WA Primary Health Alliance
Better health, together

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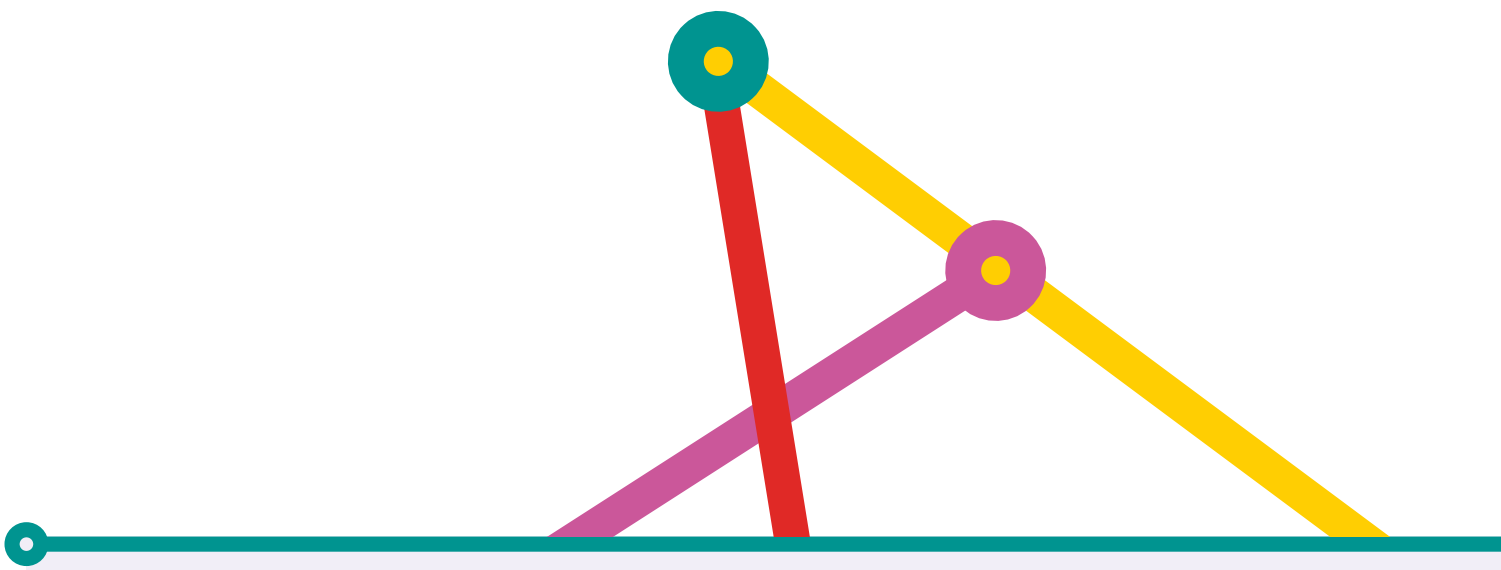
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

WA Primary Health Alliance Population Health Strategy 2021-2023

October 2021

Contents



Introduction

WA Primary Health Alliance (WAPHA) is funded by the Australian Government to operate the three Primary Health Networks (PHNs) in Western Australia (WA): Perth South, Perth North, and Country WA. WAPHA is responsible for planning, guiding, and directing investment towards primary health services, including population health.

Population Health is defined by WAPHA as:

...an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. To reach these objectives, it looks at and acts upon the broad range of factors and interrelated conditions that have a strong influence on our health[1].

WAPHA has two key objectives:

- To improve the efficiency and effectiveness of primary health care services for patients, particularly those at risk of poor health outcomes; and
- To improve the coordination of care to ensure patients receive the right care in the right place at the right time.

WAPHA works in partnership with State and Local Governments to build capacity and identify funding opportunities to address key risk factors for chronic illness, in line with the *WA Health Promotion Strategic Framework 2017-2021*. Consequently, WAPHA does not commission services in primary health care prevention, promotion programs or public health campaigns. In addition to our role as a commissioner of population health services, WAPHA is committed to building the capability and capacity of the primary health care sector to respond to the needs of people experiencing health issues.

This document provides an overview of WAPHA's strategy for population health, in line with the guidance set by the Australian Government and our Strategic Plan: Better Health, Together 2020-2023. This Population Health Strategy has been prepared to support informed decision-making and understanding our population health priorities.

1 Source WAPHA Lexicons viewed 8 April 2021.

This Strategy draws upon and aligns with WAPHA's strategic direction

Our Population Health Strategy aligns to WAPHA's Strategic Plan – Better Health, Together 2020-2023 and is also informed by the *National Chronic Conditions Framework 2017, National Immunisation Strategy 2019-2024*, and *National Cancer Screening Programs for Breast, Bowel and Cervical Cancer* focusing on system wide as well as local place-based planning. Ongoing refinement of the WAPHA Population Health Strategy will also be informed by the Australian Government's 10 Year Primary Health Care Plan and the Preventative Health Strategy 2021-2030 when published.

WAPHA's Strategic Plan

Our vision and direction for the next three years:

- Provides an overview of WAPHA's vision, mission, and values
- Outlines four strategic priorities – our significant commitments for the next three years
- Outlines four drivers of success – the pivotal enablers for our strategic success
- Provides guidance on our path for successful implementation.

