Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2019-2022:

Core Funding

GP Support Funding

Perth North 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	**CF 1: Managing Chronic Conditions**
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Population Health
Needs Assessment Priority	**Priorities:** • PNGP1.2 Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (p.82) • PNGP1.4 Increase access to allied health services and chronic disease management programs provided by allied health practitioners. (p.84) **Possible Options**: • Ensure commissioned services incorporate self-management options and incorporate discharge planning processes for all clients. (p.83) • Improve access to chronic disease management programs, i.e. integrated chronic disease program, diabetes/asthma and Chronic Obstructive Pulmonary Disease (COPD) education, health navigation. (p.84)
Aim of Activity	Chronic disease is a major health burden in Australia. Vulnerable, disadvantaged people are at higher risk of chronic health 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 place based services for people with chronic conditions are making an impact on the health needs of the populations they serve with 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	Existing activities will continue to be funded, they are: • Respiratory Care Coordination - The service provides community-based care coordination for patients with advanced respiratory disease - specifically those who require domiciliary oxygen. • The COPD Primary Acute Integration - The service provides education and support to patients with COPD (non-oxygen dependent) who are

	discharged from Joondalup Health Campus (JHC), to integrate their care with primary health practitioners and community-based services and increase self-management. The service will collaborate with JHC and hospital based Respiratory Physicians, to deliver general practitioner (GP) education to improve care and management of COPD patients in the primary health care sector. • Primary Care at Home -The service provides primary health care to vulnerable and disadvantaged people who are currently engaged with community and social services. The service takes healthcare into the homes of some of Perth's more vulnerable people, whether that be a house, hostel or community residential facility. The service provides health assessment, treatment, development of an individualised care plan and connection to a GP. • Persistent Pain Program -The program aims to help persistent pain sufferers improve self-management of their pain through expert education, individual case management, support, goal setting and improved use of community healthcare services. The program also aims to build the capacity of the primary health sector in identified locations to provide improved chronic pain management. The program is designed so that participants can explore a range of different strategies for living well leading to: reduced reliance on medication for pain management, reduced requirements for emergency care and participants not requiring referral to a higher level of hospital-based care. 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 feedback) 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	People who are vulnerable and disadvantaged and whose primary health care needs are not being met.
Indigenous specific	No
Coverage	Perth North PHN
Consultation	The PHN consulted and consults with a range of key stakeholders in the planning and commissioning of services. Major stakeholders at a state level include: • Australian Government Department of Health • Western Australia (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 Australian (WA) • Australian Medical Association AMA Council of General Practice (WA) • 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) • General Practitioners in Perth North PHN region • Private Health Insurers including Medibank Private and HBF • Health Service Providers and Hospitals • Pharmacy Guild of Australia – WA Branch • Pharmaceutical Society of Australia • North Metropolitan Health Service and East Metropolitan Health Service • Local Governments • People living with CHF, their family and carers
Collaboration	Perth North PHN works with commissioned providers, General Practice and consumer and carer groups, the WA Department of Health including Health Service Providers, to develop and strengthen strategic partnerships, co-commission, where appropriate, and better utilise existing funding where possible. Examples of collaboration: • Chronic Obstructive Pulmonary Disorder Hub - foundational members include the WA Primary Health Alliance, South Metropolitan Health Service, Silver Chain Group, Novartis Pharmaceuticals, Asthma Foundation, Lung Foundation, WA Department of Health, Respiratory Testing Services, Pharmaceutical Society Australia and Arche Health. The COPD Hub was formed following the release of the Potentially Preventable Hospitalisation Hotspot Report which identified COPD as a leading cause of Potentially Preventable Hospitalisations in metropolitan Perth. The aim of the Hub is to work with experts from across the system to plan and improve care for patients with COPD. • The Respiratory Care Coordination service was collaboratively designed between WA Primary Health Alliance (WAPHA) and Silver Chain to provide identified support services around the provision of domiciliary oxygen to patients. • COPD Primary Acute Integrated Service was co-designed between Joondalup Health Campus (administration, respiratory physicians, nurse specialist, out-patient rehabilitation), Silver Chain and WAPHA (including GP representative). The service works alongside the acute services provided by JHC and community based primary health services such as pulmonary rehabilitation, GPs and Priority Response Assessment/Hospital in the Home to support the best practice clinical care for patients with COPD.
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 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? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
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. Ruah Community Services was joint funded with Silver Chain to provide the Primary Care at Home service for vulnerable people. As of 1 July 2019, funding will only be provided to Silver Chain. Based on thorough assessment, WAPHA does not anticipate any adverse consequences from this.
Total Planned Expenditure	

