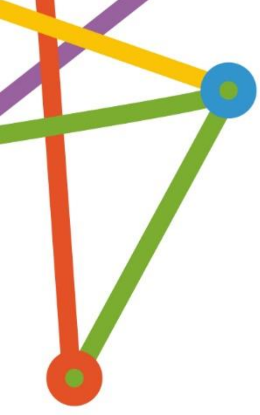

WA Primary Health Alliance
Better health, together

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

Perth South PHN Activity Work Plan

Core Operational and Flexible

Summary View
2021/2022 – 2024/25

Presented to the Australian Government Department of Health and Aged Care

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CF 1000 - Managing Chronic Conditions

Activity Title

Managing Chronic Conditions

Activity Number

1000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

Chronic disease is a major health burden in Australia. Vulnerable, disadvantaged people are at higher risk of chronic health conditions

This activity aims to provide integrated primary health care services in:

- Areas where need has been demonstrated.
- Determining 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 HSI 1000 - Health System Improvement).

The Primary Health Network (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 and other primary health professionals and develop the capacity of the primary health workforce.

Description of Activity

The Managing Chronic Conditions initiative provides nursing and allied health services, tailored to the needs of the PHN region. Services consist of:

1. COPD Supported Discharge – the service works in collaboration with Asthma WA's COPD Community Based Care service, to provide clinical care coordination to individuals with chronic obstructive pulmonary disease (COPD), who are non-oxygen dependent, within one week of discharge from hospital due to a COPD related admission. The service connects the patient to primary care including facilitated connection to general practice, with the aim of establishing more effective care in the community and reduced hospital admissions. The service recruit's patients from eight metropolitan hospitals.

2. COPD Community Care – the service works in collaboration with the Silver Chain COPD Supported Discharge service, to provide community support and education to individuals with COPD, within one week of discharge from hospital due to a COPD related admission. The service connects the patient to primary care including facilitated connection to general practice, with the aim of establishing more effective care in the community and reduced hospital admissions.
3. Primary Care at Home -the service provides primary health care to people at risk of poor health outcomes and difficulty accessing appropriate services 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 individualized care plan and connection to a general practitioner.
4. 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.
5. Perth South West Region - Healthy Lifestyle Project -the project was designed to provide a multifaceted, multidisciplinary approach to obesity which promotes long-term sustainable lifestyle changes in the areas of nutrition, physical activity, mental health and child health, with sustained weight loss being one of the desired outcomes. The project is highly accessible and affordable for people who are overweight or obese, living in the Cockburn area, and who are considered to be socio-economically or otherwise disadvantaged or vulnerable. It reduces barriers to entry for those who need it most.

The PHN will continue to develop and maintain close working relationships with contracted service providers and will formally review services at six- and twelve-month 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,
- how effective services and systems are in relation to patient experience and, patient health outcomes, service/system integration and

- service sustainability including provider experience/governance.

Using the new WA Primary Health Alliance Performance Management Framework, the PHN will measure and track providers performance to 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.
The PHN will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Perth South PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services.	12
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11

Coverage

The following areas within the Perth South region – Armadale, Albany, Bunbury, Belmont-Victoria Park, Canning, Cockburn, Fremantle, Gosnells, Kwinana, Mandurah, Melville, Rockingham, Serpentine-Jarrahdale, South Perth, Wheatbelt-North.

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$2,275,508.16	$1,859,596.40	$1,763,692.46	$1,763,692.46

CF U1010 - Primary Care Chronic Disease Support Services

Activity Title

Primary Care Chronic Disease Support Services

Activity Number

U1010

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

To provide Innovation Grants funding for commissioned service providers to:

- Improve integration and coordination of primary care services.
- Build on available resources and workforce needs.
- Introduce innovation.
- Encourage cost effectiveness and enhanced service integration.

The distribution of Innovation Grants funding will aim to improve the health outcomes and experiences of care provision and build capacity and integration in the chronic disease sector.

Description of Activity

This activity provides a series of Primary Care Innovation Grant funding in three key areas:

1. Treatment services / waitlist / service model optimisation in priority areas
   - Grants will be provided to commissioned service providers to supplement existing treatment services, reduce waitlists and optimise current service models.
2. Establishment of Local Integrated Health Hubs
   - The establishment of Local Integrated Health Hubs in specific areas where there are multiple commissioned providers and populations of people with complex health needs. The Hubs will coordinate services and patient care across professional, organisational and sector boundaries to provide integration and quality service provision. This activity will aim to assure the delivery of effective, efficient clinical care and self-management support for people with chronic conditions.
   - The Local Integrated Health Hubs will also enhance planned interactions to

support evidence-based care, provide clinical care coordination services for complex patients, ensure regular follow-up by the care team, and provide services that are patient centred and that fit with their local needs.

3. Innovation Grants to Primary Care Practitioners and Service Providers focused on the Primary Health Networks (PHN) Performance and Quality Framework (PQF) Indicator improvement.
   - Primary care practitioners and organisations will be provided with an opportunity to apply for funding to build and enhance innovation and capacity within chronic disease services in primary care to support people more effectively with chronic diseases in the community.
   - Grants will be aimed at supporting primary care providers to reduce unnecessary hospitalisations and enhance integrated care pathways, service coordination and service linkages.
   - Grants will be aligned to the PQF Indicators to enhance performance in areas of identified need.

This activity provides non-recurrent services and supported innovation activity. No clients will be impacted by the end of this activity.

Perth South PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services.	12
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
1 July 2019	30 June 2022

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$90,000.00	$0.00	$0.00	$0.00

CF 2000 - Developing System Capacity /Integration

Activity Title

Developing System Capacity/Integration

Activity Number

2000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

To support the primary health care sector by:

- Providing general practitioners and primary health care clinicians with an online health information portal (HealthPathways) to assist with management and appropriate referral of patients when specialist input is required.
- Facilitating integrated holistic services to reduce the impact of chronic disease by providing enablers for service and patient level integration.
- Providing general practices with access to a platform license to support patient centred care through the extraction and analysis of general practice data.

Description of Activity

HealthPathways License and Support:

- The Primary Health Network (PHN) will continue to purchase the HealthPathways license and associated support. The license allows the PHN to use the online system for general practitioners and primary health clinicians that provides additional clinical information to support their assessment, treatment, and management of individual patient's medical conditions, including referral processes to local specialists and services.

My Community Directory

- Enhancement of My Community Directory primary care directory data, delivered in partnership with Mental Health Commission.

Holistic Services

- The PHN will license access to the GP Book via a widget embedded within the service referral pages of HealthPathways. This will provide up to date, accurate information to general practitioners about specialists and allied health providers within the PHN region, with the ability to search by

practitioner name, specialty, gender, language, telehealth, and billing.

Business Intelligence Tool License

- The PHN will continue to purchase the data extraction tool license during FY22/23. The license allows the PHN to extract general practice data for practice analysis and aggregates general practice data for service planning, reporting and population health needs. Supports patient centred care. During FY22/23, the PHN will roll out Primary Sense, a business intelligence tool to all qualifying general practices.

Note: More detailed information about these programs is provided in activity GPS 2000 - HealthPathways.

The PHN will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Perth South PHN Needs Assessment

Priorities	Page reference
Support primary health care providers to manage chronic disease populations and build the capacity for self-management.	11
Reduce non-urgent emergency department attendances and improve access to alternative services.	12

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$516,177.98	$331,398.42	$361,398.42	$361,398.42

CF 2010 - Clinical Referral Pathways

Activity Title

Aged Care and Dementia Clinical Referral Pathways

Activity Number

2010

Existing, Modified or New Activity

New Activity

PHN Program Key Priority Area

Population Health

Aim of Activity

This activity will lead the development, access to, and maintenance of region-specific referral pathways for general practitioners and other health professionals.

This activity aims to:

- Support access to the HealthPathways tool by primary care practitioners in the region.
- Promote best practice care and enhance local clinician's awareness of referral options and services.
- Improve collaboration and integration across health care and other systems.

Activity outcomes are to develop and enhance Primary Health Network's (PHN) HealthPathways content, create better linkages between primary health care services, other provider's, and relevant services, improve the patient journey and increase practitioner capabilities and quality of care provided.