Below is our commitment to our Strategic Priorities in the context of Population Health

WAPHA's Population Health Strategy has been developed to complement our Strategic Plan

Below is our commitment to our Strategic Priorities in the context of population health.

Commission services in a planned and targeted way

WAPHA will be strategic in how we allocate finite resources and commission services to ensure we maximise outcomes for consumers. This strategy provides a blueprint and explains the factors we will consider when determining how, for who, and where we commission Population Health services[2].

Promote and prioritise an integrated health system

Our Population Health Strategy highlights our commitment towards a collaborative approach to Population Health. It describes how we intend to partner with other commissioning agencies, peak bodies, GPs, other service providers and communities to create a more coordinated and integrated Population Health system.

Continuously improve primary health care practice

Through the implementation of regular monitoring, evaluation, and quality improvement activities, WAPHA will work to ensure safe and high-quality Population Health services in primary health care.

The Population Health Strategy outlines priorities focused on developing primary health care practices that provide culturally competent and safe services to meet the needs of consumers and carers.

Empower people in our communities

Local communities have a critical role in improving individual and place-based population health outcomes. Our strategy describes how we aim to increase access to holistic, person-centred care, to support the most vulnerable members of our community

2 For this document, and with recognition of the contextual nature of Population Health terminology, we have used the terms consumer, patient and individual interchangeably.

Population Health Strategy - What are we going to do?

WAPHA will support the population health system in Western Australia through:

- Leadership and advocacy at the system level;
- Facilitating the coordination and integration of quality population health programs in the primary health care setting;
- Commissioning sustainable, adaptable, and evidenced based chronic conditions programs;
- Supporting General Practice quality improvement and innovation.

We aim to:

- Explain the principles that underpin our population health approach.
- Outline our core population health priorities.
- Assist WAPHA staff to ensure procurement aligns with the PHN and WAPHA commissioning guidance for population health.
- Interrelate this strategy to all other WAPHA Priority Strategies

Integration of Care – Working together with a shared focus on person centred care

What are we going to do with our partners to achieve a more integrated system?

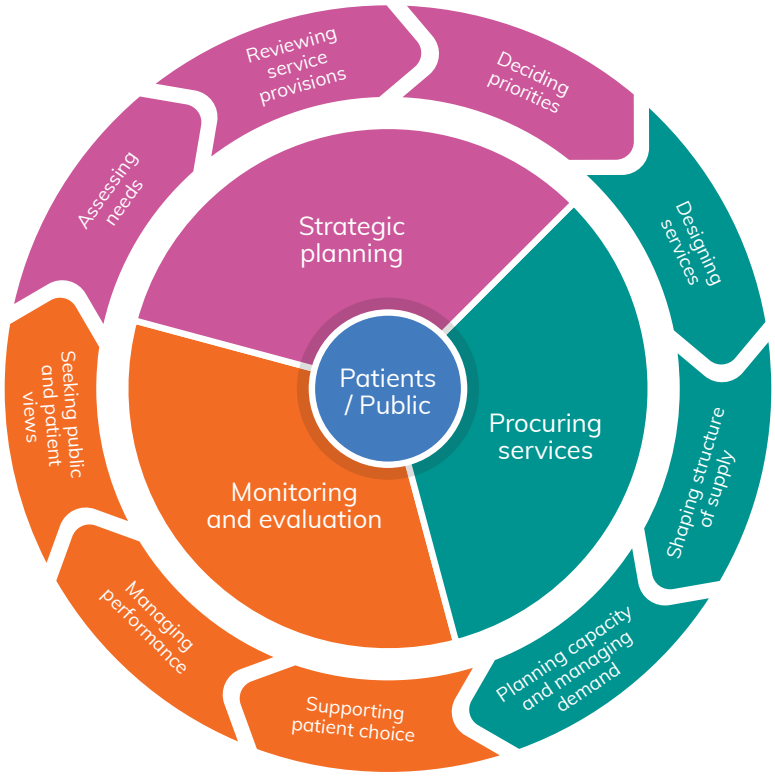
- Participate in developing a shared vision, joint governance and leadership, planning, and funding to provide a mechanism to address fragmentation of services, duplication, and inefficiencies in service provision.
- Facilitate a partnership approach to achieve greater communication and coordination across the population health system.
- Identify and build on assets existing in the local community and work together with the community to address gaps.

Using a collaborative approach, WAPHA will work alongside the community and all levels of government to advocate for a robust population health network that seeks to develop connected communities, aimed at addressing heath inequity and disadvantage on a system, regional, local, and individual level.

Commissioning for Better Health

Commissioning for Better Health guides our approach to commissioning to ensure that the services we fund are evidence-based and targeted to meet the needs of people at risk of poor health outcomes. We direct our investment to support local primary health care services be more efficient and effective, easy to navigate, well connected and close to home.

In line with PHN Commissioning Resource, WAPHA's Procurement Policy and approved *Activity Work Plans* we commission services in a manner that seeks to achieve our strategic objectives, provides value for money, and results in positive outcomes for service users.