Funding Source	**2019-2020**	**2020-2021**	**2021-2022**	**Total**
Planned Commonwealth Expenditure - Core Flexible Funding	$1,572,805	$1,602,507	$0	$3,175,312
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 and Integration**
Existing, Modified, or New	Existing Activity

Program Key Priority Area	Population Health
Needs Assessment Priority	**Priority** • PNGP1.3 Engage with primary health care providers and local hospital networks to improve transitions of care, care coordination and service linkages. (p.83) **Possible Option** • Encourage general practice to utilise health pathways to direct patients to appropriate health care providers. (p.86) **Priority** • PNGP1.2. Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (p.82) **Possible Options** • 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.82) • Build capacity of primary care and general practice to intervene early in conditions that might progress for people with risk factors. (p.84)
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.
Description of Activity	**HealthPathways License and Support** The PHN will continue to purchase the HealthPathways license and associated support. The license allows the PHN to use the online system for GPs and primary health clinicians to provide additional clinical information to support their assessment, treatment and management of individual patient's medical conditions, including referral processes to local specialists and services. **Review of additional HealthPathways (17/18 underspent)** The number of pathways due for review is unusually high due to the HealthPathways WA program commencing three years ago with a large number of pathways going live at one time. Streamliners (the organisation providing the backend support for the HealthPathways websites) prepared the budget estimate and had not considered the volume of pathways coming up for review in the financial year, plus the ongoing localisation work. Streamliners have not had a process in place to alert when estimated hours were being exceeded. This is being rectified and a process put in place to ensure estimated hours are not exceeded. Therefore, the PHN will not experience the same increased funding demand in future years. **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 aggregate general practice data for service planning, reporting and population health needs. It supports patient centred care. 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	Perth North 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 includes 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:
	Providers:
	• Streamliners
	Partners:
	• The WA Health system – partnership agreement to enable endorsement of process and provision of subject matter experts
	  ○ WA Country Health Services
	  ○ WA Department of Health - Health Networks
	  ○ 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	☐ 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? No
Total Planned Expenditure	

Funding Source	**2019-2020**	**2020-2021**	**2021-2022**	**Total**
Planned Commonwealth Expenditure - Core Flexible Funding	$235,652	$235,652	$0	$471,304
For Approval – 17/18 Unspent Funds	$50,937			
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** • P1.3 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) 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 hospitalisations 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 standardised hospitalisation 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 hospitalisation rate for heart failure for Aboriginal Western Australians was 1.7 times the rate for Aboriginal and Torres Strait Islander people nationally[2]. Identified areas with high rates of avoidable deaths, hospitalisations and risk factors for heart failure as indicated in Perth North PHN 2018 Needs Assessment (p.21) include: Swan District, Wanneroo and Bayswater-Bassendean: • The most common cause of chronic heart failure is coronary heart disease and prior myocardial infarction, hypertension and diabetes. The Swan District has significantly higher rates of avoidable deaths from circulatory diseases and ischaemic heart disease, and significantly higher rates of hospital admissions for circulatory system diseases. • Additionally, Swan District had a significantly higher prevalence of diabetes and proportion of males with at least one of four risk factors, i.e. current smoker, high alcohol intake, obesity and low exercise levels. • Wanneroo has identified hotspots for angina and congestive heart failure and a significant proportion of males and females with one of four risk factors for chronic disease and significantly higher rates of diabetes. • Bayswater-Bassendean had significantly high rates of avoidable deaths from circulatory disease and ischaemic heart disease, and a significantly higher rate of residents with high blood pressure and residents who are overweight.
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,*

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

[2] This relative difference is primarily attributable to the high rates in remote WA and is a particular issue for the Country WA PHN. It is referenced here as part of the coordinated perspective for statewide planning across PHNs.