Description of Activity

The PHN will convene the Aged Care/Dementia HealthPathways working group to provide expert guidance and oversight for the development and implementation of Aged Care HealthPathways and Dementia HealthPathways.

Aged Care and Dementia HealthPathways will be reviewed, enhanced, and developed as appropriate to the health needs of the Perth South PHN for use by clinicians during consultation with patients, to support assessment and referral to local services and supports.

Developing and implementing Aged Care HealthPathways will include the following activities:

- Consultation with local aged care health providers and clinicians to ensure expert input.
- Mapping of services as appropriate.
- Engaging clinical editors and technical writers.
- Monitoring, reviewing, and improving existing Aged Care HealthPathways to ensure currency, accuracy and consistency with medical best practice and local services.
- Identify any gaps in the current schedule of HealthPathways and develop new HealthPathways as required.
- Identification of best available resources to include in HealthPathways for GPs and health professionals to share with patients.
- Increase health professionals' awareness of HealthPathways through training and education.

Developing and implementing Dementia HealthPathways will include the following activities:

- Consultation with local aged care health providers and clinicians to ensure expert input.
- Consultation with Dementia Australia both locally and nationally to ensure best available evidence is included in pathways.
- Mapping of dementia services as appropriate to include in HealthPathways.
- Engaging clinical editors and technical writers.
- Monitoring, reviewing, and improving existing Dementia Health Pathways to ensure currency, accuracy and consistency with medical best practice and local services.
- Identify any gaps in schedule of current HealthPathways and develop new dementia HealthPathways as required.
- Assessment and review of Dementia HealthPathways content to reflect Dementia Australia checklist.
- Identification of best available resources to include in dementia HealthPathways for GPs and health professionals to share with patients in consultation with Dementia Australia.
- Implementation and promotion of dementia HealthPathways from January 2023.
- Increase health professionals' awareness of HealthPathways through training and education.

Perth South PHN Needs Assessment

Priorities	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management	11
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal populations and build capacity for patient self-management.	34
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home.	41
Support people living with dementia and their carers to navigate the aged care system and access appropriate services.	41

Target Population

The activities will focus on general practitioners, local primary care clinicians and allied health professionals.

Consultation

Consultation with occur with the following key stakeholders:

- General practitioners and other health professionals
- Dementia Australia
- Carers Australia
- Dementia Training Australia
- Dementia Support Australia
- Australian Dementia Network
- Alzheimer's WA
- Primary care clinicians
- Aged care providers caring for people with dementia.
- Health Service Providers
- Palliative Care WA
- Council on the Ageing WA
- Primary care clinicians

Collaboration

Developing relationships with key aged care stakeholders including peaks and provider organisations will be required to improve co-ordination, integration, and continuity of care at the aged care, health, primary care interface.

Key stakeholders involved in proposed activities will include:

- General practitioners and other health professionals
- Dementia Australia
- Royal Australian College of General Practitioners
- Aged Care Peak body representatives
- Consumer organisation representation
- Regional health representation
- Health Service Providers
- Other stakeholders as they are identified

Coverage

Perth South PHN region

Activity Start Date	**Activity End Date**
1 July 2022	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core HealthPathways	$240,000.00	$363,600.00	$307,850.40	$312,160.31

CF 2020 - Dementia Consumer Pathway Resource

Activity Title

Dementia Consumer Pathway Resource

Activity Number

2020

Existing, Modified or New Activity

New Activity

PHN Program Key Priority Area

Population Health

Aim of Activity

This activity will be undertaken with input from Dementia Australia to ensure the dementia consumer pathway resources are both nationally consistent at a high level and reflective of individual services and supports within individual PHN regions.

This activity will be undertaken in conjunction with Dementia HealthPathways.

The PHN will develop consumer focused dementia resources detailing the support available for people living with dementia, their carers and families, including local, state and federal government, private sector and community-driven support.

The Dementia Consumer Pathway Resources will be implemented by 1 January 2023.

Description of Activity

Dementia Consumer Pathway Resources will be developed in collaboration with Dementia Australia to ensure the resources are both nationally consistent and reflective of individual services and supports within Perth South PHN.

A Dementia Consumer Pathway Resource will be developed for use by clinicians and other primary care providers during consultation with patients, to support assessment and referral to local services and supports. Dementia Consumer Resources will also be directly available to those living with dementia and their family/carers.

This activity will be informed by broad local consultation including with, but not limited to, local primary care clinicians, allied health, aged care providers and consumers to determine the current gaps and opportunities in the model of care for people living with dementia.

Dementia Consumer Pathway Resources will be progressively implemented from 1 July 2022 and in place by 1 January 2023 and will include:

- Consultation with Dementia Australia and other health providers and clinicians to ensure expert input.
- Mapping and detailing support available for people living with dementia, their carers and families within the PHN.
- Identification of key agencies supporting people living with dementia and their family.
- Monitoring, review and improvement of e Dementia Consumer Resources to ensure currency, accuracy and consistency with best practice and local services.
- Promoting the Dementia Consumer Pathway Resources to increase health professionals' awareness of current resources.
- Coordinating webinars targeted at health professionals to promote Dementia Consumer Pathway Resources.

Target Population

People living with dementia, their family and carers, GPs, health care staff in the Perth South PHN region.

Consultation

Developing relationships with key stakeholders including peaks and provider organisations will be required to improve coordination, integration, and continuity of care at the aged care, health, and primary care interface.

Consultation will occur with key stakeholders and include:

- Dementia Australia
- Carers Australia
- Dementia Training Australia
- Dementia Support Australia
- Australian Dementia Network
- Alzheimer's WA.

Collaboration

Key stakeholders involved in proposed activities will include:

- Dementia Australia
- Royal Australian College of General Practitioners
- Aged Care Peak body representatives
- Consumer organisation representation as appropriate
- Other stakeholders as they are identified

Perth South PHN Needs Assessment

Priorities	Page reference
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home.	41
Support people living with dementia and their carers to navigate the aged care system and access appropriate services.	41

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
1 July 2022	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Dementia Consumer Pathway Resource	$40,000.00	$20,129.03	$10,258.06	$5,032.26

CF 3000 - Chronic Heart Failure

Activity Title

Chronic Heart Failure

Activity Number

3000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

To enhance the role of primary care in the management of Chronic Heart Failure (CHF) in line with the National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand (2018) Guidelines for the Prevention, Detection and Management of Heart Failure in Australia 2018; and to reduce Potentially Preventable Hospitalisations (PPHs) through an integrated person-centred model of care for CHF.

Consistent with these guidelines WA Primary Health Alliance is interested in exploring opportunities for collaborative, integrated action on chronic heart failure, recognising:

1. The significant burden of disease Chronic Heart Failure represents in the Western Australian community, and in particular locations.
2. The opportunity to shift the focus of care more towards management of patients with chronic heart failure in primary care, with appropriate support from the acute and community care sectors.
3. The evidence of unmet need in specific communities across Western Australia, as indicated by WA Primary Health Alliance's Needs Assessment.
4. The strength of the evidence-base for primary care involvement in the multidisciplinary care of patients with chronic heart failure.
5. 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, WA Primary Health Alliance will develop initiatives that target improvements in the management of patients who have chronic heart failure in order to achieve the principles that underpin the Quadruple Aim which are to:

- Patient Experience – improve the patient experience.
- 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, WA Primary Health Alliance engaged in a short-term process to resolve gaps in services; opportunistically funding activities that would build capacity in the primary care sector to work in the area of Chronic Heart Failure.

Examples include but are not limited to:

- Upskilling GPs in accordance with the new guidelines.
- Provision of patient resources to improve literacy and engagement and ensuring cultural sensitivity.
- 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 will be inclusive of major stakeholders and will look to develop activities in the following areas:

1. Multidisciplinary Heart Failure Team Care:

- Facilitating involvement of GPs and other primary health care practitioners (e.g., practice nurses, community pharmacists, physiotherapists) in the multidisciplinary care of patients with heart failure.
- Commissioning of the Pharmaceutical Society of Australia WA to deliver education and training on medication management.
- Commissioning heart failure specific exercise physiology classes for patients discharged from Fiona Stanley Hospital in conjunction with Curtin University.