We are also guided by the Quadruple Aim, a well-regarded framework for optimising health system performance. It outlines four principles that governments, health care planners and providers need to concurrently focus on when designing and examining primary health care delivery. PHNs, the Australian Government and State/Territory Governments now accept the Quadruple Aim to measure, monitor and evaluate services and models of care.

Patient Experience of Care
- Reduced waiting times
- Improved access
- Patient & family needs met

Population Health
- Improved health outcomes
- Equity of access
- Reduced disease burden

Quadruple Aim

Improved Provider Satisfaction
- Sustainability and meaning of work
- Increased clinician and staff satisfaction
- Teamwork
- Leadership
- Quality improvement culture

Sustainable cost
- Cost reduction in service delivery
- Reduced avoidable/unnecessary hospital admissions
- Return on innovation costs invested
- Ratio of funding for primary: acute care

Context

WAPHA's Population Health Strategy focus is on chronic conditions, which are long lasting, can create a significant burden of disease for the Australian population with a major impact on physical, mental, social, and economic well-being. It was estimated in 2017-2018 that:

- nearly 50% of Australians have 1 or more of the 10 most common chronic conditions,
- 1 in 2 hospitalisations involved one of those 10 most common conditions,
- nearly 9 in 10 deaths were associated with the same diseases, and that
- Rates of chronic conditions are higher for adults living in challenging socioeconomic environments.[3]

Similarly, in WA, the *WAPHA 2019-2022 needs assessment report* identified management of chronic conditions as the population priority for each region, targeting those people with an increased susceptibility to adverse health outcomes[4], to:

- Reduce and manage chronic disease.
- Build workforce capacity and capability, in the primary care setting, to manage chronic disease and respond to mental health and alcohol and other drug related issues.
- Promote integration and care coordination to improve chronic disease management.
- Reduce unnecessary hospital admissions and emergency department attendances.
- Create pathways for people with co-morbid chronic conditions and mental health and alcohol and other drug issues, to increase access and improve health outcomes for those most in need.

WAPHA is required to improve, monitor, and report to the Australian Government Department of Health on specific outcome indicators for population health in the primary care setting. These include addressing local needs, addressing barriers to access, building the competency and capability of health workers, commissioning evidence-based health care services that are integrated and providing quality coordinated care to local communities.

While it is not intended to have a disease specific approach to chronic conditions management, any significant investment by WAPHA in the management of chronic conditions will need to focus on those chronic conditions with the highest incidence and prevalence which are most amenable to an integrated and coordinated approach and meet a demonstrated need, ultimately leading to a reduction of potentially preventable hospitalisations (PPHs) over the next three years

WAPHA also supports and promotes the National Bowel, Breast and Cervical Cancer Screening Programs and the State-wide Immunisation Program by focusing on, and supporting, general practice quality improvement activities and assisting with community awareness initiatives, workforce training and community education that encourages participation.

What is a chronic condition?

To inform commissioning, WAPHA uses the definition as mandated by the Australian Government in the National Strategic Framework for Chronic Conditions 2017.

Chronic conditions:

- have complex and multiple causes;
- may affect individuals either alone or as co-morbidities with other conditions such as mental ill health;
- usually have a gradual onset, although they can have sudden onset and acute stages;
- occur across the life cycle, although they become more prevalent with older age;
- can compromise quality of life and create limitations and disability;
- are long-term and persistent, and often lead to a gradual deterioration of health and loss of independence; and
- while not usually immediately life threatening, are the most common and leading cause of premature mortality[5].

WAPHA also acknowledges that the Australian Government Department of Health considers some people in the community with severe risk factors including but not limited to alcohol use, unspecified chronic pain and obesity may be "unable to self-manage or comply with care and treatment" and therefore this makes them eligible for Chronic Disease Management services and medical benefit scheme items[6].

Using a risk stratification approach that supports identification of patients with high coordination and multiple provider needs will also facilitate a person-centred approach[7] consistent with the quadruple aim.

3 *https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview*
4 Such as Culturally and Linguistically diverse communities, Aboriginal and Torres Strait Islander People, homeless, elderly, those with a severe disability, carers, victims of domestic violence
5 Australian Health Ministers' Advisory Council, 2017, National Strategic Framework for Chronic Conditions. Australian Government. Canberra.
6 General Q1.3 https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement-qanda
7 *The Fourth Australian Atlas of Healthcare Variation, Chronic disease and infection: potentially preventable hospitalisations*

How to use the Population Health Strategy

The following elements of this Strategy, along with the Australian Government's Guidance materials, outline the parameters for what is in scope for WAPHA. Our priorities and corresponding initiatives describe the changes we seek to make to the primary health care system in alignment to the Quadruple Aim. It is important that all WAPHA's activities align with **one or more of the priorities/initiatives**. In addition to these, specific strategies aligned to our platforms and programs are outlined and are to be read in conjunction with the priorities/ initiatives. All elements should inform WAPHA's operational actions.

1

Principles

Is the service/activity consistent with our guiding **principles** for management of chronic conditions?

2

Partnerships

Have we defined how we will best utilise **partnerships** for this service/ activity?