	Detection and Management of Heart Failure in Australia 2018; and • reduce Potentially Preventable Hospitalisations through an integrated person-centered model of care for CHF. Consistent with these guidelines, WAPHA is interested in exploring opportunities for collaborative, integrated action on CHF, recognising: • The significant burden of disease CHF represents in the Western Australian community, and in specific locations; • The opportunity to shift the focus of care more towards management of patients with chronic heart failure in primary care, with appropriate support and pathways to and 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 and Lessons of Location report; • The strength of the evidence-base for primary care involvement in the multidisciplinary care of patients with CHF; • 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 plans to develop initiatives that improve integration between primary, secondary and acute care and target improvements in the management of patients who have chronic heart failure to achieve the principles that underpin Patient Centered Medical Home (PCMH) and 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 will engage in a short-term process to attend to immediately resolvable 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; • patient resources to improve literacy and engagement and ensuring cultural security; • virtual cardiac rehabilitation in community, particularly country; • 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** o 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; o 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** o 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** o 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 Perth North PHN. • Wanneroo: Alexander Heights-Koondoola
Consultation	The PHN has consulted, and consults, with a range of key stakeholders in the planning and commissioning of services. Major stakeholders at a state level 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 AMA Council of General Practice WA • WA Mental Health Association • Royal Australian College of General Practitioners WA Faculty • WA General Practitioner Education and Training

	• General Practitioners in Perth North region. • Private Health Insurers including Medibank Private and HBF • Area Health Services and Hospitals • Pharmacy Guild of Australia – WA branch. • Pharmaceutical Society of Australia. • North Metropolitan Health Service and East Metropolitan Health Service. • Local Governments • People living with CHF, their family and carers
Collaboration	A Chronic Heart Failure Workshop for interested stakeholders occurred in November 2018 to commence the project. This group contributed to an initial consultation regarding gaps in services, and what was possible in management of CHF 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 Potentially Preventable Hospitalisations for CHF. These collaborators have already been identified above and are already actively involved in the Steering Committee for the project. They include the WA Department of Health, Consumers, Cardiac Specialists, Area Health Services and 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? 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	$909,000	$909,000	$0	$1,818,000
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 (incorporating activities OP 8-Strategic Direction, OP 9-Commissioning, OP 10-Population Health Planning from updated AWP 2016-2018)
Needs Assessment Priority	N/A
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, local government 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 that 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 around shared data capture and linkage to inform planning. **Commissioning** • Identify opportunities for state-wide and place-based joint planning and co-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 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** WAPHA: • Develops, aligns and operationalises WA population primary health priorities within the context of Commonwealth primary health care policy, the evidence base and 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 which 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 stakeholders to develop appropriate service responses. • Procuring - using a range of approaches based on an analysis of the market place including EOIs, Request for Proposals and Request 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:
	  • How well targeted and efficient services are - using a diverse range of data collection methods (i.e. provider reports, referral agency feedback, patient opinion) for each of the commissioned services will provide the PHN with the information to:
	  ○ Assess improvements to health outcomes.
	  ○ Help shape future service provision and/or seek alternative commissioning activity.
	  • 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	Perth North PHN
Consultation	At a local level the Clinical Council and Community Advisory Council provides a valuable consultation forum through which to gain insight and input to the

	integration of WAPHA's work within local health pathways and provider networks.
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 • 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 of Mental Health, WA Council of Social Services 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	$2,464,080	$2,487,024	$0	$4,951,104
Planned Commonwealth Expenditure – General Practice Support Funding	$0	$0	$0	$0
Total Planned Commonwealth Expenditure	$2,464,080	$2,487,024	$0	$4,951,104
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 Communication**
Existing, Modified, or New Activity	Existing (incorporating activities OP 11-Stakeholder Engagement and OP 12 Communication and Marketing from updated AWP 2016-2018)
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 co-design 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 channels 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	Not applicable

Activity	
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 • and 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 support meaningful engagement
Coverage	Perth North 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 • 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 Service delivery start date: July 2019 Service delivery end date: June 2021
Commissioning method and approach to	Not applicable

market	
Total Planned Expenditure	

Funding Source	2019-2020	2020-2021	2021-2022	Total
Planned Commonwealth Expenditure - Core Health Systems Improvement Funding	$368,227	$371,655	$0	$739,882
Planned Commonwealth Expenditure – General Practice Support Funding	$0	$0	$0	$0
Total Planned Commonwealth Expenditure	$368,227	$371,655	$0	$739,882
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, 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 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 Department of 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 done 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	Perth North 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, WA 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	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known