- Commissioning Curtin University to develop and implement educational vignettes for primary care clinicians.

2. Workforce capacity
   - Includes developing capacity in the primary care workforce to be effective partners in the multidisciplinary care of heart failure patients. This includes training in areas such as medication management and expanding nurse led clinics which incorporate multidisciplinary team care models.

The Primary Health Network (PHN) will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Perth South PHN Needs Assessment

Priorities	Page reference
Increase access to best practice management for people with chronic heart failure.	11

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
1 July 2019	30 June 2022

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$283,878.32	$0.00	$0.00	$0.00

CF 4000 - Healthy Weight

Activity Title

Healthy Weight

Activity Number

4000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

To build general practitioner and other practice staff, knowledge and skills in early detection and primary care intervention to prevent chronic disease. This will be achieved through a targeted strategy to tackle overweight and obesity in a structured and intensive way through early intervention and management in general practice.

To develop early intervention and management pathways of overweightness and obesity by supporting GPs and other primary health care professionals and their patients, with innovative, scalable, and sustainable approaches, programs, and tools for 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 evidence based and accessible commercial weight management programs.

The project will encourage clinical leadership of healthy weight strategies, an understanding of exceptions for surgery based on Body Mass Index (BMI) and management of overweight and obese patients whilst on surgical wait lists. WA Primary Health Alliance will focus on creating sustainable behaviour change for general practitioners 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 WA, from a primary care perspective.

Description of Activity

The overweight and obesity management strategy in general practice will include the following strategies and actions:

1. The provision of evidence-based tools for the management of weight and prevention of obesity for general practice, including:

   1. Survey of general practitioners and practice nurses regarding gaps, barriers, and opportunities for better management of overweight and obesity in general practice.
   2. Development of a practice toolkit for general practitioners including synthesis and applicability of current guidelines.
   3. Implementation of a general practitioner led evidence-based weight management program (e.g., ANU Change Program which is available free to Primary Health Network (PHN) for use within general practices).
   4. The use of Chronic Disease Management Plans via MBS for people with complex obesity, where clinically appropriate.
   5. General practitioners and General Practitioner Registrar education regarding prevention, detection, and management of obesity. Awareness of stigmatisation and inequity.
   6. The use of PDSA (Plan, Do, Study, Act) cycles of continuous quality improvement (coaching and support from WAPHA practice support staff).

2. The provision of information and advice on referral pathways in general practice, including:

   - Multi-disciplinary team care pilot.
   - Up to date information on local programs and services for general practices.
   - Further development and promotion of HealthPathways, referral and management pathways for overweight adults and older adults, childhood obesity and bariatric surgery.

3. General practice support includes:

   - Information on new eating disorder MBS item numbers.
   - Training in difficult conversations – scripting and support for general practitioners using the Australian National Health Service and WA Health resources.
   - Assistance with uptake of MBS items that can assist in weight management and obesity.
   - General practitioner training event (informative and academic), focused on general practice continuous professional development (CPD) streams on difficult conversations, empowering behaviour change, and care management including multidisciplinary team care.

4. WA Healthy Weight Action Plan
   - Provision of funding support for the ongoing implementation of WA Healthy Weight Action Plan (WAHWAP) activities.
   - In alignment with Strategy 1 of the WAHWAP, ensure the successful operation of The Weight Education and Lifestyle Leadership (WELL) Collaborative through enabling a dedicated project coordination and secretariat function, which aims to allow integrated, coordinated overweight and obesity associated planning and action across WA.

The PHN will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Perth South PHN Needs Assessment

Priorities	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11
Support primary care to promote healthy weight and healthy lifestyle changes.	11

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$138,904.35	$30,000.00	$30,000.00	$30,000.00

CF 5000 - Strengthening general practice in WA: Comprehensive Primary Care

Activity Title

Strengthening general practice in WA: Comprehensive Primary Care

Activity Number

5000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

This activity complements the existing practice support offered through the PHN Core Operational funding stream for Health System Improvement, General Practice Support activities (HSI 1010).

This activity aims to strengthen and improve the primary care response and access to general practice using the foundations of the Comprehensive Primary care (CPC) program, based on the Quadruple Aim of the Patients Centred Medical home, and using Bodenheimer Building Blocks.

The activities will use data driven quality improvements, focusing on enhanced leadership, team-based care and patient management responding to their needs, for example:

- Patient centred – shared decision making that respects personal goals and provides support to patients to self-manage.
- Skilled, integrated, multi-disciplinary teams which work to the top of their scope, in partnership with patients.
- Data informed, continuous quality improvement and decision making to improve population health and access to care.
- Data and care plan sharing with allied health and the public and private hospital sector; Improved models of care and customer service which encourage patient loyalty to their general practitioner and the practice maximising their care outcomes.
- Sustainable business models which are adaptable to changes in the health system and patient needs.

Description of Activity

Perth South PHN will continue to deliver two key initiatives under this activity:

1. Comprehensive Primary Care (now offered to a broader range of practices).
2. Enhanced Practice Support.

These initiatives focus on building the capacity and capability in general practices to respond to current and emerging Commonwealth policy direction for primary care, for example, the Workforce Incentive Program (WIP), Practice Incentive Program (PIP) and Quality Improvement (QI) incentive, by developing scalable and sustainable business models and enhanced models of care.

The initiatives are consistent with the Quadruple Aim of Patient Centred Medical Home model utilising the Bodenheimer Building Blocks to achieve high performing practice.

General practices will be supported to:

- Lead and develop practice teams to successfully undertake an evidence based and staged process to undertake practice transformation using QI processes.
- Improve continuity of care with allied health, tertiary, and secondary services through integrated models of multidisciplinary team-based care, data sharing, integrated care plans and specialist in-reach programs.
- Have an opportunity to influence, co-design and trial general practitioner led models of care and incorporate existing local services that:
    - are integrated, place based and supported by a multi-disciplinary team.
    - are tailored to meet the needs of individual practices and patients.
    - build on existing and/or introduce new and innovative models of care that reflect national and international best practice.
    - are scalable, sustainable, and adaptive to future changes.
    - improve coordination and continuity of care to ensure better health and social outcomes for patients.
    - build practices' capacity and capability to deliver responsive patient centred care, that empowers patients to be informed and engaged in the management of their own health care.
- Have access to a Community of Practice – a support network of other practices, to network, share lessons learned and best practice; leadership and change management training and development activities; business education, training and support for optimising practice systems, revenue, productivity, efficiency, and overall performance of the business; training to

support general practices in the use of clinical software programs.
- The PHN will deliver COVID-19 preparedness and response activities and support the management of chronic disease and screening initiatives.

The PHN will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target group

Perth South PHN Needs Assessment

Priorities	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11
Reduce non-urgent emergency department attendances and improve access to alternative services.	12

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
1 July 2018	30 June 2024

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$0.00	$0.00	$67,500.00	$67,500.00

CF 6000 - GP Incentive Funds Activity

Activity Title

GP Incentive Funds Activity

Activity Number

6000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Workforce

Aim of Activity

The activity aims to:

- Identify barriers to accessing high quality general practice services within the Peel region.
- Provide support and other incentives to attract and retain general practitioners (GPs) to areas of need.
- Work with general practice within the Peel region to develop and implement longer term strategies around GP workforce.
- Provide support and other incentives to upskill GPs in the region, to help meet local health needs.

The intended outcomes of this activity are to help increase the efficiency and effectiveness of the health care system and improve the health outcomes of the community in the Perth South PHN region.

Description of Activity

Following consultation with general practices in the Peel Region and with Rural Health West, the PHN will implement and commission activities to attract, recruit and retain GPs to the area.

Activities planned to achieve this activity include:

2021-22.

- Coordinate a regional Exceptional Circumstances Review District Priority Area Application for practices in the Mandurah and Pinjarra regions that were disproportionately affected by the Modified Monash Model status of the region.
- Develop and deliver a marketing campaign to support the attraction and retention of GPs to the region. This will be aligned with campaigns underway from relevant Local Government and the Peel Development Corporation.