3

Priorities

Does the service/activity align with our defined **priorities** for the management of chronic conditions?

4

Platforms & Programs

What **platforms and programs** would the service/activity align with?

5

Place

Will the service/activity be delivered sustainably in a **place** we are targeting? Is it the right care, in the right place at the right time?

6

Performance

Have we defined how we will evaluate the **performance, purpose, and outcome** of the service/activity?

1. Principles

1. All our commissioned services are safe, culturally appropriate, of high quality and informed by best practice.

2. We work closely with key stakeholders and the community, to achieve an integrated, coordinated Population Health system.

3. Commissioning increases chronic conditions self-management[8] and health literacy[9] where appropriate.

4. We orient our commissioned health services around General Practice to better support consumers, carers, and clinicians.

5. We make strategic commissioning decisions to direct our finite resources to where they will deliver the most impact, based on evidence.

6. We commission outcomes which have most value to the consumer and community as well as to the health service and system[10].

8 The National Chronic Disease Strategy (2005) defined self-management as "active participation by people in their own health care". This is increasingly seen as important, given the rising burden of chronic illness and the resulting effects on the health system

9 Health literacy relates to how people access, understand and use health information in ways that benefit their health. People with low health literacy are at higher risk of worse health outcomes and poorer health behaviours. https://www.aihw.gov.au/reports/australias-health/health-literacy

10 https://ahha.asn.au/sites/default/files/docs/policy-issue/blueprint_summary.pdf

2. Partnerships

Our Strategic Plan outlines mature collaborative partnerships as a key driver to our success. We work collaboratively and purposefully at a metropolitan, regional, and remote level with consumers, carers, health care providers (primary, secondary, and tertiary), social care services, local government, and other stakeholders to understand complexities and gaps, identify what is needed to develop seamless care pathways, and work across the care continuum to improve health outcomes. At a local level, we utilise and create partnership arrangements, and promote existing networks and advisory groups to enhance integration and improve information flow across the system.

Our commitment to our partners is below:

Consumers, families, and carers

WAPHA is committed to person-centred care and recognises the value of the knowledge and experience of consumers regarding managing their health condition. WAPHA will demonstrate this commitment through co-design and building relationships with consumers, families and carers as well as supporting people to be self-directed and informed partners in their health care.

General Practice

WAPHA recognises the role of General Practice in the prevention, early intervention and treatment of chronic conditions and provision of cancer screening and vaccinations. WAPHA is committed to enabling GPs to inform service design, ensuring their role is elevated and integrated where possible. This also includes other members of the general practice care team, such as practice nurses and Aboriginal Health Workers.

Community health and social services

Through engagement with diverse local primary care and community service providers, including local government, we will explore opportunities to leverage current strengths and facilitate collaborative responses to achieve system level change. These connections are important in developing inter-agency responses to complex health and social care problems.

Aboriginal Community Controlled Organisations (ACCOs)/ Health Services (ACCHSs) and community representatives

WAPHA fosters relationships with Aboriginal people and communities that are built on respect and trust and works closely with ACCHSs and ACCOs to facilitate culturally safe service delivery. WAPHA recognises the importance of choice for Aboriginal people in the services they access and actively supports strategies to enhance cultural appropriateness across the primary health care system.

WA Department of Health (DOH) and WA Health Service Providers (HSPs)

WAPHA and WA DOH (particularly the Clinical Excellence Directorate) work together to improve integrated service delivery through planned and coordinated commissioning, structured system-change, and a commitment to better health outcomes for Western Australians. This is reflected through development of formal Partnership Protocols with the WA DOH and WA HSPs and the WA Healthy Weight Action Plan

Peak bodies

WAPHA understands the importance of involving peak bodies in the design of models of care, advocacy, developing a healthy workforce as well as collaboration and consultation with the members they represent.

3. Priorities

3.1 Chronic Conditions Management, Cancer Screening, Immunisation, and the After-Hours Strategy

We have identified six (6) elements necessary for an integrated and comprehensive chronic conditions management program, as outlined below. These elements are articulated in the best practice Chronic Care Model developed by Wagner et. al. and expanded by others[11] and will be the major focus for priority initiatives and commissioning, informing our approach to systemic, regional, and local change. The aim is to drive the development and refinement of new and existing evidence based primary care chronic conditions coordination and care. In addition, the WAPHA Population Health Strategy includes priorities and initiatives for cancer screening, immunisation, and after-hours programs as well as ongoing support for general practice.

