no cost to practices who have a data sharing agreement with the PHN. • Providing ongoing training and support to leverage the Pen suite of tools

	• Providing data reports to practices and assisting in their interpretation and application. • Providing support and coaching to set up a QI team to undertake regular QI activities. • Assisting general practices to register and actively participate in My Health Record. • Providing support and training to GPs to use secure messaging systems. • Providing support and training to embed recall and reminder processes in practice. • Providing support and training for the QI practice incentive program. • Assisting practices to embed the 10 building blocks of high performing primary care in line with the quadruple Health aim.
Associated Flexible Activity	CF 2: Developing System Capacity/Integration
Target population cohort	General Practice who support Country WA PHN community and health consumers.
Indigenous specific	No
Coverage	Country WA PHN
Consultation	The PHN has consulted and continues to consult with a range of stakeholders, including: • Consultation to inform quality improvement activities o Community, carers and consumers o Health and social care sector organisations. • Feedback from active participants in activities: o Aboriginal Community Controlled Health Organisations o General practices
Collaboration	**Providers** o PenCS
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No

Total Planned Expenditure				
Funding Source	2019-2020	2020-2021	2021-2022	Total
Planned Commonwealth Expenditure - Core Health Systems Improvement Funding	$12,801	$12,694	$0	$25,495
Planned Commonwealth Expenditure – General Practice Support Funding	$19,478	$19,478	$0	$38,956
Total Planned Commonwealth Expenditure	$32,279	$32,172	$0	$64,451
For Approval – 17/18 Unspent Funds				
For Approval – 18/19 Unspent Funds				
Funding from other sources	$0	$0	$0	$0
Funding from other sources	Nil			