- Launch GP Grant Program - 12 Grants will be awarded to Peel General Practices through a competitive process. Grants are to be used to deliver activities that will support attraction, recruitment, and retention of general practitioners with stringent conditions applied.
- Partner with the rural health workforce agency (Rural Health West), an established local recruitment firm and an overseas agency to focus on GP recruitment in the Peel region with incentives being offered over and above the standard commercial terms to ensure focus on the region.

2022-23

- Coordinate a package of strategic incentives for practices in the Peel region to embed long term solutions to workforce issues.
- Development and launch of professional development, education, and training activities to support the retention of GPs. It is anticipated that this will be completed in partnership with Rural Health West, the Peel Health Campus and WA General Practice Education and Training.

The PHN will continue to consult and collaborate with key stakeholders to ensure activities are responsive and dynamic in response to workforce need.

Consultation

The activity will be guided by the WAPHA Stakeholder Engagement Framework which has been developed by the organisation to set clear standards and expectations for staff and external stakeholders, including:

- South Metropolitan Health Service
- Royal Australian College of General Practice
- WA General Practice Education and Training
- Australian Medical Association
- Peel Health Campus (Ramsay Health)
- Peel Development Commission
- Peel Regional Development Australia
- Local Government (City of Mandurah, Shire of Murray, Shire of Waroona, Shire of Serpentine/Jarrahdale)
- Hunter New England Central Coast PHN
- Tasmania PHN
- Elected members of Parliament (State and Federal) inclusive of Hon. Member for Canning Andrew Hastie

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Collaboration

Activities will occur with support from the following stakeholders:

- Rural Health West
- Nominated general practitioners and staff within the Peel Region
- Peel Health Campus
- WA General Practice Education and Training

Perth South PHN Needs Assessment

Priorities	Page reference
PSGP1.1 Increase access to general practice and improve the management of chronic disease management.	87

Coverage

Perth South PHN locations of Mandurah and Serpentine-Jarrahdale

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Activity Start Date	Activity End Date
15 June 2021	30 June 2023

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$500,000.00	$250,000.00	$0.00	$0.00

CF 6010 - Urgent Care Clinics Public Awareness and Education Campaign

Activity Title

Urgent Care Clinics Public Awareness and Education Campaign

Activity Number

6010

Existing, Modified or New Activity

New Activity

PHN Program Key Priority Area

Population Health

Aim of Activity

To reduce primary care type presentations at emergency departments by building knowledge and raising awareness among consumers about their options as part of a larger project to provide alternative and optimal urgent care options in a general practice setting.

Description of Activity

WA Primary Health Alliance has partnered with the WA Department of Health (WADoH) to address behavioural change encouraging people to choose primary care over hospital options. The optimal urgent care model has been identified as a General Practice Urgent Care Network (GPUCN), with membership for existing general practices demonstrating direct action towards integrated urgent care, supported by development and implementation of a public awareness campaign to improve urgent care awareness and knowledge, and demonstrated use of the GPUC Network.

A key component of the GPUCN project is the handover of patients from the GPUCN to the patient's usual general practitioner. This will be facilitated by use of the MEDrefer platform which connects to the practice software and populates the clinical handover information for easy submission by the general practitioner to the patient's usual practice. Deidentified data is also captured for use in monitoring project outcomes and measuring success.

Practices apply to participate in the GPUCN project. They are accepted into the network if they demonstrate the minimum expectations for how urgent care services are to be delivered within the GPUCN project. Membership to the GPUCN Project allows primary care urgent care providers endorsement within the DoH and WA Primary Health Alliance's community education and awareness campaign, support for improving lines of communication with public hospital emergency departments, opportunities for networking and direct contribution to the development of future policy and strategy for urgent care services in WA.

Success of the GPUCN is dependent on people's awareness and acceptance of such services. The intention is that the GPUCN will assist people's knowledge of primary care urgent care, options for management of urgent care, and specific locations for where urgent care can be managed. The GPUCN project has leveraged the National Health Services Directory and the booking platform vendors to create an Urgent Care landing page which shows all the general practices participating in the network and their next available urgent care appointment. This appointment can be booked directly via the landing page or HealthEngine, HotDoc, AutoMED, and CODD.

Training for general practice staff to up-skill in urgent care is a key component of the project. This includes general practitioners, practice nurses and other administration staff who manage the reception desk.

Further support for a public awareness and education campaign for the Urgent Care Clinics which is co-funded by WA DoH. The campaign included the development of the web interface and the public awareness campaign running on billboards, television, and online platforms across the metropolitan area and the South West region.

The Primary Health Network (PHN) will continue to monitor and assess the impact of COVID-19 on access to the primary health care services commissioned within this activity. Where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Perth South PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services.	12

Coverage

Perth South PHN locations of Armadale, Belmont-Victoria Park, Bunbury, Canning

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Activity Start Date | **Activity End Date**

1 January 2023 | 30 June 2025

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$0.00	$0.00	$52,500.00	$52,500.00

CF 7000 - COVID-19 Primary Care Support

Activity Title

COVID-19 Primary Care Support

Activity Number

7000

Existing, Modified or New Activity

New Activity

PHN Program Key Priority Area

Population Health

Aim of Activity

The activity aims to provide support for Australia's COVID-19 Vaccine and Treatment Strategy to the primary, aged care, and disability sectors within the Perth South PHN region.

The intended outcomes of this activity are to support and strengthen the primary health system and improve the health outcomes of the community.

Description of Activity

The PHN will advocate best practice approach of the COVID-19 Vaccine and Treatment Strategy to the primary, aged care, and disability sectors by:

- Providing guidance and expert advice to GP Respiratory Clinics, general practices, Aboriginal Community Controlled Services, residential aged care facilities (RACF), disability accommodation facilities and governments on local needs and issues.
- Coordinating the delivery of vaccination services to RACFs.
- Supporting vaccine delivery sites in their operation and ongoing quality control.
- Provide guidance on how COVID-19 positive people will be managed safely and effectively through primary and community care services.
- Continue to consult and collaborate with key stakeholders to ensure activities are responsive and dynamic in response to primary care needs.

Perth South PHN Needs Assessment

Priorities	Page reference
C19 Provide commissioned services, general practice and other primary care providers with regular and current COVID-19 information and assistance in pandemic planning.	15
C19 Work with commissioned services supporting vulnerable populations to ensure these groups ae fully supported in the event of future pandemics.	15

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
09 September 2021	31 December 2022

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core COVID-PCS	$426,907.68	$740,000.00	$0.00	$0.00

CF 8000 - COVID-19 Vaccination of Vulnerable Populations

Activity Title

COVID-19 Vaccination of Vulnerable Populations

Activity Number

8000

Existing, Modified or New Activity

New Activity

PHN Program Key Priority Area

Population Health

Aim of Activity

The activity aims to support and coordinate local solutions that enable the delivery of vaccinations to vulnerable populations including aged and disability care workers, those without access to Medicare, and individuals who cannot access or have difficulty accessing the vaccine through existing mechanisms.

Description of Activity

The PHN will continue to consult and collaborate with key stakeholders to ensure COVID-19 vaccination activities are responsive and dynamic in response to community need.

The PHN will:

- Collaborate with COVID-19 vaccination providers including general practice, pharmacy, PHN contracted providers, state health services and nurse practitioners to enable access of the COVID-19 vaccination to vulnerable people.
- Facilitate partnerships and work with local government, community organisations and Aboriginal Community Controlled Health Services on tailored solutions to suit local context.
- Communicate existing relevant COVID-19 assessment and vaccination funding mechanisms for vaccination services to GPs and health professionals.

The activity will be guided by the WAPHA Stakeholder Engagement Framework which has been developed by the organisation to set clear standards and expectations for staff and external stakeholders.