Each initiative is aligned to one of the strategic priorities from our Strategic Plan:

- **Commission in a planned and targeted way;**
- **Promote and prioritise an integrated health system;**
- **Continuously improve primary care practice; and**
- **Empower people and communities.**

11 Improving Chronic Illness Care, 2015, The Chronic Care Model from http://www.improvingchroniccare.org/, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743863/pdf/v013p00299.pdf

Chronic Conditions Management		
Priority	**Initiatives**	
1 Health System Create a culture and mechanisms that promote safe, coordinated, person centred and high-quality integrated care.	1.1	Collaborate with WA DOH, other organisations and the community on joint planning, priority setting and commissioning integrated care services[12] while aimed at reducing PPHs.
	1.2	Work with HSPs, GPs and community service partners to develop an integrated chronic conditions care model in each region/PHN (where currently not developed), in partnership/co-designed with consumers and community stakeholders or supporting those models already in development or existing.
	1.3	Work towards more equitable access to primary health care, contributing to building capacity and capability in general practice, embedding care coordination, integrated care, and multi-disciplinary teams.
	1.4	Continue to support health service providers including Primary Care and General Practice Quality Improvement programs and activities.
	1.5	Support availability of low-cost services that can support improved access, such as remote telehealth support and education and coaching, in areas with limited service and high demand.
	1.6	Ensure that WAPHA's contracted providers are appropriately credentialed and accredited and underpinned by robust clinical governance systems.
2 The Community Mobilise community resources to meet needs of consumers	2.1	Commission person-centred services, focused on the holistic treatment of physical, mental, and social health issues including care pathways and programs for people with chronic conditions who have mental health and alcohol and other drug conditions, lower socioeconomic status/financial hardship and have difficulty accessing and using mainstream services e.g., developing *Equally Well* shared care programs.
	2.2	Work in partnership with non-traditional health services such as local government authorities and social services to focus on local communities' strengths and experience. Work together, to build on a community's positive assets, to create and enhance primary care services close to home[13].
	2.3	Collaborate in the development of social and emotional wellbeing approaches for chronic conditions and cancer patients in primary health care through strategies such as service planning, gap analysis, development of HealthPathways, and as informed by the community.
	2.4	Commission and support culturally appropriate and competent Aboriginal population health services in collaboration with Aboriginal people and communities and in line with WAPHA's Cultural Competency Framework.

12 Strategy 4, Rec. 10. Sustainable Health Review (2019) Final Report to Western Australian Government. Department of Health Western WA.

13 https://www.nurturedevelopment.org/asset-based-community-development/ viewed 11 January 2020

Chronic Conditions Management		
3 Self-Management & Health Literacy Support Build the capacity of service providers including general practice to empower and prepare patients to manage their health and health care	3.1	Continue to support and commission local chronic conditions programs, that incorporate self-management and health literacy[14] via phone, video and in person using validated models and tools such as a patient activation measure, Flinders Program, Macquarie Health Chronic Conditions Course and other resources developed in partnership with communities and service providers.
	3.2	Capture, utilise and share de-identified patient experience data and outcomes with the consumer and service providers, to inform patient activation and support as well as quality improvement activities.
4 Decision Support Promote clinical care that is consistent with scientific evidence and patient preferences	4.1	Target commissioning towards care for people experiencing complex chronic health issues, who can be treated within a primary care setting.
	4.2	Commission chronic conditions coordination and services using evidence-based policies/procedures, guidelines and supported by decision making tools such as HealthPathways.
	4.3	Support the assessment and management of chronic health conditions in general practice through • Investigation of strategies such as integrated team care models delivered by specialist/acute care and GPs/general practice. • GP support lines – answered by specialists to provide immediate advice on management of patients' care[15] and • Building capacity for more complex care delivered in the general practice setting.
5 Delivery System Design Assure the delivery of effective, efficient clinical care and self-management support	5.1	Work with key partners to define and confirm the roles and responsibilities of chronic conditions team members at the regional and local level.
	5.2	Focus on a multidisciplinary team approach with GPs playing a central role in chronic conditions coordination and service delivery for those with complex conditions and co- morbidity.
	5.3	Support best use of the existing and local workforce to commission flexible and innovative approach to chronic conditions care coordination, health services delivery and improving vaccination and cancer screening rates.
	5.4	Support, in partnership with key agencies, upskilling of primary health care providers to take a leadership role in care coordination and embracing new roles within their scope of practice.
	5.5	Facilitate access to targeted education, training, and quality improvement activities/programs to build workforce cultural competency and capability and ability to support appropriate ongoing chronic conditions self-management and increased health literacy of their community.
	5.6	Address the lack of provider choice in areas of workforce and service provider shortage by supporting the development of innovative models including the use of telehealth, peer support and the expanded use of the allied health workforce.

14 Health literacy relates to how people access, understand and use health information in ways that benefit their health. People with low health literacy are at higher risk of worse health outcomes and poorer health behaviours. Source *https://www.aihw.gov.au/reports/australias-health/health-literacy*

15 *Chronic disease and infection: potentially preventable hospitalisations | Australian Commission on Safety and Quality in Health Care*

Chronic Conditions Management		
6 Clinical Information Systems Organise patient and population data to facilitate efficient and effective care	6.1	Make collaborative commissioning decisions based on the most current data provided by General Practice, and Primary Care Insights, and other local, State, and National data sets.
	6.2	Capture, share and utilise patient experience data and outcomes (including patient reported experience measures [PREMS] and patient reported outcomes measures [PROMS]), to inform quality improvement, such as those used by NSW Health.
	6.3	Develop agreed protocols with WA health service providers for alternate mechanisms for sharing information including real time data across the continuum of care to facilitate coordination and integration where necessary.