market	☐ 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				
Planned Commonwealth Expenditure – Operational Funding	$435,000	$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** • PNGP1.6 Increase childhood immunisation rates for regions not meeting national immunisation targets. (p.85) **Possible Option** • Work with general practices to increase immunisation rates in regions not meeting the national immunisation targets. (p.85)
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. • Contribution to service directories containing information that practices require when making referrals to specialist and community-based services. These include 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 the challenges they 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 their continuous improvement. **Commissioning for Better Health** WAPHA has prepared a Commissioning for Better Health program to guide WAPHA's 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	CF 2: Developing System Capacity/Integration
Target population cohort	General Practice who support Perth North PHN community and health consumers.
Indigenous specific	No
Coverage	Perth North 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
	  ○ Non-Government Organisations including Cancer Council, Diabetes WA, Asthma WA, The Lung Foundation
	  ○ Rural Health West
	  ○ Communicable Disease Control Directorate
	  ○ General practices
	• Consultation to inform quality improvement activities
	  ○ Community, carers and consumers
	  ○ 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:
	• Partners for education and quality improvement activities:
	  ○ Australian Government Department of Health
	  ○ Royal Australian College of General Practice
	  ○ Australian College of Rural and Remote Medicine
	  ○ Rural Health West
	  ○ Australian Practice Nurse Association
	  ○ Non-Government Organisations including Cancer Council, Diabetes

	WA, Asthma WA, The Lung Foundation, The Heart Foundation, Pharmaceutical Society Australia ○ Pharmaceutical companies e.g. Novartis and Seqirus ○ Communicable Disease Control Directorate ○ Universities ○ WA Country Health Services - Health Networks • Partner in implementation of Practice Assist: ○ 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? 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
Total Planned Expenditure	

Funding Source	**2019-2020**	**2020-2021**	**2021-2022**	**Total**
Planned Commonwealth Expenditure - Core Health Systems Improvement Funding	$147,534	$148,907	$0	$296,441
Planned Commonwealth Expenditure – General Practice Support Funding	$231,888	$231,888	$0	$463,776
Total Planned Commonwealth Expenditure	$379,422	$380,795	$0	$760,217
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 (Incorporating activities GPS 2: Integrating Services & Systems, from 2018-19 AWP)
Needs Assessment Priority	**Priority** • PNGP 1.3. Engage with primary health care providers and local hospital networks to improve transitions of care, care coordination and service linkages. (p.83) **Possible Option** • Strategies to develop integrated care pathways in partnership with local hospital networks, health services, general practices and other clinicians. (p.83)
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. 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 National Health Services Directory, 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. **Commissioning for Better Health** WAPHA has prepared a Commissioning for Better Health program to guide WAPHA's 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	CF 2: Developing System Capacity/Integration
Target population cohort	General Practices who support Perth North PHN community and health consumers.
Indigenous specific	No
Coverage	Perth North 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 WA Department of Health - health networks. This includes 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:
	Providers:
	• Streamliners
	Partners:
	• The WA Health system – partnership agreement to enable endorsement of process and provision of subject matter experts
	  ○ WA Country Health Services
	  ○ WA DoH - Health Networks
	  ○ 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	$97,747	$98,658	$0	$196,405
Planned Commonwealth Expenditure – General Practice Support Funding	$153,635	$153,635	$0	$307,270
Total Planned Commonwealth Expenditure	$251,382	$252,293	$0	$503,675
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 (Incorporating activities GPS 1: Supporting General Practice and GPS 2: Integrating Services & Systems in 2018-19 AWP)
Needs Assessment Priority	**Priority** • PNGP1.2. Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (p.82) **Possible Options** • 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.82) • Promote digital health technologies such as My Health Record to optimise patient care. (p.83)
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 also be supported to leverage technology and digital health systems 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 (MYHR). • 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. **Commissioning for Better Health** WAPHA has prepared a Commissioning for Better Health program to guide

	WAPHA's 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	CF 2: Developing System Capacity/Integration
Target population cohort	General Practice who support Perth North PHN community and health consumers.
Indigenous specific	No
Coverage	Perth North PHN

Consultation	• 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	$17,796	$17,961	$0	$35,757
Planned Commonwealth Expenditure – General Practice Support Funding	$27,971	$27,971	$0	$55,942
Total Planned Commonwealth Expenditure	$45,767	$45,932	$0	$91,699
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			