Perth South PHN Needs Assessment

Priorities	Page reference
C19 Provide commissioned services, general practice and other primary care providers with regular and current COVID-19 information and assistance in pandemic planning.	15
PSGP1.5 Reduce rate of PPHs by working with primary care providers to target specific areas where there are higher than state rates.	89

Target Population

Populations identified as having difficulty accessing COVID-19 vaccines include (but is not limited to):

- Those who are experiencing homelessness, including those living on the streets, in emergency accommodation, boarding houses or between temporary shelters.
- People with a disability or who are frail and cannot leave home.
- People in rural and remote areas with limited healthcare options, including those who cannot travel to a regional centre.
- Culturally, ethnically, and linguistically diverse people, especially asylum seekers and refugees and those in older age groups who may find it difficult to use other vaccination services.
- Those who do not have a Medicare card or are not eligible for Medicare.
- Aged care and disability workers, with consideration to all auxiliary staff working on-site.
- Aboriginal and Torres Strait Islander people.
- Any other vulnerable groups identified as requiring dedicated support to access vaccinations.

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
9 September 2021	31 December 2022

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core COVID-VVP	$250,000.00	$672,500.00	$0.00	$0.00

CF-CV 1000 – COVID GPLRC GP-led Respiratory Clinics

Activity Title

GP-led Respiratory Clinics

Activity Number

CF-CV 1000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

This activity has two objectives:

1. To ensure that Commonwealth Department of Health and Aged Care GP-led Respiratory Clinics can effectively support community members experiencing mild to moderate respiratory conditions and to reduce overall risk of exposure to COVID-19 across the community.
2. To facilitate the coordination of the rollout of the COVID-19 vaccination program through a variety of primary care channels and in partnership with key stakeholders.

Description of Activity

GP Respiratory Clinics

To maintain ongoing support to the GP-led Respiratory Clinics and general practice community and health providers by:

- Supporting the ongoing distribution of personal protective equipment to primary care services as directed by the Department of Health issued guidance.
- Collaborating with specialist health emergency providers for best practice guidance on infection control protocols.
- Utilising existing strong links between local service providers, including general practice clinics, pathology providers, local hospital networks, Aboriginal Community Controlled Health Services, Aboriginal Medical Services, organisations supporting CALD communities and minority and marginalised groups, Royal Australian College of General Practice and Australian Medical Association WA branch.
- Continue to support and fund GPRCs with capacity to expand services into

the afterhours (including weekend) period.
- Liaise with State and Commonwealth Health Departments to optimise the contribution of GPRCs.
- Ongoing communications strategy to increase public and health sector awareness of the role of GPRCs.
- Engage with GPRCs and general practices in their areas in advance of the GPRC program ceasing. Prior engagement will be needed to enable continuity of access to primary care services for patients with respiratory symptoms.

The GP-led Respiratory Clinics will take pressure off public hospital emergency departments and general practices by providing assessment and testing for respiratory illnesses, in addition to dedicated treatment to people with mild-to-moderate symptoms of fever or sore throat, cough, fatigue, or shortness of breath.

COVID-19 vaccination

To provide support for the COVID-19 Vaccine and Treatment Strategy (Strategy) to the primary, aged care and disability sectors as follows:

- Supporting the ongoing distribution of personal protective equipment in line with Department of Health issued guidance.
- Providing guidance and expert advice to GP-led Respiratory Clinics, general practitioners, Aboriginal Community Controlled Health Services, residential aged care facilities, disability accommodation facilities and governments on local needs and issues.
- Support vaccine delivery to be integrated within local health pathways to assist with the coordination of local COVID-19 primary care responses, including identification and assistance for GP-led Respiratory Clinics and general practices interested in participating, and ensuring consistent communications to local communities.

Perth South PHN Needs Assessment

Priorities	**Page reference**
C19 Provide commissioned services, general practice and other primary care providers with regular and current COVID-19 information and assistance in pandemic planning.	15
C19 Work with commissioned services supporting vulnerable populations to ensure these groups are fully supported in the event of future pandemics.	15
C19 Develop mechanisms to increase safe and easy access to GPs and commissioned services during a COVID-19 lockdown and encourage patients to continue consulting their general	15

practitioner.	

Collaboration

The PHN continues to work with the WA Department of Health, Health Service Providers/Local Health Networks, local emergency department teams, contracted service providers and other key providers to support the state's COVID response.

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
20 October 2020	30 June 2022

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
COVID-GPLRC	$545,031.04	$0.00	$0.00	$0.00

CF CV 2000 - Workforce Infection Control and Surge Capacity

Activity Title

Workforce Infection Control and Surge Capacity

Activity Number

2000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

To support infection control training to the primary care, aged care, and broader health care workforce sectors.

Description of Activity

This activity will include dissemination and direct delivery (online if appropriate) of training materials, development of training plans for the sector in their areas and development of an Infection Prevention and Control HealthPathway for General Practitioners.

This activity will also support coordination activities to identify options to address workforce shortages in the Perth South PHN regions.

Perth South PHN Needs Assessment

Priorities	Page reference
Develop mechanisms to increase safe and easy access to General Practice and Commissioned Services during a COVID-19 lockdown and encourage patients to continue consulting their General Practitioner.	15

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
16 May 2020	31 December 2022

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Core Flexible COVID-19 VVP	$183,969.83	$0.00	$0.00	$0.00

CF CV 9010 - Living with COVID-COVID 19 Positive Community Care Pathways

Activity Title

Living with COVID – COVID-19 Positive Community Care Pathways

Activity Number

9010

Existing, Modified or New Activity

New Activity

PHN Program Key Priority Area

Population Health

Aim of Activity

This activity will support effective and efficient community care management of COVID-19 patients outside of hospital and provide confidence and assurance to the community and health professionals in the region. It will support and strengthen the health system to manage the anticipated increase in COVID-19 cases and support people in the community who may be positive and not require hospitalisation.

Description of Activity

WA Primary Health Alliance will work in partnership with Health Service Providers (HSPs), general practitioners (GPs) and the Aboriginal Community Controlled Health Sector (ACCHS) to develop or update COVID-19 positive community care pathways for the Perth South PHN region. The pathways will:

- Provide clear treatment and escalation pathways through the local health system which supports both primary care and hospitals so that they are not overwhelmed or treating patients in clinically inappropriate settings.
- Be consistent with the overall national scheme for COVID-19 positive community care pathways, with relevant State guidance, and with the Royal Australian College of General Practice guidelines for care of COVID-19 positive patients.
- Be responsive to the needs of at risk populations, including people in residential aged care facilities, older Australians, Aboriginal and Torres Strait Islander Australians, people with disability, culturally and linguistically diverse groups, and people in socioeconomically disadvantaged

circumstances.
- Support efficient testing arrangements including after hours access to assessment and care.
- Clearly delineate between formal hospital in the home arrangements (where the patient is admitted by a doctor to receive care delivered by a hospital) and where the patient does not require admission GP-led care in the community.
- Information will be provided about resources and services that could assist with caring for COVID-19 positive people in the community.
- Development, ongoing review and maintenance of a number of comprehensive statewide localised HealthPathways for the assessment, management and treatment of COVID-19 positive patients, in line with National, State and Royal Australian College of General Practitioner guidelines.
- The HealthPathways will include vaccination, infection prevention, infection control and practice preparedness information.
- Work in partnership with the WA Department of Health and Health Service Providers to develop a core COVID-19 Positive Community Care Pathway for Western Australia, with localisation as required

Perth South PHN Needs Assessment

Priorities	Page reference
C19 Connecting vulnerable older adults residing in RACFs and in the community to mental health support services including the use of technologies to improve social connectedness.	15
C19 Provide commissioned services, general practice and other primary care providers with regular and current COVID-19 information and assistance in pandemic planning.	15
C19 Work with commissioned services supporting vulnerable populations to ensure these groups are fully supported in the event of future pandemics.	15

Target Population

This activity focuses on primary care needs of people living in the Perth South PHN catchment to enable the provision of health care to COVID-19 positive clients in the community

Consultation

The PHN consulted with and continues to consult with a range of key stakeholders in the planning and delivery of the Living with COVID initiatives, including:

- WA Department of Health
- Local Health Networks
- Regional Emergency Response Operations Committees
- Royal Australian College of General Practitioners WA
- Aboriginal Health Council of WA
- WA Council of Social Services
- Local Government Areas
- Subject Matter Experts pertinent to HealthPathways development

Collaboration

The PHN is working with the Royal Australian College of General Practitioners WA, WA Department of Health, Local Health Networks, Health Service Providers, Aboriginal Health Council of WA, WA Council of Social Services, Local Government Areas, PHN Contracted Service Providers and other key stakeholders to support the state's COVID-19 response.