Cancer Screening	
Priority	**Initiatives**

To collaborate with our partners to support the implementation of the WA Cancer Plan 2020-2025[16] to:
0. Find cancer early and reduce risk through improving participation in cancer screening programs.
1. Enable sharing of health information between service providers in the acute and primary health care setting and their clients.
2. Upskilling primary care professionals to promote cancer screening, address behavioural risk factors for cancer and identify signs and symptoms of cancer early.
	• Amplify other agencies' cancer screening awareness campaigns through existing channels such as Practice Assist, social and traditional media platforms.
	• Co-design, adapt or adopt best practice cancer screening and treatment HealthPathways that are easy to navigate and provide a seamless experience for consumers, carers, and clinicians within the local community setting.
	• Continue to support Primary Care and General Practice Improvement Program (PIP)[17], Quality Improvement Programs and other activities including:
	  ○ Support to recall and follow up clients due for cancer screening.
	  ○ Promotion of cancer screening campaigns.
	  ○ Provision of joint education and training programs in collaboration with partners such as HSPs, Cancer Council WA and the Royal Australian College of General Practice.
	• Support primary care activities and resources relating to the WA Healthy Weight Action Plan.
	• Develop HealthPathways and promote access to psycho-social care for people living with chronic conditions and those receiving cancer treatment.
	• Promote the roll out and use of My Health Record to share information across the continuum of care and with consumers.

16 WA Cancer Plan 2020-2025 https://ww2.health.wa.gov.au/Articles/U_Z/WA-Cancer-Plan#:~:text=The%20WA%20Cancer%20Plan%202020,cancer%20outcomes%20for%20Western%20Australians

17 An incentive program for General Practice that provides incentive payments for GPs who achieve agreed performance criteria for the management of asthma, diabetes, cervical screening, and indigenous health. The PIP also provides incentives for after-hours care, e-health, aged care, quality prescribing, teaching and rural care.

Immunisation Program	
Priority	**Initiatives**
To support the implementation of the *National Immunisation Strategy 2019-2024*	Update the WAPHA Immunisation Strategy to develop and support activities over the next three years, 2021-2024, to: • Improve child, adolescent, and adult vaccination coverage across WA. • Work with partners on WA goals articulated in the *WA Immunisation Strategy 2016-2020* and in those communities most at risk of not achieving full vaccination coverage. This includes membership of key networks and reference groups. • Promote awareness campaigns including those co-designed with the community to reduce vaccine hesitancy. • Support general practice and other primary health care providers with quality improvement programs focusing on accurate data entry, client recall registers, HealthPathways and joint training and education.

After Hours Strategy	
Priority	**Initiatives**
To support the implementation of the WAPHA After Hours Strategy	• Establish care in the after-hours period as a cross-sector priority requiring a long-term partnership approach at the regional level. • Develop integrated models of care at the regional level. • Monitor and evaluate after-hours care, by region. • Enhance the health and digital health literacy and activation of people in our communities. • Identify services available for after-hours support, by region, and facilitate consistent promotion within the community.

4. Platforms and Programs

4.1 Platforms

WAPHA has developed or adopted platforms that support the delivery of commissioned Population Health services. A platform refers to one of WAPHA's key initiatives, which serve as both a foundation upon which Population Health programs can operate and a gateway to primary health care. Platforms help integrate systems of care and ensure the needs of consumers/patients are the core focus. The table below provides an overview of key health platforms to support evidenced based Population Health service delivery, including a description and a commissioning strategy for each.

Platform	Platform description	Commissioning Strategy
WAPHA RURAL HEALTH WEST Practice Assist Strengthening general practice in WA	Practice Assist provides easy access to all the information required to run a contemporary, sustainable general practice in Western Australia.	Provide tailored advice and support with immunisation and cancer screening initiatives and resources and provide professional training and education opportunities.
WAPHA HealthPathways WA Clinical decision support	An online portal providing clinicians with clear and concise guidance for assessing, managing, and referring patients (including those experiencing PH issues) across WA.	Continue to develop, update, and promote the use of chronic conditions, cancer screening and immunisation specific pathways. Utilise the pathways to promote available services and support education, training, and other activities to improve the interface between primary care practitioners and specialists working in a community or acute/ hospital setting.
My Health Record	An online summary of an individual's health information, allowing access to patient health information across different health settings and locations. Use of My Health Record can support the management of chronic disease as it enables health professionals to better manage complex care, particularly when patients move between health providers or geographical locations. It also contributes to clients' self-management of their condition.	Continue to promote the uptake and use of My Health Record by consumers to increase health literacy and by registered health care providers across the continuum of care to access information such as: • hospital discharge summaries • shared health summaries; • event summaries, • significant health events; • MBS and PBS history and up to date medications; • medication, prescription and dispense records; • e-Referrals and specialist letters; and • pathology and diagnostic imaging reports
my community directory	*My Community Directory* An online directory of local health, social and community services across the state.	Continue to promote the uptake and use of My Community Directory by consumers and registered health care providers across the continuum of care to access up to date and place-based information. Seek collaborations with local governments and other community and health agencies to adopt and encourage use. Recognise the value of My Community Directory as a community information resource on after-hours primary health care services and collaborate for consistent promotion within the community.

4.2 Commissioned Programs and Projects

WAPHA commissions population health programs and projects developed locally or specifically funded as part of Australian Government programs. The table below and subsequent pages provide an overview of key commissioned population health activity including scope, individual strategy, and the guidance to follow when commissioning.

Program/ Project	Scope	Commissioning Strategy	Guidance followed
Integrated Team Care (ITC)	Contributes to improving health outcomes for Aboriginal people with chronic health conditions through access to care coordination, multidisciplinary care, and support for self-management. Improves access to culturally appropriate mainstream primary care services (including but not limited to general practice, allied health, and specialists) for Aboriginal people.	• Work in partnership with Aboriginal and Primary Care stakeholders to implement the recommendations of the WAPHA Aboriginal Health Strategy to ensure new and existing service models across the State meet the identified needs of the community. • Support the development of cultural competency and capability across commissioned services and general practice. • Support organisations and workforce involved in delivering the program to develop skills and knowledge relevant to care coordination and integration.	*Integrated Team Care Program Implementation Guidelines* *WAPHA Activity Work Plans* WAPHA Aboriginal Health Strategy (in development) *Cultural Respect Framework 2016-2026* *NSQHS Standards User guide for Aboriginal and Torres Strait Islander Health*
Integrated Chronic Disease Care (ICDC) Country	Support primary care providers to improve the management of country clients with chronic conditions and reduce unnecessary hospitalisations through strengthening self-management, effective care pathways, service coordination and service linkages[18].	• Work in partnership with commissioned services, Western Australian Country Health Services (WACHS) and other key stakeholders to develop evidence based, chronic conditions models of care to meet the needs of the community across country regions, confirming roles and responsibilities of each agency/ service. • Focus on those chronic conditions with the highest incidence and prevalence which are most amenable to an integrated and coordinated approach and meet a demonstrated need, ultimately leading to a reduction of potentially preventable hospitalisations (PPHs) over the next three years • Support the development of cultural competency and capability across commissioned services. • Facilitate and support mechanisms that allow organisations, and the workforce delivering the program, to build skills and team-based systems.	*National Strategic Framework for Chronic Conditions*

18 Country WA PHN Activity Work Plan 2019-2022

Program/ Project	Scope	Commissioning Strategy	Guidance followed
Healthy Weight Action Plan (HWAP) 2019-2024	Recommendation 2a of the WA Sustainable Health Review (2019) is: '...halt the rise in obesity in WA by July 2024 and have the highest percentage of the population with a healthy weight of all states in Australia by July 2029'. As a program steward for the WA Healthy Weight Action Plan (2019-2024), WAPHA has committed to specific actions and commissioning which contribute to weight management in the primary care setting, in collaboration with key stakeholders.	• Future commissioning will be focused on integrated weight management services in the primary care setting.	*Healthy Weight Action Plan 2019-2024*
Chronic Heart Failure (CHF) 2022-25	Development of a primary care led multidisciplinary care model for Chronic Heart Failure.	• Establish project governance and management structures. • Develop the implementation plan. • Pilot a model of CHF multidisciplinary care in two locations (metropolitan and country) informed by WAPHA needs assessment and local priorities. • Support General Practice in coordinating care with specialist support. • Assess overall workforce capacity and development opportunities.	*National Strategic Framework for Chronic Conditions* *Guidelines for the Prevention, Detection and Management of Heart Failure in Australia 2018*

Program/ Project	Scope	Commissioning Strategy	Guidance followed
After Hours Strategy	Development of after-hours primary health care services that are accessible, integrated into local health pathways and provides continuity with peoples' usual general practice.	• Identify and engage with key stakeholders to develop partnerships aimed at pursuing an evidenced based regional approach to after-hours primary care services based on local, state, national and international expertise, and relationships. • Engage in co-design of person-centred models of care with providers and stakeholders, including the community. • Facilitate targeted support to improve health and digital health literacy for vulnerable communities. • Develop regional-specific recommended cascade approaches to seeking relevant services in the after-hours period, including population-specific pathways. • Collaborate with HealthDirect to embed the online Symptom Checker, Risk Checker, helpline information in relevant websites and other options that promote the recommended regional cascade approach to seeking care in the after-hours period.	Australian Government After Hours Program Operational Guidelines (in draft) Australian Government After Hours *Practice Incentives Program (PIP)*

5. Place

Health service provision is not uniform across WA and this has a profound effect on health care utilisation and outcomes. The variation that results is largely due to misaligned governance, planning, and funding. The consequence is a multiplicity of providers, with competing and overlapping objectives and incentives and little integration. The system is unbalanced because the drivers are, and simply funding more services in those locations that have a higher-than-average rate of disadvantage, for example, will not fix the problem. It is more complex and requires a systemic approach. Thus, WAPHA is developing a multilevel integrated approach to commissioning.

Given our limited resourcing and important role in supporting general practice, WAPHA must be deliberate in where it directs investment. Commissioned services that can be provided virtually (telephone, internet) will be available to people irrespective of their location, while in-person services will be developed as suites of place-based offerings.