WA Health: Ongoing collaboration with WA Health to inform the development of relevant COVID-19 response guidelines and processes through regular meetings.

Coverage

Perth South PHN region

Activity Start Date	**Activity End Date**
1 March 2022	31 December 2022

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
CF-CV-LWC	$150,000.00	$37,500.00	$0.00	$0.00

CF CV 9020 - Living with COVID – Support for Primary Care from the National Medical Stockpile

Activity Title

Living with COVID – Support for Primary Care from the National Medical Stockpile

Activity Number

9020

Existing, Modified or New Activity

New Activity

PHN Program Key Priority Area

Population Health

Aim of Activity

To support the management of COVID-19 positive cases in the community through access, compliance arrangements, and distribution of Personal Protective Equipment (PPE) and pulse oximeters from the National Medical Stockpile (NMS) to individual primary care practices within the region which includes to general practices, General Practice Respiratory Clinics (GPRCs), Aboriginal Community Controlled Health Services (ACCHSs).

Description of Activity

The PHN will ensure distribution to general practices, ACCHS and GP Respiratory Clinics of PPE and Pulse Oximeters by providing and maintaining a gateway for ordering, monitoring distribution and arrival items (in association with DHL) and responding to urgent requests for PPE in extenuating circumstances.

PPE is available to general practice, ACCHS and GP Respiratory clinics willing to see COVID-19 positive patients face-to-face includes:

- PPE bundles - One PPE bundle will support approximately 4 weeks of COVID-19 positive patient consultations per clinical staff member (i.e., 40 patient consultations 20 patients with 2 consultations each. Clinicians with an existing high COVID caseload, or who are in a hot spot, will be eligible to apply for top up PPE or additional pulse oximeters.
- Pulse oximeters will be available to hotspot or outbreak areas, with a maximum of 5 offered. Clinicians will be responsible for distributing the oximeters following assessment of patients who are at high risk of developing serious symptoms and provide a pulse oximeter to use at home.

- P2/N95 respirators and eye protection will be available to GPs, ACCHSs and GP Respiratory Clinics willing to support COVID-19 positive people virtually, and respiratory patients face-to-face, until 31 March 2022.

In addition to distribution of PPE from the National Stockpile, the PHN will continue to facilitate access to PPE or where there is a major outbreak, or a hotspot has been declared by the Commonwealth Chief Medical Officer, or to health practitioners with demonstrated need, including where:

- There is no local supply available commercially.
- Practices are in a location where there may be community transmission of COVID-19.
- Practices that have an unusual number of patients presenting with respiratory symptoms.

Perth South PHN Needs Assessment

Priorities	Page reference
C19 Provide commissioned services, general practice and other primary care providers with regular and current COVID-19 information and assistance in pandemic planning.	15

Target Population

- General Practice Respiratory Clinics (GPRCs), Aboriginal Community Controlled Health Services (ACCHSs) clinicians who agree to see COVID-19 positive people face to face.
- Community Pharmacists administering the COVID-19 vaccinations and booster doses.

Consultation

The PHN consulted with and continues to consult with a range of key stakeholders in the planning and delivery of the Living with COVID initiatives, including:

- Royal Australian College of General Practitioners WA
- Australian Medical Association WA
- Pharmacy Guild WA

Collaboration

The PHN is working with the RACGP WA, AMA WA and Pharmacy Guild WA to ensure clear messaging and advice is provided to General Practitioners and Pharmacists re the provision of PPE via the NMS.

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
01 February 2020	31 December 2022

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
CF-CV-LWC	$101,883.36	$151,276.97	$0.00	$0.00

CF CV 9030 - Living with COVID – Home Visiting Service

Activity Title

Living with COVID – Home Visiting Service

Activity Number

9030

Existing, Modified or New Activity

New Activity

PHN Program Key Priority Area

Population Health

Aim of Activity

To increase access to medical and nursing primary care home visiting services to COVID-19 positive patients:

- Where their general practitioner (GP) does not have capacity,
- Where they do not have a managing GP, or
- During the afterhours period where the regular GP is not available.

The activity outcome is to avoid unnecessary escalation of patients to hospital.

Description of Activity

The Primary Health Network (PHN) will commission medical deputising and nurse practitioner/nursing services to provide a Home Visiting Service for COVID-19 positive patients to increase GP capacity.

General practitioners who care for COVID-19 positive people, will be able to refer COVID positive people to the service via established referral pathways, where assessment and management of COVID-19 symptoms or other health conditions is required to assist in avoiding unnecessary escalation to hospital.

Subject to workforce availability the Home Visiting Service will be provided across the 24-hour period via face-to-face home visits or where necessary, through the use of technology (telephone or video conferencing).

Home Visiting Service providers will establish and maintain relevant clinical governance and occupational health processes to manage staff risk and safety, consistent with Australian and Western Australian Government directions and guidance, and National COVID-19 Evidence Taskforce guidelines, and relevant established WA COVID HealthPathways.

The Home Visiting Service will be undertaken by suitably qualified and experienced staff, and the interaction between the Home Visit Service staff and GPs (and other relevant service providers, such as pharmacists, providers of Residential Aged Care Facility / congregate living services) will be based on established communication and escalation processes.

The PHN will focus on the management of the performance of the contracted provider/s including:

- Reviewing, monitoring, and evaluating service provision.
- Collecting required data from the service provider as described in the Deed of Variation and providing reports to Department of Health and Aged Care.

Perth South PHN Needs Assessment

Priorities	**Page reference**
C19 Develop mechanisms to increase safe and easy access to GPs and commissioned services during a COVID-19 lockdown and encourage patients to continue consulting their general practitioner.	15

Target Population

This activity will focus on COVID-19 positive people in the PHN region, with a particular focus on people living in Residential Aged Care Facilities, Mental Health Hostels and Aboriginal communities, and other high-risk groups as identified as required.

Consultation

The PHN consulted with and continues to consult with a range of key stakeholders in the planning and commissioning of the Home Visiting Service.

Key stakeholders at a state level include:

- WA Health, Health Service Providers (Local Health Networks) and Mental Health Commission: ongoing consultation to inform the development of the service specifications, appropriate alignment of services to current needs, and engagement with key stakeholders.
- Primary Health Care Professionals, including General Practitioners: ongoing consultation to inform the development of the service specifications and processes, appropriate alignment of services to current needs, and engagement with key stakeholders
- Residential Aged Care Facilities and approved Mental Health Hostels: ongoing consultation to inform the development of the service specifications and processes, and appropriate alignment of services to current needs.
- Australian Government, WA Aged Care Office: as part of the Outbreak Management Team consultation to inform the development of service escalation pathways.
- Department of Communities and sector organisations including Shelter WA and WACOSS.
- Aboriginal Health Council Western Australia (AHCWA) and Aboriginal Community Controlled Health Services (ACCHSs): ongoing consultation to inform the development of the service specifications and processes, and appropriate alignment of services to current needs.

Collaboration

- WA Health and Mental Health Commission: As part of the state's COVID-19 response planning and coordination, ongoing through regular meetings, and a letter of agreement, enabling WA Health to contribute to the provision of the Home Visiting Service to COVID-19 positive residents living in approved Mental Health Hostels (MHH).
- RACFs/MHHs: ongoing through the establishment and implementation of service delivery, communication, and escalation processes.
- General Practitioners: ongoing through the establishment and implementation of service delivery, communication and escalation processes.
- AHCWA and ACCHS**:** ongoing through the establishment and implementation of service delivery, communication and escalation processes.

Indigenous Specific Comments

Yes. This activity is targeted to Aboriginal people through the commissioning of ACCHSs. The commissioned mainstream providers do not specifically target the service to Aboriginal people, however Aboriginal people may also access the mainstream service.

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
14 March 2022	31 December 2022

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
COVID-19 LWC	$485,542.20	$183,885.55	$0.00	$0.00

HSI 1000 - Health System Improvement

Activity Title

Health Systems Improvement

Activity Number

1000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

To enhance the integration and coordination of primary health care services by undertaking data analysis and working strategically with local communities, clinicians, service providers, government agencies and other stakeholders to:

- Identify and prioritise health care needs through population health planning.
- Commission and monitor safe, high quality and culturally appropriate services to improve access to care for people with an increased susceptibility to adverse health outcomes as a result of inequitable access to the resources needed to address risks to health. Assess and realise opportunities for joint commissioning arrangements with strategic partners.
- Progressively improve system performance, health outcomes and the quality and safety of primary care services.
- Ensure primary health care gains and potential are understood and utilised at regional, state, and national levels.
- Underpin PHN and Government reform related decisions and activities with advanced digital health and data analytics capacity and governance structures that facilitate partnership approaches.
- Direct resources to where they are most needed and where they will have the greatest impact.

Description of Activity

WA Primary Health Alliance (WAPHA) is the operator of three Primary Health Network (PHN) regions - Perth South, Perth North, and Country WA. As a statewide agency, WAPHA is well positioned to systemically improve the quality, standard and connection of primary health care services across WA.

Strategic planning activities include:

- Leveraging WAPHA's statewide remit to consider and address system-wide

issues of equity and access and progress actions to address local, regional, state, and national priorities.

- Understanding and interpreting Australian Government Guidance and health policy reform and translating it for application within the local primary health care context.
- Progressing the strategic objectives of the National Health Reform Agreement and 10-year primary health care plan by working with the State-funded health system to continuously improve health outcomes and address inequity in WA.
- Continued leadership of the national PHN Cooperative and collaboration with other PHNs to ensure collective value and impact is optimised and PHN effectiveness is enhanced through sharing models of care, learnings, and resources.
- Demonstrating commitment to joint planning, shared accountability, and co-commissioning through formalised relationships with partners/system managers including the WA Mental Health Commission and Health Service Providers.
- Working with other state-wide agencies, such as the Aboriginal Health Council of WA, Mental Health Commission, and the Departments of Health and Communities to ensure that primary health care is appropriately represented to shape the direction of the WA health system and deliver better connected, patient-centred, high quality, innovative and sustainable care.
- Collaboration with training organisations, professional colleges, and health workforce agencies to plan for the future primary health care workforce and improve workforce capability.
- Cultivating local relationships and engaging with relevant stakeholders to coordinate care and develop pathways appropriate to local needs. This includes developing, trialling and evaluating integrated care precincts to attend to unmet need and reduce duplication, gaps and fragmentation in services.
- Planning, developing, and maintaining agile, comprehensive, primary health care pandemic and disaster response and management capabilities and coordinating a strong primary health care response to deliver care where and when it is needed.
- Joint advocacy on behalf of primary health care stakeholders to influence primary health care reform and decision making.
- Leading the development of evidence based, innovative, best practice models of primary health care and evaluating initiatives against the Quadruple Aim.
- Developing the cultural competence and capability of WAPHA and commissioned primary health care services to better meet the needs of

priority communities.

Data Analytics activity includes:

- Increasing data and analytics capacity and capability for WAPHA.
- Assigning appropriate data governance roles and responsibilities.
- Reducing exposure to information risk that would negatively impact WAPHA's ability to meet program objectives, as well as impose appropriate confidentiality restrictions to effectively manage disclosure risks and appropriately safeguard personal and private information.
- Improving data quality to ensure the provision of accurate and reliable information.
- Developing WAPHA's data and analytics capacity with appropriate training and infrastructure.
- Taking a systemic approach to the use of evidence; drawing critical insights to drive continual improvement in primary health care.
- Maturing WAPHA's approach to data sharing and linkage through formal governance arrangements with key stakeholders.

Digital Health activities include:

- Working across the primary health care system to enhance readiness for digital health adoption, and to improve workforce participation and confidence in digital health.
- Implementing programs within Digital Health that are guided by the objectives of the Quadruple Aim and health priorities.
- Encouraging and influencing the use of specific digital health tools, such as My Health Record and Health Pathways WA.
- Assisting health care providers to understand and make meaningful use of digital health and collaborate with partners to pilot and innovate in the digital health context.
- Prioritising good data governance and privacy principles in all aspects of digital health.
- Supporting health care providers to improve data quality and undertake data driven quality improvement.
- Taking a future focused approach to understanding opportunities for primary health care in virtual care, point of care testing and e-prescribing, for example.

Population Health Planning activity includes:

- Identifying the health priorities of the local populations in WA with a key focus on people with an increased susceptibility to adverse health outcomes as a result of inequitable access to the resources needed to address risks to

health.

- Understanding supply and demand and identifying service shortages based on a broad range of qualitative and quantitative data collected by WAPHA, received from external partners, or which is publicly available.
- Identifying barriers and enablers for access to primary health care for people with a key focus on people, with an increased susceptibility to adverse health outcomes as a result of inequitable access to the resources needed to address risks to health.
- Utilising and working towards effective partnerships with other organisations for shared data capture and linkage to inform joint planning.

Commissioning activity includes:

- Identifying opportunities for state-wide and place-based joint planning and coordinated commissioning.
- Developing and utilising frameworks to apply a consistent state-wide and locally tailored approach to the design, commissioning, monitoring and evaluation of outcome-based interventions to address prioritised health and service needs.
- Ensuring that commissioned primary health care services in WA are evidence based, meet local identified population health needs effectively and efficiently and are sustainable.
- Encouraging the coordination and partnership of local services to meet the needs of their community and to facilitate system integration.
- Continuing to monitor and respond to emerging trends in health and service needs.
- Contract managing performance of contracted providers through a relationship-based approach and monitoring and evaluating the impact of commissioned programs.
- Designing and commissioning services that remove duplication, foster connection, and strive for seamless patient care.

The WA Primary Health Alliance Commissioning cycle for both state-wide and place-based services involves:

- Planning - to identify local needs and service gaps based on data and service analysis and consultation with key stakeholders.
- Designing - using best practice models and with local and state-wide service providers and stakeholder to develop appropriate service responses.
- Procurement -using a range of approaches based on an analysis of the marketplace including EOIs, Requests for Proposal and Requests for Tenders.
- Monitoring and Review - outcome-based contracts and reporting are developed and implemented across WA Primary Health Alliance. The

implementation of the Performance Management Framework will occur with clinical mental health services the first to get standardised mental health indicators followed by other programs such as drug and alcohol, Aboriginal health, and chronic conditions.
- 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.

Perth South PHN continues 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) that, 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.

This activity will assist the PHN to:
- Understand how effective services and systems are in relation to patient experience and patient health outcomes with focus on the efficacy of treatment to deliver a positive client outcome.
- Improve service/system integration, service sustainability including provider experience/governance and findings of formal evaluation (if conducted externally).

Perth South PHN Needs Assessment

Priorities	**Page reference**
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11
Ensure integrated and stepped care services are available for people experiencing mental health issues, including younger people.	18
Improve coordinated and integrated care for people experiencing complex and severe mental health who can be managed in within primary care settings.	18
Promote integration and coordinated care pathways for clients with mental health condition and harmful alcohol and other drug use.	27

Coverage

Perth South PHN region

Activity Start Date	**Activity End Date**
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Health Systems Improvement	$2,658,258.50	$3,439,135.89	$2,547,187.05	$2,547,187.05

HSI 1010 - General Practice Support

Activity Title

General Practice Support

Activity Number

1010

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

To build capacity and capability of WA general practice to work in an integrated manner and respond to Commonwealth Department of Health and Ageing policy direction.

The activity includes two initiatives:

1. Support general practice staff and clinicians to provide 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.
2. Enabling general practice to provide holistic care to their patient population through data driven quality improvement initiatives and by leveraging technology. Consistent with the Quadruple Aim of the Patient Centred Medical Home model the activity will be underpinned by Bodenheimer's ten building blocks of high performing primary care.

Description of Activity

General Practice Support will be provided to all staff working in general practice. This includes multidisciplinary staff, such as general practitioners, practice managers, practice nurses and support staff.

Support to general practice staff - support will be provided via a number of channels.