Determining the priority locations for place-based services involves a balance of what can be achieved in terms of maximising individual benefit relative to the level of unmet need. Our place-based decision making is informed by:

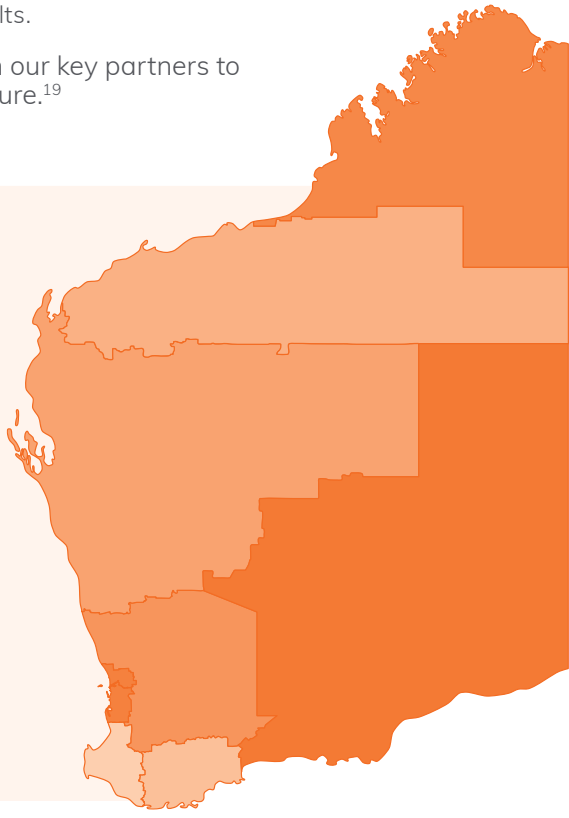
- An understanding of existing services availability. We will work in partnership with stakeholders to understand the whole system before we commission.
- Iterative needs assessments, including Population Health analysis and consultation with clinicians, community, service providers and partner agencies. We will ensure our commissioning decisions are well-defined, justified, and transparent.
- Existence of critical dependencies. We will prioritise investment in locations that offer the conditions, workforce, and infrastructure conducive to making an impact.

To achieve person-centred, quality care and to maximise finite resources, WAPHA has identified the following parameters that need to be present in each locality.

1. A collaborative approach to system integration among stakeholders.
2. Accessible GPs with appropriate scope and local knowledge.
3. Access to social services e.g., housing, financial and employment supports.
4. Pathways to care integration and coordination.
5. Service infrastructure to respond to specific groups such as youth or older adults.

Where these dependencies are not in place in a location, we will work with our key partners to establish these critical conditions, so programs can be successful in the future.[19]

We recognise that for Aboriginal people, 'place' means more than the physical location of residence. Connection to culture, family and community is central to the health and wellbeing of Aboriginal people. "Community is where we live, support family, maintain our connections to country and culture and go to school and work. These factors are important in developing a strong sense of community. We need to feel safe in our community and know we can find help, including health services close by if we need them. Maintaining and developing the connections between community and services is important in developing healthy communities." [19]



19 P. 4 *WA Aboriginal Health and Wellbeing Framework 2015–2030*

6 Performance

As articulated in our strategic plan, WAPHA's priorities include continuously improving primary health care practice and commissioning services in a planned and targeted way. To achieve these priorities, WAPHA is developing key frameworks to monitor, evaluate and measure the success of our programs and services.

0. Commissioned Services Performance Management Framework - will enable commissioned service providers to be clear on WAPHA's expectations in relation to service delivery and how performance will be measured. The Framework will support a shared understanding of performance objectives and indicators between WAPHA and service providers and support greater clarity in the commissioning process.
1. Evaluation Framework - will outline our approach to integrate evaluation across all elements of the commissioning cycle and evaluate the fidelity, quality, effectiveness, impact, and value for money of programs and services.

The *PHN Program Performance and Quality Framework 2018* assists to measure how our functions and activities contribute towards achieving PHN objectives. The following performance indicators are specific to the WAPHA Population Health Priority Program:

- P12 - Rate of potentially preventable hospitalisations - for specific chronic diseases
- PH1 - Rate of children fully vaccinated at 5 years
- PH2 - Cancer screening rates for cervical, bowel and breast cancer
- P4 - Support provided to general practices and other health care providers

WAPHA's Strategy for measuring outcomes of Population Health Programs includes:
EVALUATION Evaluating programs and services to assess impact, identify opportunities for quality improvement, confirm specific location demand and ensure alignment with Australian Government PHN Guidance Materials.
SERVICE PROVIDER PERFORMANCE Assessment of service provider's performance against *WA Primary Health Alliance's Performance Management Framework.*
SYSTEM CONNECTION Ensuring services are not operating in isolation and are connected/integrated to primary care and other services within the local health care system.
PRIORITY LOCATIONS Assessing whether there are other locations where a service should be a priority for implementation.
BEST PRACTICE Ensuring all services operate in line with best practice approaches.
BENCHMARKING Develop benchmarking to inform/improve program outcomes based on regular program level evaluation.

WA Primary Health Alliance
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An Australian Government Initiative

Acknowledgement

WA Primary Health Alliance acknowledges and pays respect to the Traditional Owners and Elders of this country and recognises the significant importance of their cultural heritage, values and beliefs and how these contribute to the positive health and wellbeing of the whole community.

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