- The Practice Assist website (www.practiceassist.com.au) allows general practice staff to search through a comprehensive library of resources, templates and factsheets on a variety of topics. They will be able to search for upcoming education events and webinars, find information on research

studies and surveys, and links to the Practice Assist newsletter. Ongoing work includes reviewing and maintaining the website keeping content up to date. It also includes generating or curating new content in line with identified needs, feedback and new policy or programs.

- The Practice Assist helpdesk provides non-clinical support by phone and email to all general practice staff with an aim to respond to simple queries within 1 business day and more complicated queries within 3 business days, this may include liaising with subject matter experts within the Primary Health Network (PHN).
- Practice Support Staff regularly provide more in-depth support and coaching, centred around quality improvement and practice needs. They also provide and navigate information and support on a range of topics including accreditation, cancer screening and immunisation. This in-depth support can occur virtually or face to face.
- 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 Connect newsletter and through practice contacts.
- Inform, educate, and utilise quality improvement tools to increase practice uptake of 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 contacts.
- Contributing to service directories containing information that practices require when making referrals to specialist and community-based services. These include HealthPathways request pages, National Health Service Directory and My Community Directory.
- Networking and education events are facilitated to allow practice managers and practice nurses to share lessons both of what works well and also the challenges they experience. Updates are also provided through these forums.
- Webinars and Community of Practice forums for General Practitioners around topical issues and priority subjects identified by the PHN and GPs.
- Updating practices on Commonwealth health policy initiatives such as Practice Incentives Program (PIP) Quality Improvement (QI) incentive and Workforce Incentive Program (WIP) to support understanding and access.
- Connecting general practices with quality, evidence-based services to support their patient needs in their catchment areas, including WA Primary Health Alliance’s commissioned services.
- Data analysis regarding the practices’ screening targets and service delivery to enable their continuous improvement.
- Utilising various modalities including face to face sessions, small group sessions and use of online/technology-based resources such as webinars and

special interest groups (e.g., Project ECHO).

Data driven quality improvement

Enabling practice transformation will have a whole of general practice approach to support data driven quality improvement (QI) activities to improve the health outcomes of the practice population. This will be achieved by:

- Providing access to a highly advanced business intelligence toolset (including data extraction) license at no cost to practices who have a data sharing agreement with the PHN.
- The business intelligence too set will support general practices to make timely decisions for better health care for their respective populations. This data supports service and business planning, reporting and population health needs.
- Providing ongoing training and support to leverage the business intelligence 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 digital health platforms including My Health Record (MYHR) and secure messaging.
- 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.

The PHN will continue to monitor and assess the impact of COVID-19 on this activity. Where required, strategies may be modified, and additional strategies commenced to help the PHN to continue to meet the aims of the activity.

Peth South PHN Needs Assessment

Priorities	Page reference
Improve the rates of cancer screening and reduce avoidable deaths from cancer.	11
Improve the rates of cancer screening and reduce avoidable deaths from cancer.	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11
Increase Aboriginal childhood immunisation rates for regions not meeting national immunisation targets.	34

Ensure Aboriginal people are accessing immunisations (e.g., influenza)	34

Coverage

Perth South PHN region

Activity Start Date	**Activity End Date**
01 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Health System Improvement	$358,996.97	$428,452.18	$319,768.64	$319,768.64

HSI 1020 - HealthPathways

Activity Title

HealthPathways

Activity Number

1020

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

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 general practitioner clinical editors who are supported by Primary Health Network (PHN) coordinators and project support staff. The team develops and maintains content and raises awareness of the product in general practice.

The main activities of the HealthPathways team includes:

- Identifying and developing new pathways (particularly relevant to COVID-19).
- Authoring the content.
- Reviewing and incorporating best practice guidelines.
- Facilitating multi-disciplinary working group meetings.
- Mapping services and updating the provider databases (such as the My

Community Directory etc.).

- Maintaining and updating the HealthPathways and the HealthPathways website.
- Facilitating pathway consultation in conjunction with WA Department of Health – Health Networks.
- Monitoring and evaluating uptake of the tool and presenting and providing education about HealthPathways.

The PHN will continue to monitor and assess the impact of COVID-19 on this activity. Where required, strategies may be modified, and additional strategies commenced to help the PHN to continue to meet the aims of the activity.

Perth South PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services.	12
Support primary care health care providers to manage chronic disease populations and build capacity for patient self-management.	11

Coverage

Perth South PHN region

Activity Start Date	Activity End Date
01 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 21 22	FY 22 23	FY 23 24	FY 24 25
Health system Improvement	$163,729.56	$174,661.09	$150,161.44	$150,164.44

HSI 2000 - Stakeholder Engagement and Communication

Activity Title

Stakeholder Engagement and Communication

Activity Number

2000

Existing, Modified or New Activity

Existing

PHN Program Key Priority Area

Population Health

Aim of Activity

Communications and stakeholder engagement activities aim to establish and nurture strong and meaningful relationships with the diversity of stakeholders in primary care.
Establishing and maintaining trusting and purposeful relationships is essential to achieving our vision of better health, together.

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 and practice improvement. Demonstrating and maintaining a positive reputation is essential as an approach to managing risks for WA Primary Health Alliance as a local commissioner, and for risks to the Primary Health Network (PHN) program.

Effective communication with our stakeholders ensures:

1. Delivery of targeted information (particularly relevant in the context of COVID-19).
2. Effective communication activities also ensure identification and understanding of the role and scope of WA Primary Health Alliance.
3. Upholding a strong reputation with stakeholders improves our ability to engage all relevant stakeholders as we mature our practice in codesign throughout the commissioning cycle.
4. 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.
5. 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 designing and achieving the intended outcomes.

Description of Activity

Communications and Marketing - WA Primary Health Alliance communications team will:

- Continue to focus on setting the communications strategy for the organisation and on delivering high quality written and digital communications both internally and externally.
- Develop strategic key messages to align with the Strategic Plan 2020-2023 targeted at specific high interest/ high influence groups and used to educate our staff, Board and Council members to ensure we speak to our stakeholders consistently.
- Continue to build our audiences and engage with them in a targeted manner, consistently and appropriately; refining our communication approach and channels, ensuring cultural appropriateness, and building on those which are most effective; developing our online/ digital presence to ensure our voice is heard and that we are part of strategically important online conversations.

Stakeholder Engagement - WA Primary Health Alliance will

- Embed the refreshed Stakeholder Engagement Framework into all areas of the organisation.
- Continue to define and prioritise stakeholders to ensure we maximise the value, or potential value, of the stakeholders' relationships with WA Primary Health Alliance. 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.
- Focus on developing commissioning approaches and practices that work towards increasing the opportunities for a collaborative design approach to be applied
- Continue to improve the ways in which community, consumers, family, and carers are engaged across the commissioning cycle.
- Implement the activities as outlined in the Stakeholder Engagement Framework Roadmap, with an emphasis in 2022/23 on our digital enablers to engagement.
- Work to increase (externally) 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.
- Further develop the WA GP Advisory Panel, in partnership with Rural Health West and RACGP (WA), to provide a trusted platform through which to engage the expertise and interest of general practitioners in operational and strategic directions setting and policy implementation.
- Investigate the potential for the WA GP Advisory Panel approach to be initiated in other disciplines of primary care, such as for Allied Health.

WA Primary Health Alliance will continue to develop and strengthen relationships with Members and Partners through formal Memorandums of Understanding and Membership arrangements with like-minded organisations.

The PHN will continue to monitor and assess the impact of COVID-19 on this activity. Increased adoption of digital engagement and communication methods has been well received by stakeholder and will continue to be used where appropriate. Where required, strategies may be modified, and additional strategies commenced to help the PHN to continue to meet the aims of the activity.

Peth South PHN Needs Assessment

Priorities	**Page reference**
Engage with primary health care providers and Local Hospital Networks to improve transitions of care, care coordination and service linkages.	90

Coverage

Perth South PHN region

Activity Start Date	**Activity End Date**
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	**FY 21 22**	**FY 22 23**	**FY 23 24**	**FY 24 25**
Health system Improvement	$509,150.17	$446,796.38	$333,459.56	$333,459.56